ESS **Extension of Social Security**

Extending health protection in Tanzania

Networking between health financing mechanisms

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Contents

Summary

The majority of the population in Tanzania are dependent on low and irregular incomes. Many people have been effectively excluded from access to appropriate health care because of the introduction in 1993 of user fees for public health services. Membership of public social security schemes including health insurance is tied to formal employment and only 4 per cent of the labour force is employed in the formal sector. Social disintegration is growing and strategies to sustain livelihood, based on social relationships and networks, are easily strained. On the other hand, new social organizations and systems are being based on profession, occupation or religion. One of their principle objectives is to secure access to health care at any time – at least at the primary care level.

However, both formal and informal social security mechanisms cover only small sections of the population. Extending coverage can be based on networking various small-scale social security schemes with mutual acceptance of membership; on developing area-based schemes; and on using local institutions like churches for implementing social security mechanisms. The diversity of such mechanisms provides choice and creates and sustains the flexibility needed to respond to different circumstances. Publicly supported measures are necessary such as the official registration of collective health-financing mechanisms, or the redistribution of resources among these mechanisms including formal social security institutions. A combination of different networks (church schemes, area-based schemes or formal social security schemes) could extend coverage to almost the whole population. However, mechanisms for the redistribution of resources among these schemes through cross-subsidies and external subsidies should be put in place. These subsidies would be accessible for all schemes provided with official registration.

Abbreviations

CHF	Community Health Fund
ECLT	Evangelical Lutheran Church in Tanzania
GoT	Government of Tanzania
NGO	Non-governmental organization
NHIS	National Health Insurance Scheme
NSSF	National Social Security Fund
PRSP	Poverty reduction strategy paper
ROSCAS	Rotating savings and credit clubs
SAP	Structural adjustment programme
TEC	Tanzanian Episcopal Conference
UNDP	United Nations Development Programme
UMASIDA	Community for Health Care in the sector that is not formal in Dar es Salaam (Umoja wa Matibabu katika Sekta Isiyo Rasmi Dar es Salaam)
VAT	Value-added tax

Introduction

Like many other countries, the Structural Adjustment Programme (SAP) policies applied to Tanzania caused severe problems, especially in the areas of social security and health care services. SAP resulted in a general fall in living conditions and livelihoods. Along with the SAP, the government in 1993 introduced fees for using health services. In Tanzania, people were used to paying for the services of private health providers, but public services had always been free. A Poverty Reduction Strategy Paper (PRSP 2000/2001), currently under implementation, waives school fees at primary level, but introduces user fees for health services. The policy of the Ministry of Health is to introduce these fees to the level of dispensaries and health centres. In some districts this system is already in place.

Most Tanzanians have a low and irregular income, which results in periodic shortages of money for family health care. During such periods they are effectively excluded from access to appropriate health services (van Ginneken 1999). Moreover, people are already financing and delivering health care needs in the *care economy,* that is, by looking after and nursing patients at home and treating ailments with popular medicine.

Since the living conditions of a population and the ways to establish social security depend on economic development, one of the main challenges is not only to create new social security systems and mechanisms but also to recognise the roots of the ongoing economic and social changes. Efforts to improve the social security system should be integrated into the national social and economic policy. It is necessary to analyse processes of impoverishment instead of using a static definition of poverty (Lachenmann 1994). This has implications for structural inequality that creates insecurity, and for the potential of self-help initiatives and organizations. The concept of *vulnerable groups* does not take account of the potential for self-help. Likewise, it is also the task of the Government to establish supportive measures to secure the incomes of people so that they can live in sustainable conditions. In addition, measures to recreate and stabilize solidarity among the population should be supported.

The aim of this paper is to present the possibilities for extending the coverage of social protection by applying the concept of social *interfaces* (Long 1989)[1], in the area of social security. It is considered that an integrated approach characterized by networking and by linking different social security arrangements is one appropriate way in which the coverage of social protection may be extended. This approach is followed because it involves all social security partners and at the same time gives people the choice between the various security mechanisms that fit their specific needs.

In order to meet the objective of extending social security, it is necessary to understand and to analyse the potential areas of conflict and interlinkages between:

[1] The concept of *interface* (Long 1989) entails not only the description and analysis of concepts and strategies at different social and institutional levels, but also their interaction and mutual influence that provide possibilities for change.

- The daily needs and social security mechanisms of people with low and irregular incomes;

- Newly developed forms of self-organization;

- Established approaches of non-governmental (NGO) health institutions; and

- Public efforts to start different types of health insurance (e.g. National Social Security Fund (NSSF), National Health Insurance Scheme (NHIS) and Community Health Fund (CHF).

The main focus of the analysis lies in the time scale, the type of social relation, the distribution of resources and the locality.

The overall goal of social policy is not only to extend formal social security schemes (e.g. insurance) to the so-called informal sector, but also to study the quality of existing social relationships and networks, sets of rules and other factors. This will strengthen the capacity of these relationships and assist their integration into nation-wide efforts of making health services accessible for all.

Social security mechanisms can be found at different levels of society, including:

- Family networks and other social relationships that are the basis of social organizations;

- New forms of self-organization with special emphasis on social protection aspects (informal social institutions); and

- Formal social security institutions.

These findings are based on empirical research, which was carried out in Tanzania between 1999 and 2001 mainly in the districts of Dar es Salaam, Arusha and Lushoto. Research instruments were primarily interviews and group discussions with representatives from different stratas of society. Most of the interviews were conducted in Kiswahili, and some in English.

The first part of this paper examines the variety of social security arrangements.

Chapter one considers the wide range of concepts that are used in the discussion of social security. In order to understand the social reality of the population it is necessary to have a broadened concept of social security – one that embraces not only formal schemes but also informal and conventional mechanisms. The strategies to construct and maintain this, in the context of events and livelihoods, are part of the social organization. In chapter two the main principles and challenges of social security are presented and described as dimensions

that need to be understood when reviewing possibilities for linking different approaches. Special emphasis is put on the change in patterns of responsibilities and benefits during an individual's life and the time gap between contribution and benefit. Chapter three highlights the complexities of the different layers of social security. Special modes of levelling out irregularities can be generated through the combinations and networking of mechanisms.

The second part of the paper explores and analyses the collective health-financing mechanisms in Tanzania, in the context of the dimensions of social security that have already been described.

Chapter four discusses briefly the different forms of collective health financing including formal and informal mechanisms. Chapter five describes and analyses the possibilities and potential for extending social protection, especially that which concerns health services. These possibilities are derived from existing linkages between different social dimensions and are then discussed in the context of health schemes already in place. Finally, in chapter six the responsibilities and tasks of the State are discussed and expanded, especially when considering mechanisms of vertical redistribution within society as a whole.

The paper closes with conclusions and a review of opportunities and possibilities of the various forms of networking.

Part I - The variety of social security arrangements

1. Social security: A concept in change

This paper is centred on concepts of social security for the informal sector including small-scale agriculture in rural areas. One of the main aspects that determine the livelihood of people in the so-called informal and subsistence sector and in small-scale agriculture is that they are constantly struggling for and establishing social and economic security. They are not living in a *status* of security but in an ongoing *process* of actively searching for security (Elwert / Evers 1983).

Since the majority of the population do not work in formal employment their security is mainly created outside the formal systems as well. Large parts of the literature on social security focus on formal mechanisms for a population that is engaged in the formal labour market. Frequently, a State-centred definition of social security does not include the contributions provided by self-help organizations (family structures, associations, and religious groups) and other social organizations like co-operatives (Lachenmann 1997b).

In the debate on social security the concept was broadened from focusing only on income generation towards the securing of livelihood and basic needs in general, but also towards formal institutions and the wider perspective of social organizations. Social security does not only include formal schemes but also conventional informal security measures. A member of a society has a series of duties and obligations to others in the society, as well as a

set of rights. These rights and obligations, which are directed towards what can be expected from other members, change during their lifetime.

Social security is an integral part of social organization and is one of the basic conditions for the survival of societies and their members. Social security implies:

- The social means and collective arrangements (e.g. social relations, institutions, and belief systems);

- The benefits provided by these means and arrangements to individuals and collectives in dealing with uncertainties that are not considered to be an exclusive matter of individual responsibility;

- Food, safe water, shelter, care, physical and mental health, education, and income.

Social security includes efforts:

- To protect against sudden loss of incomes and livelihoods,

- To protect against the reduction of means of existence, and

- To enhance people's capability to cope with uncertainties.

The definitions of uncertainty as well as the means to overcome it underlie permanent re-construction through collective action. This definition follows the perception and evaluation, and the possibilities and strategies to deal with uncertainties in any society (von Benda-Beckmann et al. 1988 and 1994). Since economic life is permanently in transformation, the mechanisms that provide security are under constant re-construction. New forms of social security mechanisms are created by groups and associations on the basis of profession, occupation or religion.

Responsibilities and entitlements within a society are defined among individuals, social units (e.g. family), and social institutions. For instance it is not easy to compare *burial societies* to groups that were established to finance health services. Death is often perceived as a social event that concerns a wider social context (village or community), whereas illness is usually the responsibility of the relatives alone. However, since transformation processes go on, these definitions of responsibility change as well, including the construction of *new relatives*. This process can be seen in new forms of social organizations like groups based in the same local area. Hence, social organization is an integral aspect of social life. This approach regards social security as a multi-dimensional complexity that is constantly re-constructed and transformed through people's action (Berger / Luckmann 1988).

The aim of extending social security to the majority of the population cannot be reached by totally formalizing security mechanisms. Those who are not formally employed

and thus not included in the formal social security system are left without any form of social security. Indeed, they have different strategies for creating and sustaining security. In all societies, there is a certain stock of informal solidarity and care mechanisms. How these various dimensions of social security are interlinked and how those linkages and interfaces can be strengthened should be considered. Since the overall goal is to extend the coverage of social protection, the analysis of interlinkages among several initiatives can provide important insights. In doing so, the division of society into formal/informal sectors can be overcome and replaced by the study of more complex fields. Different systems of social security are linked through people's action since they combine several strategies. It is important not to fit into dualities like formal/informal, or modern/traditional. These terms can only be used to describe tendencies or the direction of processes such as formalization, which concerns the linking and integration of informal and formal social institutions.

The present challenges lie in strengthening local capacities in formal/informal arrangements and supporting new emerging efforts to stabilize life conditions, strengthen social relationships and networks, and build and support the *capacity for solidarity* (Lachenmann 1997a).

2. The complexity of social security

2.1 The practice of solidarity

Solidarity is a more general concept of mutual support. It describes the presence of systems of mutual dependencies, responsibilities and entitlements within a defined group of people or a community. The practice of solidarity can take place following different principles like reciprocity, mutual aid, and redistribution. Solidarity can be defined as a complex system for the transfer of goods and services that serves people's lives and tries to improve their general situation and standard of life (Elwert 1980). This means that one prerequisite of any form of solidarity within a certain group of people and according to certain rules is the existence of resources that can be distributed. When the economic foundation and livelihoods of substantial parts of the population are increasingly weakened, the possibilities of solidarity are reduced. At least some resources need to be made available in order to take part in the community exchange of solidarity. Therefore, the importance of practising solidarity lies in the re-distribution of economic resources.

2.1.1 Distribution of resources

Shortage of income is one of the crucial factors restricting the basic capabilities of many people. However, in addition to that, it is necessary to study and consider the distribution of resources since availability alone does not automatically mean a fair distribution among members of society. This distribution follows complex regulations and rules. There is therefore a need to practice social security. The security dimensions can be relied on only as long as they are mobilized, performed and maintained. This is especially true since the fulfilment of promises is often “delayed”.

Social security usually operates on different local levels (e.g. state regulations that work at national or district levels, religious organizations with trans-national linkages as well as family networks with rural-urban ties, even trans-national and intercontinental connections). These various mechanisms underlie a pluralism of security strategies, which give people options according to the respective rules and regulations.

2.1.2 Responsibilities and entitlements

The actual performance of solidarity in the construction of social security depends entirely on entitlements. There is no direct relation between the availability of resources and security in a respective society. Rather, the resources are allocated and re-distributed through social relations. A complex system of entitlements regulates the distribution of resources, and as a result, includes and excludes individuals and groups. This takes place according to the entitlement system that is permanently reconstructed and transformed.

In general, strategies for social security are often based on gender as specific types of social relations. Entitlements and duties are derived from the type of social relationship. Priority relatives are for example, mother-in-law and daughter-in-law, divorced woman via child to the father, elder brothers of the father (baba mkubwa), and brother of the mother (mjomba).

The construction of the notion of *relatives* takes place especially after migration or the death of close relatives. In urban areas, family support still plays an important role. The *discovery* of a *new cousin* is part of the construction of family relationships.

2.1.3 The construction of reciprocity

Reciprocity is a principle that provides and permanently constructs a balance in obligations and entitlements between people and among group members. It is the prevailing form of solidarity, which needs to be a permanent consideration. Other forms are re-distribution and social assistance. In this concept, assistance and support can be understood as a kind of investment in social relationships, and at the same time, a guarantee that in similar circumstances the giver may become a receiver.

These forms of economic exchange are an integral part of the production and the construction of social security in general. The main characteristic of reciprocity is the construction and maintenance of a certain balance either in the long-term perspective, or at the actual moment, or both. This permanent construction of balance can take a very long period of time especially when applied to different generations of one family lineage and other relationships. Here, the investment takes place in the education and rearing of children in the expectation of getting the investment back in old age, in the form of general support. The interesting point here is that help and support are extended to old people who are no longer able to contribute to the mechanisms of reciprocity. Thereby the mutual aid is stretched over long periods of time, so that people benefit from a system though they do not actually contribute any more significantly. This postponement makes the solidarity mechanisms that follow the principle of reciprocity very flexible.

2.1.4 The existence of sanctions

Systems of solidarity and mutual help include instruments of sanction. Those sanctions are either positive whereby for example prestige is gained, or negative whereby the most extreme form will be the exclusion from forms of exchange and solidarity. Social control and sanctions are inevitable in order to encourage members of the solidarity system to follow the respective rules and regulations, and ensure the maintenance and stability of the system.

2.2 Social change and transformation of social relationships

Social security principles are usually altered by changes such as the trend in individualization that accompanies economic transformation. Social disintegration is growing and strategies based on social relationships and networks are easily strained, because for instance, the costs for health care can be very high. On the other hand, new social organizations and systems are being established.

With increasing monetarization and formalization (school fees and fees for health services in particular), the search for income and paid labour fosters the ongoing trend of rural/urban migration[2]. Migration brings about new ties and connections between rural and urban areas since the involvement in family networks is still maintained. Most families have at least one member who lives in town (Jambiya 1998). This migration takes place because of poverty and can cause the further impoverishment of those who are left behind. Migration changes and redefines social relationships and systems of sharing and mutual aid, making the economic entity of production smaller and more individualized. As a result, there are fewer people to share the risks. Solidarity among relatives is widened and applied to *new relatives* as well, especially after migration or after the death of relatives. This trend is increasing due to the catastrophic effects of the AIDS pandemic. New arrangements have been made in order to provide social security in these changing conditions.

2.3 Diversifying and combining income strategies

One of the basic principles of social security is diversification – both for the peasant economy as well as for income strategies in general. It is usual to find a mixture of subsistence agricultural production, and informal and partially formal employment in rural and urban areas. Through crop diversification, the harvest is secured so that if one harvest is disastrous due to certain events, other crops might flourish. The diversification of income strategies also improves security since irregularity of income can at least be moderated. A multiplicity of income strategies is also increasingly found in rural areas, since earnings from agricultural activities are decreasing due to scarcity of land, falling prices in the world market for export commodities and population growth (Jambiya 1998). As a result, self-employment

[2] Between 1989 and 1999 the urban population in Tanzania doubled due to migration and population growth. The percentage of people living in rural areas has only decreased from 80 to 68.2 per cent as significant parts of the population migrate temporarily to urban areas.

in the informal sector (trading activities or the preparation and selling of food, for instance) is one of the strategies used to gain a supplementary income.

In the context of multiple-income strategies, the strict distinction between *formal* and *informal sectors* becomes problematic, because in the every day life for most people this distinction is not relevant. In reality, a complex mixture of strategies is found where economic activities are not isolated but included in both formal and informal settings. In the construction of social security, it is necessary to analyse the interconnections of different income-generating activities. One of the thesises put forward is that *security* is not only constructed through formal and informal social organizations and institutions, but is also the aim of various daily activities and strategies (Elwert / Evers 1983). The majority of the population in Tanzania survive by relying on multiple-income strategies that may include subsistence production, self-employment, and paid labour from formal and informal employment. This applies not only for people who permanently search for security, but also for those who are in regular employment and covered by a social security scheme. However, the first priority of informal economic activities is basic income rather than the maximization of income.

In reality there is no subsistence production where the producers consume everything, or market production where everything is distributed only by market channels. Both systems are interlinked (Evers 1986), and those involved in market-trading are also concerned with subsistence-production. Informal income strategies need to be supported by subsistence-production since income is usually low and irregular.

2.4 The impact of seasonality

Seasonal income is especially important for the livelihood of the majority of the population in Tanzania that lives in rural areas and that depends on agriculture. This does not only refer to the seasons of sowing and harvesting but also to the incidence of diseases, both seasonal issues. According to Chambers (1982), several aspects of life are subject to seasonal changes. The economic costs of sickness and weakness are concentrated mainly in wet seasons and are liable to make people permanently poor. Therefore, the mechanisms of social security are very important during wet seasons when the resources to perform solidarity are less available. It is important to realize that while rural communities live in conditions that depend on seasonal cycles, agricultural subsistence-production in town is likewise dependent on the same factors.

The economic costs of sickness are principally higher during times when agricultural activities are difficult. These critical periods occur regularly and can condemn people to permanent poverty since they might be forced to sell their property at less than market value, and as a result, reduce their earning capacity.

2.5 Sustainability and time

Social security is a dynamic concept that covers the past, present and future actions of people. Through the performance and practice of solidarity, people fulfil promises that were made in the past and rely on relationships that might be able to provide support in the future. In this way social security is institutionalized, since the actual practice of solidarity takes place in the context of obligations and entitlements that are ascribed to persons depending on their social position (Berger and Luckmann 1988). According to the principle of reciprocity the investment in social relationships will be fruitful at some time in the future. Mechanisms of reciprocity are sustainable as long as people follow the rules and are able to contribute.

Investments and reimbursement, especially within one family, are carried out according to capacity and need rather than in form of debit and credit. The exchange of resources and mutual help practised in a certain context is *general reciprocity* (Elwert 1980). In a similar situation of need a contribution has to be made. This is true in future and past circumstances. We may consider for example a woman who marries and becomes a daughter-in-law. This position is linked with certain responsibilities like caring for in-laws, especially a mother-in-law. After a time this woman herself might become a mother-in-law and thus indirectly get back the time and care she had already spent. Her mother-in-law would also have got back what she had invested in her children. Life has many phases – first the needs of childhood; later the hope of income and the possibility to support others; and in old age again, a phase of needing support. Here it becomes clear that because of the time span a person may still benefit from a system of responsibilities and entitlements within one family, without any contribution. This exchange of resources and help is practised not only between two persons but also according to social positions and rules (e.g. daughter-in-law to mother-in-law).

The amount of benefit does not need to correspond directly to the contribution. As a consequence, this system is extremely flexible with regard to the different needs of its members. As Benda-Beckmann puts it: “Social Security is always also a potentiality, consisting of arrangements that are to be invoked at some time in the future, as much as it is the present fulfilment of promises made in the past.” (von Benda-Beckmann et al. 1988, p. 13). The *delayed* social security inputs build a complex network that is maintained through daily actions of the members of the solidarity system. The possibility to apply the debit/credit pattern according to social position results in a sustainable system of mutual obligations and entitlements over generations.

2.6 Principles of informal social security mechanisms

Table 1 shows the variations in the core criteria, which were developed as a result of analysing social security and its practice in informal settings.

Table 1: Principles of obligations and entitlements in informal social security mechanisms

Time	Relationship between contributor and beneficiary	Contribution/distribution of resources	Degree of relationships
Instant reciprocity	Direct (personal) relationship	Indirect (i.e., as a member of a community health fund (CHF))	People know each other (family, groups, associations)
Delayed reciprocity	Indirect (according to social position)	According to income and need	Middle range organization (i.e., District-based health fund)
		Benefit corresponds to contribution	Translocal (i.e., church based), urban-rural relation

Interfaces and linkages are evident and are constantly re-constructed and negotiated as strategies to create security. This overlapping is part of the every-day life of the population especially within family networks.

Instant reciprocity occurs when there is an equal exchange of goods with neighbours. In contrast *delayed reciprocity* pertains to the borrowing or exchange over generations as explained earlier.

Relationships can first of all be personal (friendship), or depend on the family position (father/son), with all its implicit entitlements and duties. Another form of indirect relationship in security mechanisms is developed by membership of a certain social institution (health fund), and by participation in the system of contribution and benefit.

The *contribution to and distribution of* resources by a security mechanism can follow principles of ability and need especially among families. It can also correspond to the benefit that is applied in new forms of self-organization, whereby all the members contribute the same amount and enjoy potentially the same benefit of health care up to an agreed level. Mechanisms of mutual aid and support are often established among women's groups in the form of rotating saving and credit clubs (ROSCAS), which provide the members with the opportunity to contribute regularly and to receive at expected intervals a considerable amount of money for investment into business or other activities.

The *local range* of mechanisms differs as well whereby groups and family members are known to each other, whereas members of larger schemes based on district or national institutions like churches are not.

In reality all these criteria meet, since people are usually involved in several social institutions and networks and this involvement may change during their life. People are family members, church members, or members of other religious groups. Some of them might have formal employment while others have joined new forms of self-organization and all try to follow their duties in regard to family obligations. In this way, the different spheres overlap

and build interfaces, which make the flow of resources visible as in the case of urban/rural family relationships.

The aim to extend social security coverage is pursued by supporting the capacity of solidarity and providing space and the possibility of self-control and self-organization, so that different approaches can be complementary to each other.

3. Overcoming irregular income patterns by diversification

It is very clear that there is no single solution to provide social security for health services in particular and there is a need to look for possibilities to combine several approaches. In Tanzania social protection especially in the health sector is insufficient. Family networks and other social ties cannot provide the needed security as they are easily overstrained. New forms of self-organization often come with a small range of coverage especially concerning the size of membership and benefit package. Since self-organization develops itself from the bottom of a society, the number of people it covers grows rather slowly, if at all. Therefore, an urgent question is whether and how the coverage of various arrangements can be extended.

The population in Tanzania is very diversified in regard to stability and level of income. Several modes of regulated distribution of resources only take place horizontally among people of the same income group. However, social policy should ensure that resources are shared amongst the whole of the population both vertically and horizontally.

The design of any health fund needs to be appropriate to the situation of those who should be protected. For most people, a mixture of income strategies as well as security mechanisms is applicable and thus linking and networking could extend the range of social security.

To guarantee a certain degree of social control, the interlinking of several initiatives would provide a platform for communication and exchange of experiences (Steinwachs 2000a). At the same time this could fulfil the claim of mutual social control. One important factor for the survival and sustainability of a health-fund is that irregularities can be levelled out. These may concern seasonal income especially in rural areas, the different income levels of the members of the health-fund and the changing ability to contribute to solidarity mechanisms over their lifetime.

3.1 Irregular income

Irregularities concerning income could be levelled out not only by increasing membership, but also by diversifying the type of members. A large number of members that all live in more or less the same conditions cannot provide the best arrangements for risk-sharing. Since peasants in the same rural area would all suffer the same problems concerning climate and the prevalence of sickness, the health-fund would be easily overstrained. People who depend on seasonal income collectively experience "times of hunger" and during these

times are not able to pay the cost-sharing amount required at government dispensaries. The inability to pay for health services concerns hospital care as well as primary health care and thus the principle of risk-sharing should be applied to finance the basic medical needs of the population.

In analysing the every-day life of the population, one security mechanism that stands out is the exchange of gifts among family members who live in rural and urban settings. This exchange follows seasonal patterns. For instance after harvest, crops are brought to relatives in town but in times of bad harvest rice bought in the town is brought to rural relatives because rice is more expensive in rural areas. The amount of goods exchanged in this way seems to be a large proportion when compared to goods that are distributed through market channels. Elwert (1980) estimates that for the Ayizo in West Africa more than one-fourth of basic goods are transferred and exchanged in this manner. These linkages and modes of exchange are sustainable because most people who have moved into town from their villages are planning to return after retirement, and therefore are sustaining their social relationship to the villages by continuing to contribute and invest in them. Migrants who do not continue to invest in their family ties and other social relationships are not planning to go back to their villages (Bossert 1988). The support from rural areas can even sustain the life conditions of relatives with irregular or informal incomes by providing resources out of subsistence agriculture.

Modes of rural/urban exchange of resources and goods are an opportunity to level out the irregularity of incomes caused by seasonal changes. A health-fund that includes members within the rural and urban population could have different modes of contribution (regular and irregular), depending on the nature of their income. Members should have the choice on the mode of contribution they wish to follow. This was done by a health-fund of the Evangelical Lutheran Church in Tanzania at Bumbuli Lutheran Hospital, Lushoto District (Steinwachs 2000b). The formally employed members with a regular income contribute monthly to the health-fund while members of the peasant community pay a contribution in several instalments according to their seasonal income.

3.2 Different levels of income

Economic justice and stability requires that parts of the population with low income need to be included in mechanisms where better-income groups participate as well. It is not possible for lower-income groups to sustain a health-fund that would be sufficient to secure the provision of the health services they need. The solidarity aspect, which is still prevalent in every day life, can be integrated in health-funds by following the principle of *generalized reciprocity* as has already been mentioned. This is the exchange of goods or services, but with a time lag, so that in similar situations a similar performance can be expected. The important aspect is the *similarity* of situations, which means equivalent rather than identical payments are made. People may contribute as much as they can in relation to their income, and in similar situations of sickness they can benefit from the fund. This principle is commonly applied in the performance of solidarity. Consequently, people with a higher income would contribute more in monetary terms.

Following this principle a health-fund should encompass different income levels with varying contributions depending on the income and situation of its members. It should be possible with local knowledge and social control to define a range of categories and to identify income groups which could be used for the payment of taxes or other community contributions like paying the zakat.[3]

3.3 Income over the life cycle

One aspect that is often forgotten is the biographical pattern with regard to contributing and receiving. It is part of the experience and knowledge of family members that an elderly person might receive more from the younger generation, and that old people had contributed when they were able to. Some members have not contributed even when they were able to and it is understood that people who have migrated into town and have not supported their relatives do not plan to go back. Since it is necessary to sustain these networks by continuous contribution, these people would not get back into the solidarity network in old age.

This time-lag may be used when creating a network of participants who belong to different age groups. Old people should be integrated not only because they are the parents of present contributors but also, in the long run, the coverage of those people who contribute now should be extended even beyond their ability to contribute.

In general, it can be said that the strategy of diversification provides a high degree of security. Creating links and networks can increase the complexity of security arrangements and make them more applicable to an individual's situation. Complex security arrangements can correspond to the varying social and biographical situation of members with more flexibility than standardized schemes. Since people take part as active members they can choose in case of need the right strategy corresponding to their individual situation, be it invoking Church solidarity, help from the kinship line, mutual aid in the neighbourhood or entitlement to financial support in rotating credit and saving societies. The plurality and interlinking of mechanisms creates complex and flexible security arrangements.

Part II - Ways to extend health protection

4. Collective health financing mechanisms in Tanzania

As in other developing countries the formal employment sector in Tanzania is very small. It is estimated that between 79 and 84 per cent of the Tanzanian labour force is engaged in agriculture (United Nations Development Programme (UNDP) 1999, World Bank 1999). The Tanzanian government estimates that the expanding informal sector (excluding

[3] The zakat is one of the 5 pillars of Islam. It should be a contribution of about one-tenth of the asset of a family that is not touched for one year. The calculation of the zakat depends on the goodwill of the person and the striving for prestige by making large contributions.

agriculture in rural areas) accounts for 12 per cent of the employed working-age population. The formal sector including civil services, parastatals and private firms is estimated at about 6 per cent of the employed population. Civil service employment was reduced drastically by about 84,000 people between 1993/94 and 1997/98, which was 24 per cent of total employment in the civil services, due to SAP measures (International Monetary Fund 1999). In 1998, 7,000 civil servants were again retrenched of whom 3,000 belonged to the health sector. Since diversity of income generating activities is one of many survival strategies, it is not easy to know the picture of the Tanzanian labour market. The German Development Service estimates that between 38 and 56 per cent of the labour force in urban, and 15 per cent in rural areas, is engaged in micro enterprises (up to 5 employees) and small enterprises (6 to 50 employees). These include family enterprises, most of them in the informal sector, which means that they are neither registered nor licensed (German Development Service 2001). The official ranking of unemployment published by the Vice President's Office shows that unemployment is especially high in rural areas and increasing in urban areas due to migration inflow (Poverty and Welfare Monitoring Indicators 1999). The true figures for unemployment are difficult to determine. According to Social Watch, 30 per cent of youth are unemployed (Social Watch 2001), but these categories are inadequate for multiple-income strategies as mentioned above.

4.1 Formal social security in Tanzania

Formal social security schemes are usually tied to formal employment. The contribution to any mechanism is divided between employer and employee, whereby the benefit is accessible for the employee and their immediate family.

According to the UNDP the adult labour force in Tanzania includes 14.6 million people (UNDP 1999). Members of the two formal social security schemes (NSSF, NHIS) number about 600,000 persons. Thus, the rate of people covered by formal social security schemes is less than 4 per cent, provided that yearly 600,000 people seek new jobs primarily in the informal labour market (UNDP 1999). Since the NSSF has not yet started to operate its health insurance component, the number of people covered for health care is even less than 4 per cent of the labour force.

In general, women tend to have less coverage than men in formal schemes since their rate of employment is lower (Kasente 2000). They might have indirect coverage secured through arrangements for their husbands, but this does not take into account those women who are unmarried or those who live in a family structure that precludes eligibility to these schemes (Wanitzek 1988). Women who live in polygamy are additionally disadvantaged since usually each woman is regarded as having a separate household and therefore obliged to contribute to its respective security system. The increasing number of households headed by a single female (unmarried, divorced, or widowed), do not have the possibility of social security if they are not in formal employment, which is rare in the case of women. In this situation, the distribution of resources and entitlements within one productive entity becomes vital.

4.1.1 The National Social Security Fund - NSSF

The NSSF is a social security scheme, which covers compulsorily every non-pensionable employee in mainland Tanzania. The programme includes pensions after retirement, survivors and invalidity pensions, maternity benefits, funeral grants and a lump sum paid on emigration. A health insurance scheme is being prepared.

The scheme was formerly a national provident fund – a compulsory savings scheme. Every member has his/her own account where the monthly contributions accumulate until they can be withdrawn at a time of benefit entitlement which includes unemployment. At present, the NSSF has 326,538 members. Half the membership contribution (20 per cent of the gross income) is paid by the employee. If self-employed workers wish to enter the NSSF they must pay the whole amount themselves, which would be a large percentage of their income. Since the employment rate in the formal sector is declining, membership of formal social security schemes is also decreasing. One consequence is that members of the NSSF, who paid their contributions for many years expecting retirement benefits, are now unemployed and withdrawing their contributions. This development is destabilizing to the NSSF. In 1998/99 out of the total sum of 9.9 billion Tanzanian shillings paid out in benefits (age, survivor, marriage, funeral, etc.), 8 billion was caused by withdrawal and 1.2 billion by the payment of pensions for old age. More importantly, these people who have ceased to be members of the NSSF by withdrawal of funds have lost their entitlements to the benefit payments, which again causes insecurity.

By starting health insurance the principle of risk sharing would be introduced whereby the benefits in the case of health care would be paid even beyond the contributed amount. Retirees, who receive benefits in the form of a lump sum and a monthly payment, discover that it is not sufficient to create and sustain decent life conditions. In addition to these benefits they need support from family networks and other alternative security arrangements like savings. As a consequence elderly people are not sufficiently secured through the formal system and therefore tend to strain conventional security arrangements even more. Their previous contribution to the formal security system (NSSF) might have reduced their need to contribute to alternative arrangements, but since health insurance within the NSSF has not yet started to operate, there is no evidence to prove this. In interviews with hospital staff (Bumbuli Lutheran Hospital, Lushoto District) who are members of an alternative scheme, it is clear that they would quit the latter in order to avoid belonging to two schemes which offer the payment of medical costs.

4.1.2 The National Health Insurance Scheme - NHIS

The introduction of the NHIS was planned to take place at the same time as that of cost-sharing (1993). However, its implementation was delayed (Mapunda 2001). At present it covers only central government employees including spouses and up to four children or legal dependants. For these employees it is obligatory to contribute to the NHIS. The contribution, which is 6 per cent of the salary, is divided equally between the employee and the government. By 1998 about 263.629 people were employed in the civil services (International Monetary Fund 1999).

After retirement members receive benefits for up to three months following which they are dependent on alternative solidarity mechanisms, similar to members of the NSSF.

4.2 Community Health Fund (CHF) managed by local government

The Community Health Fund Act, 2001 was released in April 2001, accompanied by the *CHF Model By-laws* (May 2001) and the *Council Health Service Board Establishment Instrument* (May 2001). It stipulates that the CHF should be established as a voluntary pre-payment scheme at urban or district council level. The Act was put into effect in order to give councils the opportunity to start a CHF, which up to this time had only been possible for some pilot districts. As part of the Health Sector Reform, it is the councils' decision to start a CHF. One of the objectives of the CHF is to "improve health care services management in the communities through decentralization by empowering the communities in making decisions and by contribution on matters affecting their health." (GoT 2001, p.3).

According to the Government, cost-sharing even down to the level of health centres and dispensaries, should have been introduced at the same time as the CHF, which was designed as a "safety net" for parts of the population with seasonal and irregular income.

The CHF is a voluntary pre-payment mechanism at household level. A household can consist of groups or families. Criteria like family size are to be defined by the Council Health Service Board (Steinwachs 2001b). The providers can be government or private for-profit and non-profit health schemes. The benefit package includes PHC and can be extended to provide some hospital care depending on the design of the CHF.

The *Community Health Fund Act* comments on several elements of the establishment but leaves the precise design for the Council Health Service Boards. The boards will be set up to:

- monitor CHF operations,
- ensure quality health care,
- mobilize and administer funds for the CHF,
- set up exemption criteria and review reports, and
- monitor and verify collection, expenditure and control of funds.

The involvement of community members takes place mainly on the condition that four members of the Board must come from the community ("users of health facilities"). Also the development of the ward health plans, which are the basis for calculation and use of funds, is done by the Ward Health Committees that are composed of community members (village leaders/other community members) and medical staff.

The CHF is not a new form of self-organization but a government-initiated scheme, which is regulated by the *Community Health Fund Act*. The overall management is left to district level and community participation is very limited. The CHF design goes along with subsidies in form of matching funds provided by the Government (financed through World Bank credits). It should be further explored whether these large amounts of subsidies undermine the idea of community-based self-organization.

As indicated in Table 2, the Health Service Boards can fix the amount of user fees in relation to the CHF contribution. Since this contribution is matched by the Government, and user fees are not, the Government proposes to increase user fees in the following way.

> The population living in the catchment area of a dispensary is about 10,000 people. To fully run the dispensary a contribution per family of Tsh.17,000/=[4] per year would be necessary. The Government would pay Tsh.7,000/= per family per year as subsidy, which seems reasonable compared to the support they have been providing so far in terms of equipment, staff salary and other running costs. Thus an amount of Tsh.10,000/= per family is left. The CHF contribution paid annually per family of Tsh.5,000/= will be matched by the Government through World Bank credits. Thus, a member family of CHF visiting the health facility about ten times a year costs Tsh.10,000/= but pays only Tsh.5,000/=.

Consequently, in the CHF pilot districts the user fees were increased to Tsh.1,000/= per visit, so that with the same assumption of ten visits per family per year, the amount of Tsh.10,000/= will be paid.

Table 2: Comparison of user fees and CHF contribution per family

Cost sharing	Contribution/ fees per year per family	Matching fund per year per family	Government subsidies per year per family	Total
"Adjusted" user fees	1.000 /= x 10 times = 10.000/=	none	7.000/=	7.000/=
CHF	5.000/=	5.000/=	7.000/=	7.000/=

Through the matching funds, which are directed only towards the members of CHF, people are encouraged to enter the scheme because they will pay less for their health care. The matching funds are provided only at the initial phase as an incentive to join the fund. After the CHF begins to operate successfully the matching funds will be gradually withdrawn. Therefore, one main rationale to join the CHF, which is to pay less, will then be undermined by withdrawing these additional funds and increasing the CHF contribution. The initial subsidies are supportive but their reduction at a later stage needs to be negotiated, administered and conducted in a transparent way with the strong participation and agreement of its members and the communities.

[4] 1 USD = Tsh.895/=

4.2.1 Community participation

The question remains whether the respective design of the CHF is appropriate to the life conditions of the population. The idea to start the scheme did not grow in the communities but was brought from outside. Their participation in developing it has not been very strong so far and concerned only the involvement of the Ward Health Committees, whereby - as in most formal institutions - women are under-represented. If the CHF is to operate successfully, strong community participation in developing the design and controlling the collection and use of the funds is indispensable. In establishing the CHF it is crucial to include the perspectives of women and their forms of self-organization in women groups, since women are usually responsible for health matters in the family. Thus the present form of participation of community members is strongly biased and insufficient.

4.3 Self-organization to make health services available

Due to the lack of state provisions to make health services accessible for all and because conventional social security arrangements like family relations are increasingly overstrained, many new forms of health-financing mechanisms have been established in Tanzania. Some of these were initiated and designed by health providers in order to strengthen their financial basis and to improve the quality of health services. However, the vast majority of these new forms of health-financing mechanisms are community-based schemes, which were established in self-organization. One of their main objectives is to provide security during the whole year regardless of the season, and to lower the individual burden by risk-sharing within a group of people. These new forms (through regular contributions) try to avoid indebtedness when very costly health services are needed. While the income of informal activities is irregular, contingencies like sickness are also irregular and unforeseeable. The problem starts when resources are needed but cannot be provided from income. Social security arrangements can try to level out these irregularities among their members. It has been said that with a large membership a balance would arise automatically, but this is not true as can be shown especially for the agricultural sector where seasonality is a determining factor. Other informal activities might also follow the same rhythm of income fluctuation rather than being automatically levelled out. Since all the members of a security scheme may have the same rhythm of income patterns, it is necessary to balance this pattern intentionally by designing security funds with long-term rights.

4.3.1 Interfaces of formal and informal spheres of social security

A group can bear expenses that individual members cannot pay and a group may promote redistribution among its members by designing the amounts of contribution according to income. The function of new types of social organization is to foster social cohesion, mutual aid, and the possibility for individual savings resulting in additional obligations and responsibilities. This can be an important flow of resources into family relations and a link between formal and informal agricultural subsistence economy. Employees both of the formal and informal sector including self-employed persons continue to contribute to and invest in social relations, especially family relations, by supporting relatives in rural areas. This is one reason why informal sector workers are seen as not willing

or not able to contribute a high percentage of their income to finance additional social security mechanisms. Their duties and responsibilities that come from involvement in social organizations continue to exist, and from this situation severe conflicts may arise.

While through the establishment of alternative mechanisms security can be extended to large parts of the population engaged in informal employment, there is no evidence that formal employees covered by formal security mechanisms also contribute to other alternative security schemes. Experiences from church schemes (Tanzania Episcopal Conference) in Dar es Salaam which are based on membership to a parish, show that those who are already covered or with a higher level of income were reluctant to join the scheme, since they believed there was no additional benefit for them.

Furthermore, as Benda-Beckman has shown, new forms of self-organized social security can lead people to withdraw their limited resources from the kinship sphere, and direct them into new social security arrangements (von Benda-Beckmann et al. 1988). This is especially true after migration into new social areas where social organization according to ethnicity, home area or religion becomes important. The construction of *new relatives* with rights and obligations derived from entitlements within kinship may thus withdraw resources that would have been spent on relationships within the family or origin. However, strong family ties to the area of origin make it possible to return home in old age (Orlik 1999). The process of individualization together with migration implies an increasing number of people who migrated permanently into urban areas do not intend to return. The maintenance and support of social relations and solidarity mechanisms in the area of origin depend on the perspective to return in old age (Bossert 1988). It has been stated that one-fifth of migrants intend to stay in town permanently. It can be assumed that this number has been increasing due to social transformation processes including individualization of survival strategies.

4.3.2 The need for mechanisms of redistribution

Depending on the respective scheme, different principles of organization, administration, entitlement to benefit and coverage of health care can be applied. It is useful to make a general distinction between two general principles: pre-payment and insurance. The aspect of pre-payment concerns only the time of payment. Members or member groups pay a certain contribution. The costs of necessary medical treatment can be reimbursed only out of this pre-paid financial resource. Pre-payment does not include risk-sharing mechanisms. The benefit of pre-payment relates to the period of time between the ability to pay and possible health problems that may need medical treatment. The result is that people do not have to pay when they need medical treatment, because they have already pre-paid.

Insurance principles mean that by paying a certain amount as premium, a member is insured to receive medical treatment according to the benefit package regardless of the actual cost. Members of the insurance scheme share the risk of high cost and bear the burden together. The basis of the insurance principle is the idea of solidarity whereby the members indirectly pay for each other in situations of need. Resources are re-distributed according to the individual health situation of the members through the payment of medical costs. The aspect of pre-payment is inherent in any insurance scheme.

Sen (1973) distinguishes in Table 3 between the principle of contribution and the principle of need. If a society followed criteria of performance then those who earn more can benefit more, or those at the same level are grouped and share only among themselves. In simple pre-payment schemes the cost of medical treatment can be reimbursed only up to the pre-paid contribution amount. Therefore, those who pay more can benefit more. If a society followed the principle of need in providing health services to all, then the contribution should be based on ability to pay and the benefits based on need. Health insurance follows the principle of need. The insurance principle includes the principle of pre-payment but goes beyond its limitations.

Table 3: Comparison of pre-payment principle and insurance principle

Prevailing principle	Collection of contributions	Use of contributions	Redistribution	Advantages
Pre-payment	One member – one account	Pre-paid contributions used for medical treatment	Horizontal redistribution over time, no sharing of risk	Time: Levelling out of irregular income (seasonal income)
Insurance	One account for all members	Use of collective contributions according to medical needs	Collection of contributions at one account, sharing of risk, solidarity	Solidarity: Redistribution of resources among members regarding health status, irregularity of income (different levels of income)

At present, employees with a regular income from the civil services or other formal employment share the contributions and benefits among themselves (NSSF, NHIS). The rest of the population is left to the new CHF or other alternative mechanisms. The schemes work according to insurance principles that share the risk. However, the benefit packages are limited by the ability of the members to contribute. The capacity of the population who are engaged in informal and agricultural income activities and contribute to health schemes is more limited than that of the formally employed population. Thus the benefit package of schemes in rural areas with members who have irregular and low income is smaller than the package provided by the NHIS for civil servants. The benefits that can be provided by health-funds are restricted by the limited financial resources of its members. The size and quality of the benefit package depend on the pre-paid amounts of contribution and there is no form of redistribution yet among these schemes.

Social security becomes a highly political matter since new forms of redistribution between different income levels and the provision of infrastructure and support for those who need it most are necessary. In this view, social security is a matter of social and economic justice. It is necessary to introduce vertical redistribution so that the risk-sharing takes place not only horizontally within the respective health schemes, but also beyond. The redistribution of resources includes cross-subsidies between the different schemes (subsidies for the CHF could be taken in part from the NHIS contributions), and forms of social assistance for those who cannot afford to pay fully for their health care.

5. Extending health protection coverage

As has been explained in the first part of this paper, one of the basic principles applied to create security is diversification and pluralism of actors' strategies. Through the overlapping and interface of different spheres, complex patterns of social relations and networks are created. Interfaces emerge along urban/rural relations, in the integration of different modes and levels of income, and in the linking of formal and informal employment. Moreover, diversity of security mechanisms provides the possibility to choose according to needs and circumstances. The complement to diversification is integration, which can be supported and fostered by the vertical redistribution of resources.

Applying these insights, the following three mechanisms to extend social security coverage can be distinguished.

- Networking of various small-scale social security schemes (see paragraph 5.1),
- Developing area-based schemes (see paragraph 5.2), and
- Using translocal structures to implement security mechanisms (see paragraph 5.3).

5.1 Creating networks of small-scale schemes

In urban areas and also in villages, professionals and members of occupational groups organize themselves in the form of co-operatives or associations. One of the purposes of these groups is to share their work facilities such as tools, machines and the work place. Usually members contribute to a fund that covers the expenses for electricity, work place and water. These funds might provide loans for children's education and health. Based on relations they also form groups for mutual support and aid. This may be in the form of rotating saving and credit clubs (ROSCAS) whereby everybody is entitled to get the collected sum weekly or monthly. Another possibility is the provision of credit.

These groups are based on relations of mutual trust and knowledge of the life conditions of the members. Usually credits can be used for investments into business, but sometimes they may be used to pay for health services. This is possible because if a person has problems in paying back the credit, the other group members could sell his/her work facilities or property to cover the amount owed. The main conditions here are mutual trust and knowledge, and the presence of at least some property in the form of tools, machines and so on.

As shown by Orlik (1999), the main goals of self-help organizations and associations of micro-enterprises in Dar es Salaam are directed to establish and provide social security. Although members of these organizations are entrepreneurs the main importance is not in the area of economic criteria but for reasons of security. The organizations can provide support in social difficulties like sickness, accident, death or invalidity. The family is still seen as the prime source of support for contingencies but the organization is also a resource of support

and help. Here it is seen as complementary to family support especially in urban settings like Dar es Salaam.

5.1.1 Market groups in Dar es Salaam

Several market groups in Dar es Salaam include coverage for health services up to a certain agreed level in their daily contributions. They have contracts with private health providers and members are entitled to get health services whereby the bills are paid by the health fund every month.

Two groups studied in Dar es Salaam (Wanauza Nazi / Kariakoo market and Wanachinja Kuku / Kisutu market, have a strong group identity based on their occupation and shared work facilities. All members of the groups were men. Their daily contribution is used for electricity, the work place, and other group expenses including a health fund. Since the workers pay a lump sum, they are not aware of the share of their contribution that is used to provide health services. Since the sum they pay includes provision of all the facilities tailored to fit their occupation, the networking or set-up of a common scheme jointly with other groups is only possible if the amount calculated for health services is known and transparently administered. The benefits for groups that create a network or common scheme are:

1. Common administration and management of the scheme and the account,

2. Increased and strengthened power for negotiation with the health provider, and

3. The opportunity to pay together for medical advice.

5.1.2 A network of occupational groups (UMASIDA)

One approach to keep and support the strong group identity of market groups and create a network at the same time was pursued with UMASIDA[5] in Dar es Salaam (Kiwara 1999). UMASIDA is a network of several market groups whereby every single group contributes according to its size to a special UMASIDA account and the bills are paid from this. One person is employed to do the administration and a medical assistant controls every bill that is paid. The group members benefit from these services but, on the other hand, they pay more for it. The medical control of the bills has been done without charge at present but there are plans introduced by the medical professional to charge for this service. Consequently the amount of contribution would be raised.

The principle of risk-sharing becomes significant only when a large number of members contribute. The total number of UMASIDA members might be high but since every member group has its own account as part of the UMASIDA account (simple pre-payment), the risk-sharing is only within the single groups and not within the whole UMASIDA

[5] UMASIDA: Umoja wa Matibabu katika Sekta Isiyo Rasmi Dar es Salaam (Community for Health Care in the sector that is not formal in Dar es Salaam)

network. There is no possibility to "borrow" from other groups and distribute risk within a larger community. If the respective group account is empty, the group needs to contribute again according to its size. Thus, there is no financial benefit for the group as such and also there are no possibilities to overdraw the account. There is no mechanism for risk sharing for UMASIDA as a whole.

In principle, the networking of different market groups with different kinds and phases of income is a proper way to extend the coverage of social protection. Additionally, some mechanisms for the vertical redistribution of resources and risk sharing and possibly subsidies according to the needs of members should be implemented. Practices like these may be observed in any arrangement where members contribute corresponding to wealth and income like the Zakat, the offertory in churches and even in formal social security mechanisms where members contribute a certain percentage of their monthly income (NSSF, NHIS). Possibilities for redistribution could be realized through creating only one account for the network so risk sharing is viable or creates the opportunities of getting subsidies or credit in times of lack of resources. Another possibility practised by the Mwananyamala Food Traders in Dar es Salaam, is to diversify the amount of contributions within the group. The members pay daily but according to their business activities and profit, and in doing so, the different phases of economic success can also be levelled out.

A grouping of local schemes into a network is a good chance to extend the coverage of social protection to possibly whole market areas, and maybe even further. The more diverse are the groups within the network the more stability is created, since mutuality and reciprocity become the leading principle. Small-scale businesses as well as market trading and other forms of trading are subject to seasonality and periods with higher or lower income. If several modes of contribution were applied (daily payment, monthly contribution or payment every three months) the levelling out of irregularities could take place, and members could choose the mode of contribution most convenient to their income.

Secondly, a network structure opens space for choice. A network can extend the entitlement for health services to several contracted health providers, and members of the network could seek treatment not only at one facility but at several. A network structure combined with medical advice and other technical support would encourage groups to form such a structure.

5.2 Area-based schemes

Area-based schemes have the advantage that they do not focus on a certain group of people according to criteria like income or occupation, but are open for a variety of people to join the scheme. Potentially, they should be open to everybody.

5.2.1 Community Health Fund - CHF

As described in chapter 4.2, the CHF was initiated by the Government and is an area-based scheme. It was first planned as a district-wide solidarity mechanism especially for rural

areas. The *Community Health Fund Act*, which was enacted in April 2001 states that urban councils can also establish a CHF in the respective urban setting.

5.2.2 Evangelical Lutheran Church in Tanzania - ELCT

The ELCT has developed a partnership model of health financing whereby the health fund is hospital-based, but with strong participation of its members. The health fund is open not only to members of the Lutheran Church but to others as well.

The area of coverage is defined according to geographical criteria. The population of the so-called catchment area may become members of the health fund, which is based at the respective hospital of the Lutheran Church. Each fund is administered and designed by the responsible management-team of every single health fund. Since the basic criterion of the coverage is the catchment area of the hospital, different levels of income can be combined within the health fund. The amount of contribution is fixed only in accordance with the size of a family. ELCT schemes provide primary health care and hospital care up to a certain level, which is agreed upon for the respective fund. Primary health care at hospitals is relatively expensive (Flessa 1998). Furthermore, health services provided by NGOs are more expensive than services at government institutions since the latter receive higher amounts of subsidies. As long as NGO hospitals do not provide significantly better quality care than government institutions, people tend to use the latter for primary health care as has been observed in Bumbuli where there is one Lutheran Hospital and one government dispensary (Steinwachs 2001a).

A point for discussion should be whether it is possible to create different classes of contribution according to income levels, and thus to install vertical redistribution within the health fund since the benefits would be the same for all its members. As has been mentioned earlier, this practice can be found in social institutions like churches and the Islamic community as well as in formal security systems, where the contribution to security mechanisms is directly linked to income and wealth.

An important aspect concerning the extension of coverage is its voluntary nature. Regional based schemes should leave space for alternatives that are developed by the population itself, and as shown, the complex arrangements created through the diversity of health financing mechanisms can increase flexibility and security. People can choose membership to any mechanism according to their respective needs.

5.3 Translocal structures

Since religion is a translocal construction by definition, founding health-financing networks on the basis of religion can include the diversity of different income levels. It can also overcome problems caused by the irregularity of income of large parts of the population through linking the formal/informal and agricultural sector and their respective income groups.

However, religion does not cover the whole population and leaves opportunities for choice.

5.3.1 Evangelical Lutheran Church in Tanzania - ELCT

Since the ELCT funds are attached to hospitals of the Lutheran Church, it should be possible to extend the entitlement of the members so that they could use all the Lutheran hospitals and health centres in the whole country. In this way a member living in Bumbuli but visiting friends or relatives in Arusha could use the health services at Arusha Selian Hospital (ELCT) as a member of the church-based health fund network.

It is possible that due to the varying quality of health services the user rates and hence the expenses of each hospital differ, and therefore a mode of cross subsidies within the ELCT should be established to level out these differences. The ELCT would be able to further enlarge coverage by extending the internal networking of its health funds to a nation-wide network, which would in the end embrace all Lutheran Church Hospitals.

5.3.2 Tanzania Episcopal Conference - TEC

The Catholic Church of Tanzania has begun health insurance that is based on membership of a congregation. The contracted health facilities do not necessarily belong to the church but can be run by private-for-profit health providers. The health fund is only applicable to the selected provider, which may be far away from the home area of the members of the fund. The necessary visits to the health facility can entail considerable travel costs. There is no competition among health providers because the fund members have no choice other than the contracted health provider. The TEC health schemes face severe problems primarily because the limited number of health providers contracted is usually close to the Church buildings but not necessarily to the home area of the parish members. The Catholic Church could take the opportunity to establish a network of health facilities that would provide health services financed by the health fund network. This extended network would cover different income groups since it is based on the membership to the Catholic Church, which is a criterion transcending occupation and income. When extending the network to nation-wide coverage it could even transcend regional aspects, provided that appropriate mechanisms of redistribution are implemented.

Given their size, the coverage of these schemes should be extended to those parts of the population who are not able to contribute at present but had been contributing previously. This is true for people in old age and for those who have become disabled or are suffering from long-term sickness. They should still be covered by their respective schemes and this would follow the experience of time lag that commonly occurs in solidarity relationships. It would be a form of levelling out different income levels and different abilities to contribute.

5.3.3 Community Health Fund as a translocal network

If many or even all districts and urban councils start a CHF, coverage could be extended by developing a system of mutual acceptance of membership to the respective funds. A membership card with a photo should prove someone’s affiliation. If there was a

mechanism of redistribution of funds between the respective districts, the mutual acceptance of membership would be possible, and members could use all the health facilities included in the CHF system in any district. This would be appropriate especially for those parts of the population who travel frequently due to trade or other income-generating activities.

6. Tasks of the state: Supporting an integrated approach

Aspects of State responsibility concern general structural reforms which improve the economic and income situation of the population through access to resources and which make basic social services such as education, health services and water, accessible for all. Moreover, structural reforms should aim at equity through policy instruments like redistribution of resources and subsidies. Social policy should support and empower the solidarity capacity, stabilize the base livelihood of the population, and support initiatives of self-organization.

Strengthening the diversity of mechanisms for social protection is one way to make choices available for the population and sustain flexibility, which is appropriate to the different situations faced in life. In the case of national social policy some special responsibilities may be identified.

6.1 Introducing mechanisms of redistribution

It can be argued that a strong form of vertical redistribution to finance primary health care is the tax system (International Labour Organization 2001). The tax revenues collected by the Tanzanian Government are still very low. One of the main reasons is the fast growing informal sector where it is almost impossible to estimate and collect taxes, since most of the enterprises are not registered and pursue their economic activities without an official licence. Secondly, the income of the majority is so low that it is not possible to increase the tax base (International Monetary Fund 1999). Thirdly, the Tanzania Revenue Authority, which is responsible for collecting taxes (import duties, export taxes, sales, excise and income taxes as well as VAT), failed to increase tax collection due to several problems of infrastructure and the increased scope of exemptions from import duty. The reach and effectiveness of the tax-based system in regard to the financing of the health care system is limited. However, the amount set aside in the national budget to be spent on the health sector might increase due to partial debt relief of foreign debts.

Social organization in regard to social protection takes place at different levels of society. The Government itself has initiated collective health financing schemes like the NSSF, NHIS and CHF. These schemes have been designed according to the type and area of employment. In this way they divide the clientele of the schemes according to different levels of income. There are no mechanisms as yet for the redistribution of resources such as encouraging cross-subsidies among these three schemes. Without redistribution, risk sharing only happens among people of the same income level.

The aim of social policy should be to achieve economic and social justice and to create and support sustainability of schemes where the population alone cannot entirely finance the health services they need. The State should strengthen the efforts of self-organization by establishing mechanisms of cross-subsidies between the three government initiatives (NSSF, NHIS and CHF), and alternative schemes like those developed by the churches and other initiatives. The latter should be included in systems of redistribution and subsidies whereby the entitlement to participate in these systems could be based on official registration. This aspect will be explained further below.

A step in this direction was achieved by integrating all dispensaries into the Sector Wide Approach. One element of this approach is the collective funding of the health sector by several donor agencies (Health Basket Grant). The planning guide for local authorities regarding utilization of the health basket grant states that 15 per cent of the allocation of US$0.50 per capita will be distributed among dispensaries regardless of their provider (Ministry of Health, August 2001). Thus "dispensary means Public or Voluntary Dispensary under the council" (p. 8). This means that every dispensary, be it governmental or under voluntary agencies like churches, receive the same share of the basket grant corresponding to the population living in the catchment area. The estimation of this population is based on geographical criteria such as the distance to the nearest health facility, the population density and the statistics of the respective health facility. In future it may be possible to reduce the cost-sharing at voluntary dispensaries since support from the Government will increase, and this could be reflected in lower user fees.

Basket funding is a promising instrument for directing subsidies into the health sector because it supports the process of decentralization, and the acknowledgement of the role played by the health services provided by voluntary agencies.

External subsidies and cross-subsidies are forms of redistribution of resources that could apply even to collective health financing mechanisms, provided they have been registered.

6.2 Discussing forms of official registration

Redistribution should not only happen among the schemes that have been initiated by the Government, but others as well. One prerequisite would be to provide the possibility of official registration as “collective health financing mechanism”, “health scheme”, or “health fund”. This procedure of registration should be developed on the basis of transparently discussed criteria. The registration or provision of a licence could open the door for networking of different collective health-financing mechanisms, and the mutual acceptance of membership. Through registration or the provision of a licence, various alternative social security arrangements could claim a status similar to the formal security schemes that would include the entitlement to subsidies.

The registration could be combined with quality control of health services and the administration and management of the health fund. Also mutual control mechanisms among

the network members could be demanded when providing the licence. The quality of administration as well as the quality of health could be improved when made a prerequisite of the registration. It could also facilitate the entry into vertical nation-wide mechanisms of redistribution.

To encourage self-organization, the State should provide subsidies or matching funds for self-organized schemes.

6.3 Providing room for choice

To date the formal social security schemes in Tanzania – NSSF and NHIS – are compulsory for employees and civil servants. The government-initiated CHF at district level is designed as a voluntary scheme. The experience of several collective health financing schemes has shown that the main obstacles for these schemes are adverse selection, the overuse of services, and moral hazard which means that patients tend to join the scheme when they know that they will need medical care. The compulsory nature of schemes is one way to avoid these problems, but as a consequence, employed people are restricted in their choice of them. This could be counteracted by integrating the formal schemes into networks of other collective health-financing mechanisms. In other words if the State on the one hand could provide licences and official registration to informal security mechanisms, it could on the other hand re-define the notion of compulsion by extending it to membership in *any* registered collective health-financing mechanism. The consequences would be manifold as stated below:

1. People who to date belong to one of the formal security schemes could chose membership of any other registered scheme and in this way increase the diversity of membership. The notion of *compulsory* membership in NSSF or NHIS would be changed into membership of *any* registered health scheme.

2. Membership of formally employed persons in alternative/informal security schemes could encourage others to join these schemes since formal employees promise the relative stability of resources.

3. The provision of licences along with registration and free choice would increase the competition among the schemes and should be combined with quality control.

4. Registration would entitle informal security schemes to take part in a system of redistribution of resources in the form of cross-subsidies.

5. The integration of formal and informal security mechanisms could lead to networking and modes of mutual acceptance of membership and in this way create a high degree of flexibility.

7. Conclusions

The relevance of social security arrangements to the varied life situations of the population can be supported not by standardizing social security but by strengthening the plurality of security arrangements. An integrated approach characterized by networking and linking different security arrangements could extend the coverage of social protection to those who are in permanent search for social security.

Linking and networking should be encouraged and supported at different levels.

At the *community level*, market groups and other local initiatives should build networks as demonstrated by the UMASIDA scheme. The main benefits of networking relate to the common administration and management of the scheme, and the increased power when negotiating with the health providers. The accessibility to health services can be broadened to several health providers of the network that could reduce travel costs.

Area-based schemes are examples for extending social protection and making health services accessible to those parts of the population that are excluded and marginalized, because the main criterion for membership is the place of residence. The diversity of security mechanisms in the same area (church schemes, CHF), increases choice. Additionally, area-based schemes create spaces for linking together formal and informal spheres by including members with formal employment and informal economic activities.

Translocal structures such as Tanzanian churches can support the founding of health-financing networks that embrace the diversity of different modes and levels of income in rural and urban areas. Problems caused by the irregularity of income of large parts of the population can be overcome by linking the formal/informal social spheres and their income groups. Similarly, a network of District-based CHFs with mutual acceptance of membership could provide these advantages.

If the compulsory membership in formal social security schemes such as the NSSF and NHIS were to be extended to membership of *any* registered health scheme, formal employees could have the choice to join any health scheme that they regard as attractive. The linkage of the formal and informal labour market could provide increased sustainability.

The integration of informal social security schemes into the formal system can take place by providing these informal schemes with official registration and including them in mechanisms of redistribution of resources.

This paper has reviewed various ways to extend coverage to the whole population, and including all parts of a society, in a way that would sustain and support the plurality of social security arrangements. The life situations and circumstances in Tanzania are extremely diversified and the gap between rich and poor is still widening. A network of several arrangements could extend the coverage onto almost the whole population provided that

mechanisms of horizontal and vertical redistribution such as cross-subsidies and external subsidies are in place.

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