

# Factors influencing implementation of the Community Health Fund in Tanzania

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Although prepayment schemes are being hailed internationally as part of a solution to health care financing problems in low-income countries, literature has raised problems with such schemes. This paper reports the findings of a study that examined the factors influencing low enrolment in Tanzania's health prepayment schemes (Community Health Fund). The paper argues that district managers had a direct influence over the factors explaining low enrolment and identified in other studies (inability to pay membership contributions, low quality of care, lack of trust in scheme managers and failure to see the rationale to insure). District managers' actions appeared, in turn, to be at least partly a response to the manner of this policy's implementation. In order better to achieve the objectives of prepayment schemes, it is important to focus attention on policy implementers, who are capable of re-shaping policy during its implementation, with consequences for policy outcomes.

**Keywords** Policy analysis, prepayment schemes, implementation, street-level bureaucrats, Tanzania

## KEY MESSAGES

- Implementers of policies influence how policies are experienced and their impacts achieved. Some of the problems experienced in prepayment schemes stem from the practice of their implementation.
- Although some theorists suggest that, if planned carefully, implementation can be managed through a top-down process of change controlled by central actors, the apparently powerless implementers, at the interface between the bureaucracy and citizenry, are difficult to control because they have a high margin of discretion in their personal interactions with clients, allowing them to re-interpret and reshape policy in unexpected ways.
- Implementers may react against efforts to impose policy change on them. In Tanzania, viewing the introduction of the Community Health Fund (CHF) as an imposed programme, the district managers responsible for CHF implementation gave it little support, leading to low enrolment in the schemes.
- As policy implementers are likely to react negatively to new policies formulated by national-level policy makers without their involvement, use of participatory approaches in the design and implementation of policy is necessary to engage them more actively in the management of programmes such as the CHF.

## Introduction

Through its health sector reform initiative, the Tanzanian government introduced the Community Health Fund (CHF) in 1995 as a new element in the country's health financing strategy. The CHF is a district-level voluntary prepayment scheme, introduced in parallel with user fees at public health facilities, that targets the 85% of the population living in rural areas and/or employed in the informal sector (see Box 1).

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Prepayment schemes are being hailed internationally as part of a broader solution to health care financing problems in low-income countries (Bennett 2004; Schneider 2004). However, the literature has also raised a number of problems with such schemes that throw doubt on their viability. Important issues are: limited coverage, with exclusion of the poor and those most in need of health care (Ekman 2004; Jütting 2004; Murthy and Klugman 2004); lack of capacity by the scheme managers to manage insurance and negotiate with providers for better quality care (Bennett *et al.* 1998; Derrien *et al.* 2005); and worries by rural villagers whether their payments to the schemes will be used for their benefit (Morduch 1995).

Reflecting these experiences, a particular problem for the Tanzanian CHF is the low level of enrolment of the target population after more than 10 years of operation, which at 10% falls far short of the 70% level envisaged by the government (Shaw 2002). The barriers to enrolment identified by evaluations are: a widespread inability to pay membership contributions, the poor quality of available services, a failure among communities to see the rationale for protecting against the risk of illness, and a lack of trust in CHF managers (Kapinga and Kiwara 1999; Chee *et al.* 2002; Shaw 2002; URT 2003). However, little is currently known about how these barriers vary between socio-economic groups within the overall target population. Such understanding is necessary in developing future implementation strategies that take account of differing needs across population groups. In addition, no previous evaluation has considered if and how the practice of implementation itself generates the identified problems. This paper reports a study that addressed both issues.

In investigating implementation practice, we pay particular attention to the activities of, and factors influencing, district managers, as a critical set of actors in CHF implementation. We also draw on policy analysis literature in considering these implementation practices. This literature highlights the ways in which those responsible for implementing policies influence how those policies are experienced and the impacts achieved. Although some theorists suggest that, if planned correctly, implementation can be managed through a top-down process of change controlled by central actors, bottom-up theorists, in particular, highlight the difficulties of such control given that the apparently powerless implementers effectively re-translate and re-create policy through their practices (Hill 1997; Kaler and Watkins 2001; Walker and Gilson 2004). According to Lipsky (1980), for example, public managers and workers located at the 'street level', that is at the interface between the bureaucracy and the citizenry, have a high margin of discretion in their personal interactions with clients, and specifically, in relation to resource allocation decisions. In an environment commonly characterized by resource uncertainties, they adopt coping behaviours to manage the high demands and time pressures that they face—and through these behaviours they re-interpret and re-shape policy in unexpected ways. Hill (1997: 223) categorizes these coping behaviours as 'rule breaking or careless rule interpretation, officious rule enforcement which make it difficult for the public to secure entitlements, failing to give information about entitlements,

and slow work practices which impose implicit rationing through delays'.

#### Box 1 Details of the Community Health Fund

##### Payment and benefits

- Members pay fixed annual fee per household but no co-payment when using services available at primary level health facilities.
- Households unable to pay the fee are, in principle, entitled to an exemption.
- Households not joining the CHF pay user fees when attending health facilities.

##### Organization

- District Council required to establish autonomous Council Health Service Board (CHSB) with members from local government and community to manage CHF (monitoring, mobilizing and administering funds, setting exemption policy and targets).
- CHSB works with Council Health Management Team (CHMT) to ensure quality of care and facility supervision.
- Secretary of CHSB is District Medical Officer (DMO), head of CHMT.
- At ward level, Ward Development Committee (WDC) is overseer of CHF and establishes Ward Health Committee (WHC) to mobilize communities to join, award exemptions and develop community health plans for submission to district.

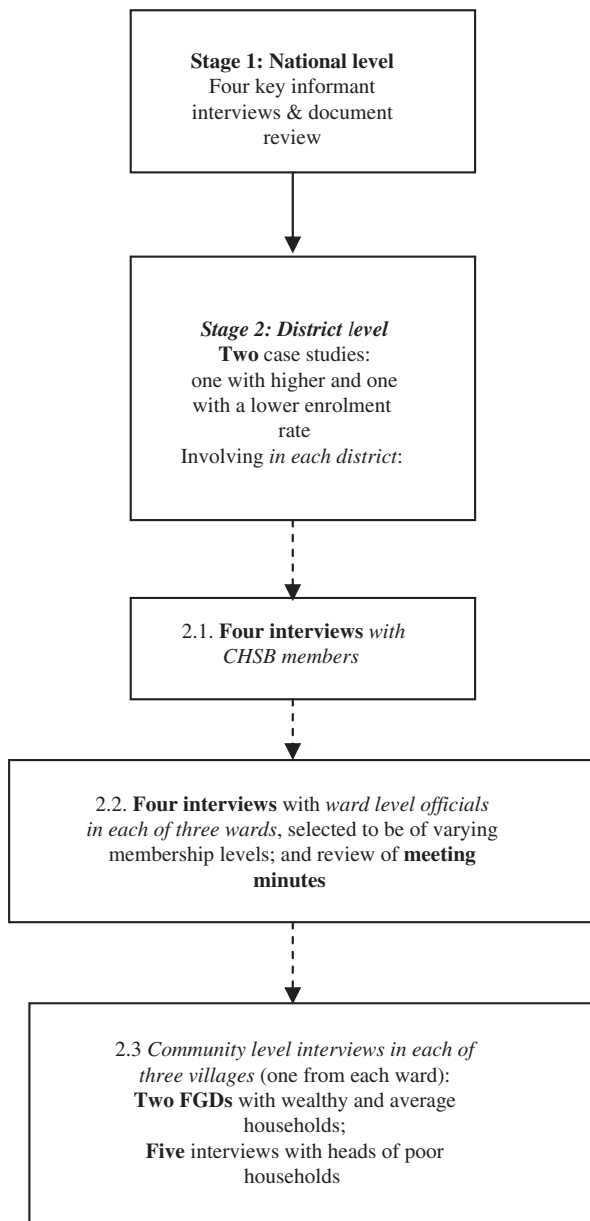
From these starting points, the dual aims of the paper are to identify the factors responsible for low enrolment in the CHF and to consider the influence of managerial practices over these problems. The paper argues that the CHF only achieved an average 10% enrolment rate in a decade of implementation due in part to these practices. It therefore highlights the need to generate and sustain the managerial support necessary to effective implementation. The rest of the paper is structured around three sections, which present the methodology, findings and implications of the study.

## Methodology

The study used qualitative methods to gather and analyse data on the experiences of implementing the CHF schemes at district level across two stages (see Figure 1). In the first, documents (policy guidelines and evaluation reports) were collected and interviews conducted at national level to understand the history of the policy and how central-level officials have interacted with district managers. The key respondents were four officials from the central Ministry of Health and the World Bank country office who were specifically responsible for CHF implementation.

In the second stage of the study, a case study approach was adopted in investigating the experience of CHF implementation at district level. The case study approach was considered appropriate for an in-depth investigation into the underlying causes of low enrolment in CHF schemes (Platt 1988; Patton 1990; Yin 1994). Since CHF activity implementation at district level involves district and ward government officials as well as the communities, it was necessary to collect data at district, ward and community levels.

A stratified purposeful sampling approach was used to choose the two district case studies. Although all districts implementing CHF experience low enrolment, two strata of enrolment rates were evident in the data available for 2002. One case study district was selected randomly from the strata with



**Figure 1** Study design and data collection approaches

relatively higher enrolment rates (with an 11% enrolment rate) and the other from that with relatively low enrolment rates (with a 4% enrolment rate). Within each district a total of three wards were then selected by randomly selecting one ward from each of three levels of membership in the district: low, medium and high. In each ward, one village was randomly selected for inclusion in the study. Finally, since the communities are not homogenous, the wealth ranking approach (Scoones 1995) was used to identify socio-economic groups in each village (wealthy, average and poor) and respondents were selected from each wealth category. Community members in each village studied assembled first to develop criteria for categorizing households according to their wealth. Using these criteria and a list of all village households, literate community members chosen from

each hamlet of the village then participated in categorizing each village household as wealthy, average or poor.

At district level, the four key respondents in each district came from the members of the Council Health Service Board (CHSB) and included the Chairpersons and Secretaries. All of these respondents, except the chairperson in one district, were district government officials. In each ward, the chairperson and secretary of the Ward Health Committee (WHC) were interviewed, as well as two members of the Ward Development Committee (WDC) (the Ward Executive Officer and Councillor). At this level we also analysed minutes of the Ward Health Committee meetings. Finally, at each village we conducted two focus group discussions (FGDs) with community residents about their experience of CHF implementation: one for the wealthy group of residents and one for the average group. However, in total we conducted 13 FGDs: six in one district and seven in another district, where we added a FGD for agro-pastoralists, given their possibly different experiences from agriculturalists (in practice, however, no major differences in experience were identified). Given difficulties in conducting FGDs with poor households, because they were generally busy working, we instead interviewed the heads of up to five randomly selected poor households, in each of the three villages selected per district (a total of 28 interviews).

The main techniques applied in data analysis were content analysis and data triangulation (Patton 1990). Content analysis involved reading through the notes of each interview, FGD and documentary review, and identifying responses relevant to the main questions raised by the study. After this analysis the data were cross-tabulated to allow comparison across sources within and between districts, and within and between national and district levels. For example, community FGD and interview data were compared within and across villages; and across districts, documentary and interview data were compared at each level (e.g. national, ward) and interview data were compared between levels (e.g. ward and district levels; district and national levels). From such analysis, common patterns in the experiences reported by all groups were identified and the experiences of different groups (community members of different socio-economic status, the two districts, district vs. national managers) were specifically examined to allow identification of key differences.

Overall, the use of the case study design enabled a detailed and in-depth inquiry of the complex issues of focus. In addition, the careful and systematic process of analysis and reflection served to ensure rigour in the analysis (Patton 1990).

## Study findings

The study findings are reported by each of the causes of low enrolment identified in previous CHF evaluations, and confirmed here.

### Inability to pay membership contributions

Analysis of documentary data shows that inability to pay annual contributions is identified as an important barrier

preventing poor households from joining the CHF. As one document notes:

‘When it comes to health care, the majority of household members declared that they were unable to cope with costs....38.7% of rural households and 27% of urban households declared that they were mostly not able to pay for health care.’ (Paratian 2004: 156)

Interview data from all categories of key respondents (from poor households to officials at ward, district and national levels) are consistent with the documentary data on this point. However, all 13 FGDs in both case study districts indicated that inability to pay was not an important barrier for average and wealthy groups.

In principle, the CHF policy design addresses this barrier by requiring districts to introduce exemption systems:

‘People who are too poor to pay the required CHF contributions will be exempted from paying.’ (URT 1999: 11)

Documents collected from the districts studied confirmed that central government guidelines on the exemptions policy were available to district managers. In addition, all six ward and eight district managers interviewed had knowledge of the policy. For example, a manager in one district remarked: ‘we had exemption but we left this responsibility to the villagers’, whilst in the other district one of the managers commented: ‘the exemption system did not work as it should’.

In contrast, however, all 28 poor households interviewed in this study across districts did not know of the exemption provision. Two of the four national-level interviewees also indicated that the CHF target population is commonly not aware of exemption possibilities.

The interview data highlight several issues linked to managers that are likely to explain why poor households did not know of or receive exemptions. District and ward managers’ responses indicated a negative attitude towards exemption. In one district, three out of the four (and in the other, two out of four) district managers commented that exemptions are difficult to implement, noting that since the number of households qualifying for exemption was large, exemption provision would erode the CHF’s financial base. In addition, a large number of interviewees at both district (three out of four in each district) and ward (two out of six in one district and four out of eight in the other) levels argued that exemptions are untenable. They all blamed the central government for not addressing the financial sustainability of the CHF.

District managers also undermined exemption initiatives in two ways. First, they simply ignored guidelines from the central government requiring them to develop exemption criteria. In one district, one of the four district managers interviewed commented that it was the responsibility of the village governments to set criteria, while the other three observed that the government did not have clear exemption criteria. In the other district, two district managers commented that it was not their responsibility to set exemption criteria, and two again argued that there were no clear criteria to guide the

exemption process. Secondly, district managers discouraged exemption proposals coming from the communities. Two wards in one of the districts had their requests for exemption refused, while in another district there was no feedback from district managers after submission of requests for exemption. As one of the ward managers observed:

‘Since the WDC submitted names of the households qualifying for exemption to the district, we have never heard about exemption matters from the WDC.’

### Low quality of health care

Across districts, the majority of poor respondents indicated that they felt the quality of services was good. However, a minority did express concerns—reflecting the dominant view of average and wealthy groups.

Table 1 shows that, across districts, there was little difference between average and wealthy groups with regard to views on the quality of health services. The few differences between villages within districts, and between districts, in the perceptions of these groups seemed likely to reflect the particular circumstances of local facilities rather than more general patterns. Four main problems with the quality of services were identified: shortage of drugs and essential medical supplies; inappropriate diagnosis due to lack of diagnostic equipment, particularly laboratory equipment; staff-related problems; limited range of services provided and lack of possibility to use health facilities of members’ choice, coupled with referral problems. Documentary analysis supports these FGD data: several studies have indicated that quality of services was low and that this was an important reason for low enrolment in the CHF (Chee *et al.* 2002; URT 2003; Kihombo 2004; Musau 2004).

Interview and FGD data indicate that managerial failure was again one of the factors contributing to low quality of care. First, district managers did not ensure supervision of health staff to support delivery of quality services. FGDs with villagers in both districts raised concerns about the improper provision of services by health workers, including corruption, pilferage of drugs, absenteeism during working hours and discrimination against CHF members. The following comment reflects particular concern about the lack of supervision:

‘Services do not reach the targeted people. There is no effective monitoring; the leaders do not go out of their offices to see what is happening at the health centre.’

Secondly, ward-level interviews in both districts identified instances where the district managers turned down community requests for funds to procure drugs and medical equipment or allow rehabilitation of health facilities, and took a long time to respond to such requests. Documentary analysis supports these findings. Minutes of one of the Ward Health Committee meetings from one of the wards studied note that:

‘...committee members expressed their dissatisfaction with the District CHF Board’s procedures for approving the Ward budgets because many of the requests from the wards



**Table 1** Perceptions of quality of care by district and community respondent group (data from focus group discussions)

District 1 (4% enrolment)		District 2 (11% enrolment)	
Average group	Wealthy group	Average group	Wealthy group
Shortage of drugs	Shortage of drugs and essential supplies	Shortage of drugs	Shortage of drugs and essential supplies
Inappropriate diagnosis due to lack of diagnostic equipment	Inappropriate diagnosis due to lack of diagnostic equipment	Inappropriate diagnosis and ineffective treatment	Inappropriate diagnosis due to lack of diagnostic equipment and ineffective treatment (drugs)
Staff-related problems:	Staff-related problems:	Staff-related problems:	Staff-related problems:
– unresponsiveness to patients' problems (wasting time in talking)	– discrimination: favouring relatives and friends	– discriminating against CHF members, favouring those paying fees instantly	– discriminating against CHF members, favouring those paying fees instantly
– maltreatment and bad language to patients	– unresponsiveness to patients' problems	– unresponsiveness to patients' problems	– unresponsiveness to patients' problems
– absenteeism (or assigned other duties)	– maltreatment and bad language to patients	– maltreatment and bad language to patients	– maltreatment (giving injection badly and bad language to patients)
– staff shortage	– absenteeism (or assigned other duties)	– absenteeism (or assigned other duties)	– staff shortage
– corruption (asking for bribes from patients)	– staff shortage	– staff shortage	
	– corruption (asking for bribes from patients)	– lack of confidentiality	
Lack of comprehensive service coupled with lack of referral system	Poor referral system	Lack of choice of desired health facility and referral system	Lack of choice of health facility of preference, comprehensive service and referral system

do not get approved or it takes the Board a long time to approve them. The members unanimously recommended that the Ward CHF Chairperson and Secretary should go to the District Headquarters to seek explanation regarding the problems surrounding approval procedures for the Ward budgets from the District CHF Board Chairperson and Secretary.'

Thirdly, district managers did not allocate a budget for CHF administration activities. District managers suggested that the districts did not have funds for CHF administration, and this was partly confirmed by interviews at national level which indicated that policy guidelines prohibited district managers from using CHF funds for administration. However, these interviews also revealed that funds could be used for quality improvement, and that as central government managers saw the CHF as just one set of district activities, they expected district managers to use their funds for general district management to support CHF administration. District managers in both districts, in contrast, saw the CHF as an additional and separate activity from their routine work. Thus one manager remarked: 'CHF was like an NGO. It wasn't a Council programme, as the CHF Board was looked at as a supra-body operating above the Council', and another commented that: 'people thought the CHF is a project with its own operating funds'. In practice, therefore, the funds available to districts for supervision or general management were not used to support CHF administration activities. The results had consequences for quality of care. For example, in one district the CHSB responsible for approving requests for drug and medical equipment procurement and health facility rehabilitation held

meetings only irregularly, whilst in the other district the CHSB stopped meeting due to the lack of funds to defray the costs (transport, per diem for Board members) associated with the Board's meetings. As one of the managers interviewed remarked, due to absence of meetings in the latter 'the district could not spend the CHF funds that accumulated in the bank account'. Similarly, in both districts meetings were rarely held at ward level—in one case, a meeting was only convened once in 6 years.

### Lack of trust in CHF managers

The level of trust in CHF officials varied among community members. Although the majority of poor households in both districts perceived CHF officials as trustworthy, responses in eight out of 13 FGDs indicate that the average and wealthy groups did not trust the officials.

While in one district, expressions of lack of trust in CHF leaders focused on the ward leadership, mentioning corruption and lack of transparency, this was seen by the respondents as the result of district managers' failure to supervise the ward-level CHF managers and health facility staff. In the other district, issues raised included a lack of information about the general operations of the CHF in the district in general, and corruption and a lack of transparency at health facilities:

'There is little knowledge about the fund. How the fund is going to help us is not known to people.'

'Past experience of embezzling public funds affects mobilization of communities for CHF negatively; people think that CHF money collectors will embezzle it.'

Across districts, the district managers' failure to respond to requests from the communities and ward committees, or delay in doing so, demoralized Ward Development Committees and Ward CHF committees, leading to a loss of community confidence in them. In addition, district managers' failure to disclose expenditure of locally raised CHF funds raised doubts about them among the communities. Respondents in five FGDs (spread across districts) identified lack of accountability as a problem:

'With regard to financial matters, we do not know what is happening. No financial report has ever been given to us.'

'They haven't told us how the money has been used. We don't understand.'

### **Failure by the community to see the rationale of insuring against health risks**

There was again variation among community members in relation to their judgement that health risks were a good rationale for insuring. Although in both districts the majority of the poor households indicated that they saw health risks as a rationale for joining the CHF, the average and wealthy groups generally argued that many people in the community did not see the reason why they should pay before they fell sick—often linking this to little knowledge about the benefits of the CHF. In one district, some FGD participants also identified problems with quality of care as deterring enrolment, and some wealthy participants indicated that there was no reason to pay in advance as they knew they could cover the costs at the time of illness.

Analysis of interview and FGD data indicates that the district managers again took little initiative to address this problem. Interviews indicate that in both districts the managers did not arrange to educate the communities before introducing and launching the CHF, because they felt they had little time for these activities. As noted by one manager:

'There was little time for preparation. As far as I can remember, preparations in the community started in May 1999 and the district launched CHF on 1 June 1999.'

One of the ward-level interviewees in one of the districts also explained how rushed the process of introducing the CHF in the communities was:

'CHF came to us like a fire brigade. The programme is good but implementation is beset with problems.'

These observations are consistent with analysis of national-level interviews which indicate that there was considerable pressure from the ruling party to implement the CHF, because it was enshrined in its election manifesto.

However, even after launching the CHF, district managers continued to invest little time in mobilizing communities. The problem appeared to be more serious in the district with a particularly low enrolment rate, where it was raised as an issue in all seven FGDs, in contrast to being raised in only two out of six FGDs in the other district.

Interview data are consistent with these FGD data. All four district managers in the district where the problem was more serious, compared with only two in the other district, indicated that mobilization visits to the communities were rare. As one manager from this district noted:

'Sensitization of communities was low in 1999; we went to all wards and achieved a 4% membership rate, but I think this has dropped because we did not go back to the wards to create more awareness.'

## **Discussion**

This study confirms the findings of earlier evaluations in relation to the causes of low enrolment in CHF schemes (Chee *et al.* 2002; Munishi 2003; URT 2003; Kihombo 2004; Musau 2004).

In addition, the study provides indications of some differences between socio-economic groups in the barriers to enrolment. For the poor, inability to pay membership contributions was the most important barrier, whereas poor quality of care, non-acceptance of the need to protect themselves against the risk of sickness and lack of trust in CHF managers mattered more to average and wealthy community members. However, although the majority of the poor households interviewed perceived quality of care to be good, expressed appreciation for the rationale of covering illness risk and indicated trust in the CHF managers, reflection on CHF activities raises some doubts about these responses. Specifically, because CHF managers made few visits to villages and schemes were not transparent, poor households had little knowledge about the schemes on which to base such judgements.

In contrast, there were few clear differences in experiences between the case study districts. On only two issues could differences be identified, with more severe implementation problems in the district with particularly low enrolment, where CHSB and Ward Health Committee meetings were no longer held and where community mobilization for CHF was particularly weak.

However, the findings do suggest that district managers' actions influenced the way in which the CHF was implemented and contributed to generally low CHF enrolment rates. Further reflection on their actions also suggests that they might be seen as the coping behaviours of street-level bureaucrats.

With respect to exemptions, for example, and as also reported elsewhere (Chee *et al.* 2002; URT 2003), district managers' actions provide evidence of rule breaking, careless rule enforcement and failing to give information about entitlements. They neglected central government guidelines about setting exemption criteria, passing the buck to village governments and grumbling that there were no clear criteria for household identification. At the same time, district managers rejected requests for exemption from Ward Development Committees, strictly adhering to the CHF Act of 2001 (which makes the Ward Development Committees responsible for providing exemptions to poor households: URT 2001) despite the central government guidance and expectation that they would support Ward Development Committees in implementing

exemptions. Finally, they failed to give information about exemptions to the possible beneficiaries.

Similarly, district managers' responses to requests from wards for funds demonstrated officious rule enforcement and slow work practices, and contributed to the quality of care and trust barriers to enrolment among average and wealthy groups. They turned down ward requests for funding and failed to allocate funds to CHF administration activities on the grounds that the guidelines forbade them from spending CHF monies on administrative activities. Lack of funds for administration activities then prevented the CHSBs and Ward Health Committees from holding meetings and conducting CHF mobilization activities. Such problems were also likely to have had consequences for quality of care; another study conducted in one of the case study districts noted that: 'The CHF management seemed to be short of funds to meet travel costs and other expenses for committee members to attend meetings. For lack of meetings, which were important in deciding the disbursement of funds, replenishment of medical supplies in the health facilities could not be done in a timely manner' (Kihombo 2004: 15). In addition, as also indicated elsewhere (Munishi 2003), they delayed dealing with requests coming from wards. The following comment by a study conducted in other CHF districts again shows that these tendencies were common in management of the schemes:

'Lengthy bureaucracy...delayed feedback on CHF progress and honoring WHCs' plans. Strategies to cut down the red tape will rekindle people's trust in the scheme.' (URT 2003: ix)

Where such delays were linked to requests for information on CHF fund expenditure, district managers inevitably sowed the seeds of dis-trust in themselves. In addition, their failure to supervise health facilities, perhaps an indicator of the lack of effort they devoted to the task of district management, probably contributed to poor quality of care and community concerns about corruption at facility level. Delaying tactics by health workers in Tanzania's public health services were also found by another study (Kamuzora 2004).

However, is it fair to hold district managers responsible for these sorts of actions—do the roots of these problems lie with them or elsewhere? Clearly managerial practice within the Tanzanian health system is strongly constrained by the limited overall levels of resource availability in this low-income country (Burki 2001). However, resource constraints seemed to have limited direct influence over CHF managerial practices and managers did appear to have some decision space to act differently. They could, specifically, have done more to tackle the problems experienced in CHF implementation. For example, although there may have been some contradiction in available guidelines, the managers did not take any initiative to bring the problems surrounding exemptions to the central government authorities' attention. Similarly, the managers took little initiative to address the lack of a dedicated CHF administration budget. Although correct to state that they were not allowed to use CHF monies for administrative purposes, they could have used other funds available to them for some CHF activities. For example, it would have been possible to use 'district basket

funding' (combined government and donor funds available for district services) to support committee functioning or supervision of primary care facilities. Furthermore, in one of the case study districts the managers made no effort to use the CHF funds that had accumulated over time for any purpose related to improving quality of care, as allowed by the guidelines.

Moreover, instead of being influenced by resource constraints, managers' actions may have reflected the way in which higher level authorities engaged with them over the CHF policy. The policy was apparently initiated at the central level, with little input from district managers:

'Indeed, one of the major weaknesses of the Health Sector Reform Programme is its top-down approach. The CHF also has a strong top-down dimension because the idea originated at the Ministry of Health with support of the World Bank.' (Munishi 2003: 123)

Pressures from the ruling party to speed up implementation may then explain why the district managers interviewed in this study felt that the introduction of the CHF was an imposed and rushed process, which gave them little time for preparation and left a number of key issues unclear (e.g. exemptions, funding for administrative activities).

In this context, district managers' actions (and lack of action) might be seen as the coping strategies of street-level bureaucrats, reacting to pressures from above and moulding the practices of policy implementation, with negative consequences for policy goals. Other studies have certainly shown that policy implementers react negatively to new policies formulated by national-level policy makers without their involvement (Gilson *et al.* 2001; Mwangi 2002). Tanzania is no exception. For example, Mwangi's (2002) study reported how district managers reluctantly implemented the Health Management Information System (HMIS) imposed on them by the central Ministry of Health under the influence of donors, viewing it as a burden generating additional and unremunerated work. Policy analysis theory also warns that as actors responsible for implementation exercise considerable discretion, they are difficult to control and may react against efforts to impose policy change on them (Hudson 1989; Parsons 1995).

Extending enrolment to all groups is likely to require a range of policy and managerial responses given the variation in enrolment barriers faced by different socio-economic groups. However, to develop such strategic action it will also be important to take account of the factors influencing the work of district managers. Policy guidelines may need to be clearer and less confusing, and ways of engaging district managers in more active management of the programme are likely to be necessary. The use of participatory approaches in the design and implementation of Benin's Bamako Initiative programme, for example, generated their active involvement in its management (Gilson *et al.* 2001).

## Conclusion

Overall, this paper adds to current analyses of pre-payment schemes in two ways. First, by investigating differences in enrolment barriers between households categorized by socio-economic status and the managerial factors that help to

generate these barriers, this paper provides evidence that can support management efforts to improve the performance of prepayment schemes. Secondly, by exploring managerial practices as an influence over policy implementation and scheme performance, the paper highlights the need for future studies of prepayment schemes to consider in more detail the influence of implementation factors over scheme performance. Identifying more clearly the causes of current implementation problems is vital in considering how they can be addressed.

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