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Social protection in an electorally competitive environment (2): The politics of health insurance in Tanzania

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Abstract

This paper analyses the introduction and expansion of health insurance schemes in Tanzania. Health insurances were introduced around year 2000 as part of a more general health reform process aimed at improving access to health services. The paper argues that the health insurances were driven by a policy coalition of bureaucrats and transnational actors, who, inspired by international trends, framed reforms as a way for the ruling party to live up to one of its core priorities since independence, namely, improved and, eventually, universal access to health services. The introduction of insurances was expected to help mobilise funds and improve the working of the health care system for this purpose. However, judged by their modest design and slow implementation, the ruling political elite remained ambiguous about health insurances. Politically, a fast rollout was perceived to be risky. Similar political considerations may explain the reluctance to expand health insurance coverage through a mandatory scheme that bureaucrats and development partners have propagated recently. The rejection of the initial design for such a scheme came as a surprise to the policy coalition, which did not enjoy the same access to key decisionmakers as in the past. Concurrently, and driven by increased electoral competition, the ruling party has increasingly focused on improving access through the expansion of physical health infrastructure. This has the additional advantage of being highly visible among the rural majority of the population, who overwhelmingly vote Chama Cha Mapinduzi (CCM). This is our second paper on social protection in Tanzania.

Keywords: Tanzania, social protection, health insurance, universal health coverage, political settlement, health financing, elections

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Introduction

This is the second of two papers on social protection in Tanzania. The first paper, 'Social protection in an electorally competitive environment (1): The politics of productive social safety nets (PSSN) in Tanzania',¹ provides for a general introduction to the two papers, outlines the historical political dynamics of social protection in the country and analyses the contemporary political economy of Productive Social Safety Nets (PSSN), a cash transfer programme rolled out after 2012 as part of the bigger and long-standing Tanzania Social Action Fund (TASAF).² By comparison, the topic of this paper, the introduction and expansion of health insurances in Tanzania, has a longer history, dating back to the year 2000, when they were first introduced as part of a more general health reform process aimed at improving access to health services. By then, the discrepancy between the promises of universal access to services under African socialism³ and the harsh reality of limited access became ever harder to defend for the ruling politicians. The introduction of economic structural reforms aimed at realigning expenditure with state revenues had only worsened the situation. Timewise, the realisation that change was required to some extent coincided with the reintroduction of multi-party elections in 1992, which led to a reform process that was increasingly intertwined with the electoral cycle.

Overall, the two papers argue that both the introduction of PSSN and health insurances mirrored international trends at the time of introduction, but that the design of interventions and the timing of their implementation are decisively influenced by Tanzania's political economy. It is not uncommon to depict reforms as having been imposed on Tanzania (for a health-sector example, see Chimhutu et al., 2015), and indeed, the influence of international development partners is undeniable in both sectors. A reform coalition of bureaucrats and development partners has often driven the development of reforms and policy interventions. Generally, ruling party governments were more preoccupied with improving access to social services and accepted proposals as long as they were not directly opposed to this goal and helped keep donor money flowing, a major priority throughout the period. Major reforms were rarely, if at all, designed and implemented without the blessing of the very top of the Tanzanian political system and were typically introduced with some very Tanzanian characteristics.

¹ Jacob and Hundsbæk Pedersen (2018).

² Both papers are part of the larger research programme, Effective States and Inclusive Development (ESID) that is looking at the politics through which people's lives and livelihoods are improved. See www.effective-states.org.

³ African socialism in its Tanzanian version was linked to the conviction of the country's first president, Julius Nyerere, that approaches to modernisation different from traditional socialism or communism were required in Tanzania, because the country was dominated by peasant agriculture, not industry and classes. This was coined in his Swahili term for African Socialism, 'Ujamaa', with its notions of brotherhood or familyhood (Bienen, 1967; Hyden, 1975; Havnevik and Isinika, 2010).

A characteristic feature of the introduction of health insurances was the way in which a policy coalition of bureaucrats and development partners framed reforms as a way for the ruling party to live up to one of its core priorities since independence, namely improved and, eventually, universal access to health services, while at the same time improving the efficiency of the sector through the introduction of fees and insurances. The latter were also seen as a way to mobilise additional funds for the sector. Whereas the ruling Chama Cha Mapinduzi (CCM) had never given up on the rural majority rhetorically, it had often not implemented pro-rural programmes in practice. CCM's renewed focus on the rural majority was linked to the political dynamics in the country: electoral competition became steadily tougher with the reintroduction of multi-party elections in 1994-95 and, in particular, with the 2010 elections onwards, when a stronger and better organised opposition gradually emerged, particularly in urban areas. In the case of health insurances, this meant that it was an important priority to avoid putting additional burdens on the rural majority of the population without guaranteed improved access. Participation by people outside the formal sectors therefore became voluntary.

At the same time, the ruling party increasingly focused on improving access through the expansion of physical health infrastructure, which had the additional advantage of being highly visible in electoral campaigns. Occasionally, this led to conflicts with development partners, who tended to prioritise management reforms aimed at improving the quality of services. This points to tensions over the distributional impact of reforms. Dating back to the early years of independence, in CCM there has been an emphasis on hard work and self-reliance as the core and better alternative to over-reliance on FDI and development donor funding. Whereas this never meant that Tanzania denounced aid, it meant that priorities have, at times, been more towards supporting community-driven projects and public work, for instance the construction of classrooms and health clinics, over other public service reforms. These types of intervention had the added political advantage that they provided a platform for local politicians and bureaucrats, until recently almost completely controlled by CCM, for distributing benefits. Combined, these elements may help explain why health insurance only reached 22 percent of the population in 2016 (URT, 2016) and why progress in terms of getting closer to universal insurance coverage – which is a major development partner priority – has stalled at the time of writing this report; the political risks of introducing mandatory insurances that may not live up to expectations are considerable.

Tanzania is an interesting case, as it has not witnessed any of the major disruptions – in the form of coups, civil wars, urban riots or regime change – that have characterised so many other African countries. Rather, it has had the same ruling party in different guises since Tanzania mainland gained independence in 1961. Whereas the country has pursued quite variegated policies over the years, the party has never renounced on its adherence to African socialism or the idea of universal access to basic services. Tanzania has also been the biggest major recipient of development assistance, measured as a percentage of total assistance to sub-Saharan Africa, at times receiving close to 10 percent (Edwards, 2014). It thereby

provides us with a case in which we can follow gradual as well as sudden changes in the country's political settlement, internal party ideas and ideology, and the influence of external ideas, often introduced by development partners, that combined are expected to shape social protection outcomes.

Informed by a process-tracing methodology, this paper is based on a review of the relevant political economy and health insurance literature. combined with field research in mainland Tanzania between November 2017 and June 2018. The health insurance literature search was conducted using EBSCOhost, a leading social science database, using search phrases such as 'Tanzania', 'Health', 'Reform', 'Policy', etc., combined with cross searches in Google Scholar. Generally, there was much literature on specific diseases and much less on the politics of the health sector and health insurance in Tanzania, which have not previously been systematically analysed from a political settlement perspective.⁴ Fieldwork methodologies combined interviews with participant observation. A number of semi-structured, in-depth interviews were conducted with previous and current government bureaucrats, development partner representatives, researchers and consultants, and civil society organisations (private sector associations, a trade union and an NGO) working on health issues. The interviews focused on policy-making processes past and present and on their own and other stakeholders' involvement in them. We also witnessed the Joint Annual Health Sector Review Policy Meeting in Dar es Salaam on 24 January 2017, which brought together all important stakeholders in the health sector. The meeting offered the chance to observe different actors articulating their issues of interest. We also had informal discussions with some of the attendees.

Mobilising resources in the early 1990s: Technocratic reform and political sensitivities

The reform of the Tanzanian health sector began gradually at the end of the 1980s, when actors within the Tanzanian government, faced with increasing economic constraints and a dysfunctional healthcare system, began realising that, whereas free and universal coverage may have been the ideal of the party-state (see also Jacob and Hundsbæk Pedersen, 2018), access to hospitals and healthcare services was in reality quite limited for the rural population (Morrisson, 2002; Mbekeani, 2009; Bech et al., 2013). In 1988-89, a process was initiated to formulate a National Health Policy, the first of its kind, with the appointment of ministry employees to advise the government (URT, 1990). The Policy is in many ways an ambiguous document. On the one hand, it refers to the international 1978 Alma Ata Declaration, which called for primary healthcare for all by 2000, emphasised the role of the state in achieving this, and became a guiding policy for the WHO in the years that followed. On the other hand, the Policy mentions the possibility of charging user fees, stating that, since the government at that time could not afford the free health-care services it would have liked to provide to its citizens, 'the government is looking into ways

⁴ There have, however, been analyses that have included aspects of the power dynamics influencing the development of the sector. See, for instance, Bech et al. (2013); Mbekeani (2009); Maluka (2013); Fischer and Strandberg-Larsen (2016).

people can contribute in paying'. In another major change, the Policy encourages the provision of services by the private sector (URT, 1990), something which was allowed the following year.

The introduction of user fees to generate more funding for the health sector mirrored international trends, though these were introduced rather late in Tanzania compared to other countries, due to a general resistance within the ruling party towards liberalising reforms (Loewenson, 1993; see also Jacob and Hundsbæk Pedersen, 2018). In 1987, the World Bank published a policy study, *Financing Health Services in Developing Countries: An Agenda for Reform*, which explored avenues for increasing payments by the rich for health services in light of the state's reduced ability to increase, let alone maintain, spending on health. Also in 1987 a regional WHO meeting gave rise to the Bamako Initiative, a joint WHO and UNICEF initiative in the context of financial constraints in Africa that led to African ministers of health adopting a resolution calling for the introduction of new financing mechanisms, notably in order to accelerate coverage of primary healthcare with a focus on the availability of drugs.

In the Tanzanian case, the transnational influence was obvious, not only through the transmission of ideas, but also through direct involvement by development partners. Funding for the reform process came from a World Bank credit, the Health and Nutrition Project 1990-1996 (extended to 1999) (World Bank, 1999), and preparations were initiated, with analyses showing that the existing system was biased in favour of wealthy Tanzanians in urban areas. The report furthermore found significant willingness to pay (among the urban population) if this could improve access. The decision to implement fees did not, however, guarantee a smooth implementation. From the World Bank's point of view, the introduction of user fees also seems to have been relatively slow. The World Bank credit's implementation report states that implementation was delayed in the early years, partly because of a lack of experience in managing such projects, and partly because of weak government ownership. The latter point also reflects the fact that a 'basic design flaw was made in making these policy changes (on user fees and on pharmaceutical reforms) conditions of project disbursement, resulting in stalled activities during the first three years' (World Bank, 1999). However, a change in leadership in the reform secretariat helped speed things up. The delays could suggest that the reform had been 'imposed' on Tanzania from the outside and subsequently met resistance from within, as suggested by Hutton in his general analysis of shifting World Bank policies (Hutton, 2004). Indeed, the fact that the new leaders in the reform secretariat changed tack and strategically worked with Tanzanian ruling-party politicians to persuade them on the need for reform suggests that the fees were not exactly met with enthusiasm from within.⁵ The World Bank staff involved had a clear preference for the user fees and insurance that were introduced during the period (Shaw and Ainsworth, 1994; Shaw and Griffin, 1995). However, a former staff member insists

⁵ Interviews with involved bureaucrats 13 December 2017 and 11 January 2018.

that it was the reform-minded sector secretariat in the Ministry of Health that was driving the process:

'The issue as technocrats was to make sure to implement the government will [which] was to make sure that the services are available. And you cannot do that without the correct resources. So instead of people saying their child died because it could not access healthcare, you just say they can save the child by the price of just one chicken. Because the price up to today is the value of one chicken. The chicken can come from the households (...) That logic is not written in books from Europe'.⁶

Undoubtedly, it also helped that a clearer policy on how to exempt poor and vulnerable groups was formulated soon after the introduction of user fees in 1993. Again, the change clearly mirrored international trends, as the World Bank's *World Development Report* in 1993, in response to resistance and protests going way back into the 1980s, suggested that governments might want to provide free or below-cost services for the poor (Lea, 1993; Loewenson, 1993). Their implementation in Tanzania, however, came with some very Tanzanian characteristics, as they were implemented only one year later, in 1994 (Munishi, 2010; Maluka, 2013), noticeably quick when compared to the slow implementation of the fees. In this regard, it is also worth noting the correlation with the first multi-party elections in Tanzania, namely the local government elections in 1994.⁷

The process became the first example of the emergence of a policy coalition of bureaucrats in the Ministry of Health and the World Bank, which became a feature also in the later introduction of health insurances. Under the Ministry of Health, a dedicated secretariat emerged, staffed by people who had been educated abroad and were convinced that change was required. They did not see the introduction and gradual expansion of fee provisions as having been imposed by development partners. Rather, they pushed for change themselves, because of their experiences with deficiencies in the existing system, and allied with the World Bank during the process. They saw their main challenge not with the Bank, but with hesitant politicians. Not only did they have to convince a worried incumbent president, Mwinyi, about the proposed changes; the secretariat also went to north-western Tanzania to visit the country's first president, Nyerere, who had been the major advocate of the free healthcare system and had often effectively hampered liberalisation reforms in the years following his resignation in 1985 (see Jacob and Hundsbæk Pedersen, 2018).

⁶ Interview with former bureaucrat, 13 December 2017.

⁷ A similar correlation between fee exemptions and elections could be observed in 1999, again a year of local elections and a year prior to the general elections (2000), when the government announced in the government gazette and in local newspapers that people over 60 would be exempted from fees. However, it is also worth noting that exemptions rarely worked well in practice (see Mubyazi, 2004; Mubyazi et al., 2006).

Tactically, rather than arguing for policy change, the secretariat opted to argue that changes would improve the existing system by moving towards universal access, no longer only in policy, but also in practice:

‘We have a policy of free healthcare. It is good. Being a technocrat, you are not being appointed to be fired by the President for making a mistake. You tell them in a meeting that getting medicine is very difficult because you do not have the input...that is the message we had. It is free but not available. Make it available! And then make it free. Exempt those who cannot pay. And tell everyone to stay healthy.’⁸

Acceptance of the reforms by the two presidents and the cabinet shows that the bureaucrats’ tactic was successful. Whether the success in convincing the politicians was because the latter had been persuaded to believe in fees as a tool to improve the health sector, or simply reflected their wish to keep development partner money flowing, is hard to tell, but it does suggest that Tanzanian bureaucrats had a major stake in the changes. The introduction of fees began with the introduction of modest fees at referral hospitals in 1993, being expanded later to ever more institutions (Abel-Smith and Rawal, 1992; Shaw and Griffin, 1995; Mubyazi, 2004; Mubyazi et al., 2006; Mbekeani, 2009), to district hospitals in 1996, and gradually to lower healthcare facilities (health centres and dispensaries) between 1996 and 2008 (Munishi, 2010; Mujinja and Kida, 2014). At rural health centres and dispensaries, fees were only introduced in the early 2000s (Mubyazi et al., 2006).

Reform and public health insurances under multiparty democracy

Overall, the quality and infrastructure of healthcare in the early to mid-1990s deteriorated and there was little coordination between the government and development partners. A major retrenchment of health staff was carried out, reducing their numbers from 67,000 in 1994 to 54,000 in 2001 (though some of these were ghost-workers). At the same time, development partners, lacking confidence in the government system, implemented their own, parallel projects, for instance, through NGOs. In the late 1990s this led to efforts to improve coordination of programmes, linked to a more general commitment by both parties after a stand-off had led to a grand bargain in 1994-95 (see Jacob and Hundsbæk Pedersen, 2018).

With support from the WHO, Tanzania embarked on reforms of the referral infrastructure system and the management of the healthcare system through its Health Sector Reform Programme and Health Sector Plan of Action (1996-99). This led to more decentralised governance of the health system, overlapping with the more general local government reform programmes that aimed to delegate greater responsibility for service delivery to the district level. Again, the international influence was clear, as these reforms mirrored the recommendations laid out in the World Bank health sector study mentioned above, which, apart from user fees, also

⁸ Interview with former bureaucrat, 13 December 2017.

recommended the introduction of health insurance, improved efficiency of private-sector resources, and decentralisation (Akin et al., 1987).

The attempt to improve coordination took another step in 1999, with the introduction of the first in a number of health-sector strategic plans, the Health Sector Program of Work (1999-2002), in which development partners and the government agreed on a sector wide approach. This led to the establishment of a Health Basket fund, involving the major development partners immediately or soon after (Mapunda, 2003; Daima Associates and ODI, 2005; OECD and Ministry of Foreign Affairs, 2007). Coming out of the reform programme, following a series of district pilots during the second half of the 1990s, a health insurance was introduced through the passing of a National Health Insurance Fund (NHIF) Act in 1999, targeting government employees, and a Community Health Insurance Fund (CHF) Act in 2001, targeting the rural population and those without formal employment. The latter was supported by the World Bank and was later mirrored in an urban equivalent, *Tiba Kwa Kadi* (TIKA, meaning 'treatment by card'), also supported by the World Bank (Mbekeani, 2009; Rwegoshora, 2016).

The process towards the introduction of the health insurances was similar to the one behind the introduction of user fees by way of a policy coalition between reform-minded bureaucrats in the Ministry of Health and certain development partners, though this time there was less resistance from the political system. Insurance schemes had already been mentioned in the 1995 CCM election manifesto, stating that 'we aim to see plans to start health insurance is finalised' (CCM, 1995). The 2000 CCM manifesto merely mentioned that these insurance schemes were on their way (CCM, 2000). The designing of the two schemes happened as concurrent processes. The differences in the final design and the timing of their introduction again had to do with tactical considerations with respect to how to convince sceptical politicians. Again, bureaucrats argued that the proposed changes would improve and help mobilise more funds for the existing system, rather than change it fundamentally.

The initiative behind the health insurance schemes came from bureaucrats in the Ministry's reform secretariat, but it was implemented drawing on a World Bank credit. The work was first and foremost by Tanzanians from or hired by the Ministry of Health, but supported by experts sent by the World Bank. WHO was also involved, but in a less influential role. A number of studies were carried out on the economics of health insurances, and the perspectives of stakeholders, including employers and employees, were collected. This was done not only to gain knowledge, but also to involve stakeholders early on. Not only did the studies show that a health insurance system was possible; they also showed a willingness to pay among many Tanzanians, who increasingly felt the consequences of the user fees they were charged when using health services. According to bureaucrats, this was intentional:

'The driver for the insurance schemes is actually...when you start, you put user fees. But you cannot have user fees forever, then it will become a private

sector. So we are doing this to put the government to start insurance: “Hey guys, it is expensive to pay from your pocket, so why don’t you pool so whenever become sick first gets the services with no extra costs”⁹

Study tours to Zimbabwe, Philippines and Thailand, all countries with functioning health insurance schemes, were also conducted, as well as a trip to a country considered a failure, Kenya, in order to learn from their mistakes.

Politically, the introduction of health insurance schemes was potentially as challenging as the introduction of user fees had been. Therefore, the design and implementation were carefully planned. Not least the burden-sharing aspects were potentially explosive and the two schemes ended up with different models. Whereas the NHIF for public sector workers and government employees was designed to be mandatory, funded by a 3 percent deduction from salaries and an additional 3 percent top-up from the government, the CHF for poor and informally employed Tanzanians was voluntary. The CHF was piloted very early on in one district to gain experiences. Initially, the district councils were supposed to pay for the poor who could not, but that was not how it ended. Instead, the government offered CHF members a government top-up similar to the one offered to members of NHIF. As one bureaucrat noted, making the scheme mandatory would have been like imposing a tax, something that there was no great appetite for at a time of multiparty-democracy.¹⁰ Indeed, the government under President Mkapa increasingly stressed the importance of accommodating liberalising reforms with social measures that would help improve the benefits of reform (URT, 2000; see also Jacob and Hundsbæk Pedersen, 2018).

A mandatory universal CHF scheme would also have been expensive and a cost that the government, wary of relying too much on donor funding, was reluctant to incur. The voluntary nature of the design ensured that implementation would be slow and not put too big a drain on government resources. Secondly, the funds from the CHF were to be administered locally by local boards (which is how the fund derives the ‘community’ in its name), a strong CCM tradition of involving locals in management issues as part of a traditional emphasis on the ideas of hard work and self-reliance (see Jacob and Hundsbæk Pedersen, 2018), but which also provides local leaders, at that stage still overwhelmingly belonging to the CCM, with a platform to appear as the ones bringing services to the electorate.

This time, there seems to have been a broader policy coalition than was the case with the introduction of user fees, in that there was more explicit support from the top of the political system, including the president. The president under whom they were introduced, Benjamin Mkapa (1995-2005), viewed by many as the most neoliberal of Tanzania’s presidents, reiterated in a speech in 2003 entitled ‘The healthcare we need and can afford’, that ‘even the people in the most remote corners of Tanzania

⁹ Interview, 13 December 2017.

¹⁰ Interview, 11 January 2018.

have an equal right to medical care' (Mkapa, 2013). Resistance was more likely to come from CCM traditionalists in parliament and parts of the labour movement unions. Therefore, the NHIF was deliberately introduced first. The existence of an insurance scheme for government employees, bureaucrats and government believed, would make it hard for sceptical decision-makers to oppose an insurance scheme for the poor majority that would allow them similar benefits.¹¹ Furthermore, CHF was designed as a *community* health fund, in line with a long-held CCM idea that development initiatives should build on various types of community involvement and contributions. In practice, this also gave local leaders, who were overwhelmingly CCM supporters at the time, a platform that could be used for electoral purposes. Thus, the design of the intervention involved a degree of patronage.

Election-wise, the design of the schemes meant that the introduction was unproblematic. The public-sector employees made up a small part of the population, and resistance only came from the powerful teachers union, Chama cha Walimu Tanzania (CWT), whose rural members had hitherto enjoyed access to primary health services free of charge, but they were completely ignored.^{12,13} For CCM decision-makers, the introduction of health insurance schemes did not signify the abandonment of the state's responsibility to ensure universal access to healthcare services. Instead, the introduction signified another way to mobilise funds to reach the goal of universal coverage, a goal which began reappearing in official documents in the 2000s. A similar emphasis on mobilising additional funds was also the main reason why the government, in a conflict with a major donor, later insisted on keeping user fees, which by then had come to cover most services (see Box 1 below).

Health insurance has been a growing part of the Tanzanian healthcare system ever since, but the roll-out has been slow. For CCM, universal access to health services was to be achieved through expanding and improving the public health care system more than through health insurances. The 2007 National Health Policy thus still referred to the Alma Ata Declaration on primary healthcare for all. Initially, the CHF grew only slowly, but by early 2016 it was covering 12 percent of the population.¹⁴ Part of the increase is funded by district officials 'encouraging' recipients of the PSSN cash transfer scheme, introduced from 2012 onwards, to become members. In the formal sector, in 2005, the National Social Security Fund (NSSF), the state-controlled

¹¹ Interviews with bureaucrats, 13 December 2017 and 11 January 2018.

¹² Interview with former bureaucrat, 14 June 2018.

¹³ Associational organisations like trade unions have been historically weak in Tanzania ever since independence, as the ruling party has sought to control independent sources of power. Their autonomy increased with liberalisation and the reintroduction of multi-partyism in the early 1990s (Tripp, 2000), but trade unions never got to play any significant role under liberalisation.

¹⁴ There is a great deal of uncertainty about the figures on health insurance coverage, which vary widely for similar time periods in different documents. At times, they have been inflated, probably for political purposes (interview with former bureaucrat 14 July 2018).

Box 1. The politicised politics of fees

In the early to mid-2000s, fees and fee exemptions became an issue of conflict between the Tanzanian government and some development partners headed by the UK Department for International Development (DFID). In 2001, Uganda had abolished user fees after studies had showed their detrimental effects on the access of the poor, and DFID wanted Tanzania to follow suit (Nabyonga et al., 2005). By then, even the World Bank and the US government were revisiting their policy advice on fees, which, it was argued, raised fewer funds than budgeted for, were often mismanaged, and reduced access for the poor. With the 2004 World Development Report, *Making Services Work for the Poor People*, the World Bank abandoned user fees as a panacea for improving efficiency in the health sector, though did not necessarily abolish user fees per se (Hutton, 2004; Mundial, 2004).

The Tanzanian government, however, at the instance of its reform-minded technocrats, whose advice was sought by President Mkapa, and supported by other development partners, held onto its position. The bureaucrats in the Ministry of Health convinced the president that the Tanzanian healthcare system needed the fees to raise funds and improve the working of the system. The incident also became embedded in more generally fraught relations with the Western development partner community over flawed 2015 elections in Zanzibar, over which they threatened to cut aid:

'The donors make a lot of noise. They publish, they write, and they promise a check of 10 billion [probably Tanzanian Shillings, ed.]. But unfortunately [for the said development partners, ed.], this was Mkapa's time. Unfortunately the Zanzibar issue, there was a quarrel with the partners in the GBS [General Budget Support, ed.], and they cut off the supply. And they said that next time we will cut the check in health. And then the president asked, "OK, what do you advise? Let us proceed".'¹⁵

In other words, the president, supposedly linking the two incidents, decided to keep the fees, because the threat of development partners cutting aid demonstrated how fragile the financing of the healthcare system would become without fees.

pension scheme for private-sector employees, introduced a Social Health Insurance Benefit (SHIB) with a semi-mandatory payment component for its members. Other smaller private sector health insurance providers exist, as do informal micro-health insurance schemes provided by, for instance, churches and cooperatives, but on a very small scale (Mills et al., 2012). As of 2016, 22 percent of the population is insured through the major publicly controlled schemes, according to figures from the Ministry of Health (URT, 2016)

¹⁵ Interview with former bureaucrat, 13 December 2017.

The re-emergence of the universal access health policy agenda

Whereas the early reform periods were characterised by a policy coalition between bureaucrats in the Ministry of Health and aid development partners, this changed in the 2000s. As a way to gain the population's acceptance of the hardship brought about by liberalising reforms, which could otherwise potentially undermine the legitimacy of the alliance between the ruling party, the private sector and FDI, the idea of universal access to services re-emerged among ruling politicians. It started with the Vision 2025 development programme, which catered for the reintroduction of universal primary education (URT, 2000), but later spread to the health sector. Whereas this did not signify a return to classic African socialism, with the state as the only provider of services, it was a recalibration of the relation between state and market throughout the economy. In the early phases of structural adjustment, Tanzanian ruling politicians had mainly made their mark on health sector reform by deciding the speed of implementation of the reforms aimed at adjusting expenditure to revenue and attempts to raise funds through, for instance, user fees, health insurance, and the accommodation of development partner priorities. In a context of increasingly competitive elections, they now began introducing their own interventions, focusing more on reaching out to the rural majority, who made up the core part of the population and who tended to vote CCM. This was also in line with the core of CCM's ideology.

In the health sector, the first sign that something was amiss was the introduction of the ten-year Primary Health Services Development Programme (MMAM) (2007-2017). Whereas the collaboration between government and development partners had improved with the sector wide approach and the Health Basket fund, a number of global health initiatives targeting specific diseases like HIV-AIDS, malaria and leprosy, at times linked to the Millennium Development Goals, led to renewed fragmentation of development partner interventions through parallel structures. Tanzania did have some success in aligning these with national health policy priorities, but the issue of power inequalities in the dialogue between government and development partners persisted (Mwisongo et al., 2016; Fischer and Strandberg-Larsen, 2016). With the MMAM, it was the government, headed by the president, who reportedly said that 'we need a plan like the Ministry of Education, which had used it to expand free primary education'.¹⁶ Whereas MMAM provided for a broader range of interventions aimed at improving health prevention, promotion and advocacy, among development partners it was seen as a reversal to a classic Tanzanian government emphasis on expanding physical infrastructure.

The making of MMAM had not really been discussed with the development partners, who were preparing for a new multi-year Health Sector Strategic Plan, which was, and still is, part of the normal government–development partner dialogue. Furthermore, the first version of the MMAM was in Kiswahili, which most actors on the development partner side were not able to read. Many partners were surprised,

¹⁶ Interview with former bureaucrat, 14 June 2018.

and feared that the plan would prove unaffordable, leading to clinics empty of staff and medicine, and would distract from a focus on improving quality in the sector, and indeed, to this day many facilities remain unfinished or staffed with unqualified personnel (Mujinja and Kida, 2014). Still, one may argue that, since the priorities in MMAM had been a part of the CCM's election manifesto in 2005 (CCM, 2005), the programme should not have come as a surprise, but it did. MMAM directly emphasised the importance of fulfilling the 2005 CCM election manifesto promises, which focused particularly on child and maternal mortality rates (which remain high to this day) by expanding physical health infrastructure.

Whereas the reduction of child and maternal mortality was also a priority internationally, the inclusion in the Manifesto indicates that the MMAM was also a matter of electoral politics. Communities were supposed to deliver 20 percent of the input to the financing of the programme through labour and material inputs (URT, 2007), a welcome platform for local CCM leaders, who would be the implementers in places. That political motives were involved was also the perception among other stakeholders in the sector, such as this NGO representative, who reflected on the dynamics relating to the programme:

'The interest of the government is to get re-elected. So they come out with, I would say, simple strategies to convince citizens that they have performed. And for them, they thought that, if you engage in infrastructure expansion, these are the numbers that are visible and are easy to sell on political platforms. And that is what happens until today. And then we ended up with a lot of ghost facilities – new facilities that are not operating.'¹⁷

By then, most development partners had stopped supporting physical infrastructure, apart from Denmark's Danida and German's KfW Development Bank, who supported rehabilitation of physical infrastructure through grants to local governments. Initially, MMAM seems not to have had any significant on development partner funding, which remained high, at 40-50 percent during in the following years (World Bank, 2018).

Apart from electoral politics, however, the divergence of views between the government and the development partners reflects certain differences in thinking that led to further fragmentations of health sector reform. Development partners were generally focused more on improving the quality of services. This was reflected in the Health Sector Strategic Plans that were developed through a dialogue between the Ministry of Health and development partners in the wake of the reforms of the 1990s: the Second Health Sector Strategic Plan (2003-2008) aimed at providing *quality* health services; the Third Health Sector Strategic Plan (2009-2015) aimed at establishing partnerships for delivering on the Millennium Development Goals; and the Fourth (2015-2020), which also aimed at improving quality, had an additional element of promoting public-private partnerships, an element that had recurred in

¹⁷ Interview, 15 December 2017.

most plans, but gained more prominence here (Bech et al., 2013; OECD and Ministry of Foreign Affairs, 2007).

To sum up, the idea of health insurance and universal access to health services mirrored shifts in international policy paradigms, but with regard to the latter, Tanzania was an early mover and its intervention came with some very Tanzanian characteristics. Still, the different priorities among government and development partners that appeared with MMAM in 2007 did not mean that collaboration came to a halt. It was more that a pattern was emerging, in which the government continued collaborating on the administrative reforms of the health sector that would improve its efficiency and quality and keep the development partner funds flowing, while pursuing a separate track reflecting long-held ruling party priorities on expanding public health infrastructure that were popular and could help win elections. Bureaucrats, generally preoccupied with raising funds for the sector, seem to have gone along with the CCM priorities on MMAM and health infrastructure, on the one hand, while also pursuing a single health insurance in collaboration with development partners, on the other. On the issue of a single national health insurance that came next, for the first time they got caught in the middle.

The idea of a single national health insurance scheme

The idea of expanding health insurances in order to reach near universal coverage was introduced in the third Health Sector Strategic Plan of 2009, which saw insurance schemes as a means to increase funding for the sector (URT, 2009). Again, the idea of universal national health insurance coverage mirrored the changing international policy paradigms. In the late 2000s, the agenda of universal health coverage re-emerged, most conspicuously reflected in a resolution passed by the UN General Assembly in 2012. This resolution urged member states to avoid substantial fee payments and to implement mechanisms for the pooling of risk, an agenda that was embraced and propagated by the WHO (Vega, 2013). Bureaucrats and development partners soon translated the idea of universal insurance coverage into that of a *single* and *mandatory* national health insurance scheme, mentioned in the Health Sector Strategic Plan IV of 2015 (URT, 2015). The previous government did not object to the idea, but after the 2015 elections, the new administration, characterised by its greater centralisation of decision-making, rejected the proposed design of the scheme. This led to renewed uncertainty over the future of health insurance.

The idea of a *single*, national health insurance had received very strong support from development partners and ministry bureaucrats from the beginning. Among development partners, it was in particular a priority of a group of the bigger development partners, organised in the Providing for Health (P4H) network that had been introduced by Germany and France as a G8 initiative aimed at raising funds for universal health coverage, and which now included influential development partners like the WHO, ILO, USAID, SDC (Swiss), the Global Fund, the World Bank and regional development banks, Spain, and Morocco. These development partners, in

particular the World Bank and WHO, believed that the healthcare system would be easier and cheaper to manage than the existing fragmented insurance schemes. In the beginning, USAID had some reservations with regard to a single insurance and suggested the importance of multiple insurance providers to enhance competition. However, USAID were later convinced by fellow P4H partners, who therefore reached a common position on single health insurance.¹⁸

The work on designing the new Social Health Protection System with universal coverage through insurances began in 2012, through the development of a Health Financing Strategy, as outlined in the third Health Sector Strategic Plan in collaboration between development partners and an interministerial steering committee (URT, 2016). It would be a major reform, as existing insurance schemes by early 2016 only accounted for 3 percent of total health financing and covered approximately 22 percent of the population, of which more than half (12 percent of the population) was made up of the more voluntary Community Health Fund (CHF), while the other half by the public sector employees' mandatory National Health Insurance Fund (NHIF) (7 percent), private insurances (1 percent), community-based health insurances (1 percent) and the private sector's Social Health Insurance Benefit (SHIB) (0.12 percent) through members' contributions to their pension fund, the NSSF (URT 2016). The reform would provide for a unified system, based on NHIF financing services for the minimum benefit package from service providers, public as well as private ones, but allow for private insurers to top up with additional services. It would also provide for a more equitable system, taking as its point of departure the fact that existing insurance members tended to be relatively well off, also those who were members of the CHF. Services were now to be provided through a single pool based on needs, not income (URT, 2016).

A final draft was ready in January 2016, covering the period 2016-2026. In line with previous reforms, a number of studies had been undertaken to gather experiences. Its main element was a standard minimum healthcare benefit package at all levels of care. In a transition phase, existing NHIF members would enjoy additional benefits in a plus package with access to referral hospitals at all levels. However, all Tanzanians, over time, were envisaged to move towards this plus coverage. There would be a ten-year roll-out period, the first four years being spent on setting up the system legally and institutionally, and the following years for accelerated implementation. The proposal would require significant additional finances, around 70 percent of current costs, most of which was envisaged to come from domestic sources – primarily the additional funds from mandatory enrolment, especially by including all in the formal sectors, and the government, through taxes to cover the poor, but also through pooling of existing development partner parallel structures for specific diseases.

As potential sources for additional government funding, three were mentioned in particular, namely (i) taxes on tobacco and alcohol; (ii) levies on mobile

¹⁸ Interview with donor representative, 6 April 2018.

communication; and (iii) drawing from the surplus of public corporations. Only the former is mentioned again towards the end of the plan. The Philippines' taxes on alcohol and cigarettes, Korea's on cigarettes, and Ghana's financing model through a share of VAT revenues, as well as through a communication services tax, were mentioned as models in this regard (URT, 2016: 39). Increased government funding would help reverse the trend of falling government health expenditure as a proportion of total spending, which had been from 11 percent in 2011-12 to 8.4 percent in 2014-15 (URT, 2016). Since health spending as a percentage of GDP, according to World Bank data, had remained constant over the same period, this fall must have been covered by development partners and increased private contributions, the latter rising sharply at the beginning of the period (World Bank, 2018). However, when the plan reached cabinet secretaries in November 2017, it entered troubled waters, as it moved from being more of a technical issue to being one about politics.

Initial rejection of the proposed single national health insurance scheme

Before Christmas 2017, the proposal for a single national health insurance scheme was brought before the inter-ministerial committee of cabinet secretaries, the last step before cabinet approval. The committee, however, rejected both the idea of a *single* health insurance scheme and major elements of the financing plan. Overall, the committee of permanent secretaries accepted the idea of mandatory insurance cover, but demanded major changes to its design. First and foremost, the committee wished to maintain two schemes, by maintaining the NHIF for government employees and the CHF for those in the informal sector (Ministry of Health, 2017b). This meant that the two schemes, whose administrations had already been merged under the NHIF, were again to be split. This would undermine much of the cross-subsidisation in the scheme that had been so appealing to many of the donors.

People within or close to the government point out that it reflects a real worry that by merging a functional NHIF with a poorly functioning CHF, which for years has struggled to channel funds to facilities in rural areas (Borghini et al., 2013), the end result might be a system that is dysfunctional for everyone, which would be politically risky for the government and the ruling party. Not only would it alienate government workers, like teachers and health personnel, who make up hundreds of thousands of influential voters throughout the country, it might also alienate the rural poor, who would have to pay new taxes and would be faced with mandatory enrolment without obtaining access to the promised services. As an NGO representative pointed out, there is a difference between promising people health insurance coverage and then implementing it with the resistance that mandatory enrolment and payment would create, an issue made more acute with increasingly competitive elections, as in Tanzania:

'The implementation of the law was going to be a little more controversial than passing the law. Because you were now going to force people to join the insurance. That is not a very interesting political undertaking. It would be mandatory. That has to happen in the beginning. I do not see that happening

smoothly in the fourth year [i.e. close to the next general elections, ed.] of this administration¹⁹

The potential cross-subsidisation – through the inclusion of formal private sector employees in CHF – that is still on the table is, furthermore, resisted by the Ministry of Finance. This position probably also reflects the interests of formal sector workers, though their main trade union, TUCTA, did not take part in the discussions in the health financing technical working group preparing the scheme; nor did the Tanzania Association of Employers. The position was also aligned with the concerns of the main private sector associations, which had been involved in the design process through the health financing technical working group, the Association of Private Health facilities of Tanzania (APHTA), the Association of Tanzania Insurers (ATI) and Tanzania Association of Pharmaceutical Industries (TAPI), and which were generally sceptical about the single mandatory insurance, which they feared could potentially undermine the position of private providers. They felt that some elements had been bulldozed through by some development partners.²⁰ The Ministry of Finance was also behind the rejection of another proposed source of funding in the financing plan, namely new, earmarked consumption taxes.

The official reasons for the rejection were, however, slightly different. Apart from the maintenance of a two schemes, the cabinet secretaries pointed to the need of a proper, overall, strategy and not merely a finance strategy. This requirement was not a mere formality, but a standard condition for passing new laws and indeed the finance strategy had been unclear on a number of issues.²¹ For instance, the finance strategy proposed a free choice of health service providers, allowing all users in the single health insurance to shop between providers. This would be a significant improvement for the CHF members who have hitherto been bound to their district, but its practical consequences in terms of migration from rural to urban areas with better coverage, and the costs this would entail, were not accounted for in the strategy.

On a more speculative note, the rejection of a single national health insurance scheme may also reflect the fact that CCM policy preferences were changing under the current administration. An insurance system with a free choice of providers could be seen as a vehicle for private health service providers. Indeed, the private health sector associations had strongly supported this particular element of the scheme.²² Public–private partnerships (PPPs) in the sector had also been official Tanzanian policy since 1993 and many development partners, coming from systems with strong private health service providers themselves, would also be fine with it (Lea, 1993; Bech et al., 2013; White et al., 2013). However, during the implementation of MMAM, from 2007 onwards, we also know that private providers were often undercut by the construction of new public facilities in their vicinity (another reason why some donors

¹⁹ Interview 15 December 2017.

²⁰ Interview 15 December 2017.

²¹ Ministry of Health senior official at meeting, 24 January 2018.

²² Interview with private sector representatives, 14 March 2018. See Daily News (2016).

had criticised MMAM). To this day, some bureaucrats and decision-makers remain sceptical about the private sector, which is influential, but covers only a small part of the population, mainly in urban areas.

The rejection left the leading people in the development partner group, who had been working on the proposal for several years, in shock. They felt that collaboration with the government through the then Ministry of Health and Social Welfare (MoHSW) had been smooth, but clearly this had not guaranteed that the proposal was aligned to government priorities. In fact, they had been working closely with people from the Ministry of Health, whose management was, at the time of the preparation of the Health Financing Strategy, not stable. Key positions tended either to be occupied by acting managers, i.e. persons taking up positions temporarily, or had a high turnover. The new Minister of Health, who took over at the end of 2015, strongly supported the scheme,²³ but this was not enough to secure approval. In other words, the links of the policy coalition of bureaucrats and development partners to the decision-makers, who would have the final say in the reform, were too weak.

In fact, maybe the policy coalition of bureaucrats and development partners should not have been that surprised about the rejection of the single insurance. There were signs that the single mandatory insurance scheme may not have been as important a priority for the CCM as it was for the development partners and ministry bureaucrats. The 2015 CCM manifesto merely highlighted the success of both NHIF and CHF in terms of increased enrolment (CCM, 2015), and had not committed itself to a single universal insurance scheme. Instead, it repeated past promises to increase physical infrastructure, providing each of the country's more than 12,500 villages and its almost 4,500 wards with a dispensary, and each of its 184 district-level authorities with a hospital, goals that were far away, none exceeding 50 percent of functioning facilities (URT, 2018). Nor is insurance mentioned in the latest draft for a new health policy from October 2017, despite it strongly emphasising the importance of universal access to health (Ministry of Health, 2017a).

Discussion: The future of health insurances in a changing political settlement

The delays in reaching universal coverage through health insurance, introduced as an idea in 2009, are remarkable when compared to another recent partner-driven initiative, namely the Direct Facility Financing (DFF) being pushed by the World Bank and USAID, which was part of the very draft financing strategy from 2016 that should have led to a single, mandatory health insurance scheme. The DFF aims to channel funds directly from the treasury to health facilities at the local level. It immediately won the support of the government and its implementation has been fast-tracked. Whereas in some documents this is described as decentralisation (URT, 2015), we would argue that it signifies rather some degree of recentralisation as it means a bypassing of the local district authorities, which have been important components in most reforms since the early 1990s and are heavily supported by development

²³ Speech at Joint Annual Health Sector Review Policy Meeting, 24 January, 2018.

partners. Furthermore, it is worth noting that so far the DFF has been financed purely from the development partner basket fund. In the case of both the health and PSSNs, the Tanzanian government seems more willing to distribute funds when they come from development partners than when they come from the government's own sources.

With the rejection of new taxes, the single mandatory health insurance is unlikely to be implemented any time soon, unless the development partners come up with more financing. Increased enrolment could help cover some of the costs, and indeed improving the CHF and CHF enrolment is now a priority, something on which the government and the development partners agree. However, the policy documents from the ministry already show a reduction in policy commitments from 2016 and 2017 to 2018 (Ministry of Health, 2018; URT, 2018) and it is an open question if the introduction of a mandatory scheme is feasible in the near future. As outlined in our first paper (Jacob and Hundsbæk Pedersen, 2018), from around 2010 onwards, economic thinking in the CCM started changing towards a more state-centric development model, with its increased emphasis on state-owned enterprises and economic infrastructure, and this has only been strengthened with the advent of President Magufuli at the end of 2015. The allocation of funds for new social spending seems to be less of a priority.

Interestingly, there are persistent rumours that the minister of health has managed to convince the president about single health insurance. For a long time, the minister of health, having worked for or with development partners before becoming an MP in 2010, with her support for the single and mandatory national insurance had otherwise appeared more aligned with the policy coalition of bureaucrats and development partners than with the rest of the key decision-makers. However, this is yet to result in changing signals from the inter-ministerial technical committee made up of permanent secretaries and the government as a whole. As outlined above, a main challenge associated with the introduction of the single health insurance is the perceived political risks. Tanzania has witnessed intensified electoral competition in recent years and in particular since the historically competitive 2010 elections. In this context, imposing new economical burdens on the electorate without guaranteed improved access to services within a short time horizon is risky. In this, it differs from less democratic countries like Ethiopia and Rwanda, which have introduced ambitious schemes (Chemouni, 2016; Lavers, 2016).

Politically, the continued improvement of access to health services through the expansion of health infrastructure seems to be perceived as a safer bet. The investments in rural areas, which have the bigger needs, also overlap with CCM's electorate, as Tanzania is still little urbanised. This finding is line with other research showing improvements in service delivery in Tanzania driven by electoral politics during this period (Weinstein, 2011; Rosenzweig, 2015). What is more interesting, however, is that, whereas some research has suggested that the rural and redistributive leaning reflected in the promises made by the CCM during elections is mere rhetoric in order to win votes, only to be forgotten during implementation

afterwards (O'Gorman, 2012; Kjær and Therkildsen, 2012), this may no longer be the case. Studies have shown that the wealthier urban segments of the population benefited most when reforms were introduced in the early 1990s (Morrisson, 2002; Mbekeani, 2009; Bech et al., 2013). Today, the system is slightly redistributive. Whereas the current insurance scheme, with no cross-subsidisation and voluntary enrolment for the poorer segments of the population, is regressive, the healthcare system is still, according to Mtei et al. (2012), overwhelmingly financed through taxes, thus ensuring some degree of redistribution. More research is needed into the distributive effects of healthcare reform.

An additional element in the effort to improve access to health services through public services is the recentralisation of decision-making that has taken place after decades of decentralisation. Again, this is part of a broader international trend that has also been underway in Tanzania for some time. The previous president's Big Results Now programme, which has since been scrapped, thus encompassed a health sector component, with reference to which the fourth and latest Health Sector Strategic Plan stated that it would strengthen the role of the Ministry of Regional and Local Governments (PO-RALG) 'in coordination and administration of service delivery at regional and council levels' (URT, 2015). Under the current president, the entity responsible for monitoring the local governments, the Regional Administration and Local Government (RALG) unit has been moved from the Prime Minister's Office to the President's Office and much control of funds and decision-making has also been taken back from the local governments to the presidency. This means that CCM can maintain some control over municipalities and districts controlled by opposition parties, emphasising that they should implement the CCM's election manifesto (Mtulya, 2016). This also means that improvements in access to a larger extent will be seen as a CCM achievement. In the health sector, recentralisation means that development partners and to some extent bureaucrats increasingly feel sidelined, except when their proposals fit the agendas of the core decision-makers around the president.

Conclusion

Whereas the idea of a mandatory insurance scheme with universal coverage has not been rejected outright by the government, its design will be different from what the policy coalition of bureaucrats and development partners had wished for. This resembles processes of the past, where the coalition had been driving reform processes following international trends and Tanzania's key political decision-makers from the ruling party had made their mark on the final design and implementation. They had influenced the introduction of the health insurance schemes around year 2000 in a similar way. Judged by the modest design and slow implementation, health insurances were not a major priority of the ruling political elite. Politically, a fast rollout back then was perceived to be too risky in an increasingly electorally competitive environment. How would people react if they had been forced to enrol and contribute, but services were not available? Only the National Health Insurance Fund (NHIF) for government employees, introduced in year 2000, was made

mandatory. Protests by the powerful teachers' union over what they perceived to be the introduction of an extra tax were ignored. By contrast, the Community Health Fund (CHF), which was to cover the far bigger part of the population, was made voluntary when it was introduced in year 2001. This meant that it would not be perceived as an extra tax by the rural majority, a ruling party base who overwhelmingly voted CCM.

Though health insurances have been mentioned in CCM election manifestos repeatedly over time, ruling politicians have been more focused on achieving universal access health services through improving public health infrastructure than through health insurances. The goal of universal access had disappeared from policy documents during the early reform period, but it had not disappeared from ruling party thinking. With multiparty elections and a perceived need among key CCM decision-makers to couple liberalising reforms with social interventions that could help convince the population about the benefit of reform, ideas of universal access to services re-emerged, beginning with education around year 2000, but soon spreading to health. In the meantime, the policy coalition of bureaucrats and development partners was allowed to improve the system through technical reforms. In fact, major overlaps between development partner and government priorities can be identified throughout the period. An additional advantage with the expansion of public health infrastructure, often through rural community projects, was the fact that it provided a platform for local leaders, who had long been overwhelmingly CCM, that could also be used during elections. More research into the patronage elements of service delivery in Tanzania is needed.

Concerns about political sensitivity similar to those influencing the design and implementation of the schemes around year 2000 are part of the reason why the initial design of a single national health insurance was rejected recently. Indeed, intensified electoral competition has pushed CCM to further focus on the rural electorate, and with the election of Magufuli in year 2015 decision-making has been centralised. The rejection came as a surprise for the policy coalition of development partners and involved bureaucrats in the Ministry of Health, who did not enjoy the same access to key decision-makers (partly due to changes in government) as in the past, that could have secured alignment with their priorities and paved the way for a smooth passage of an insurance scheme. The intensified electoral competition in Tanzania may also help explain the difference when compared to Ethiopia and Rwanda, two far less democratic countries that opted for a faster and less voluntary roll-out of insurances. A gradual improved enrolment of the existing insurance schemes is now being attempted as an alternative, at least in the short term. Whereas the rejection was not a rejection of a mandatory health insurance per se, it is hard to see how universal coverage can be achieved any time soon without additional donor funding. Despite rumoured support from the current president for a mandatory health insurance scheme, he generally tends to prioritise expansion of transport infrastructure and productive investments over social spending. A mandatory scheme is, however, not off the table, but it will have to address the perceived political risks to be successful.

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