



Tanzania Access to Insurance Diagnostic

Document 6: Health insurance dynamics

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About the Tanzania Access to Insurance Diagnostic series

This is *Document 6* in a series of 8 documents that together comprise the findings of the Tanzanian Access to Insurance Diagnostic. The series consists of one headline findings summary and seven input documents, each focusing on a specific thematic area, that build up the evidence base to the headline findings:

- 1. Headline findings.** This document summarises the main findings of the diagnostic study across the other documents, then concludes on market potential and opportunities, the challenges to be overcome and the strategic imperatives to unlock such potential.
- 2. Context.** Document 2 outlines the macroeconomic, socio-economic, political economy and financial sector context within which the Tanzanian insurance market develops.
- 3. Insurance uptake.** Document 3 estimates the current penetration of the microinsurance market as percentage of adults in Tanzania and how insurance uptake has evolved in recent years.
- 4. Insurance industry trends.** Document 4 analyses recent trends in the insurance industry in terms of premium volumes, players and performance, asking what the catalyst for the next wave of growth required towards an inclusive insurance market will be.
- 5. Product and distribution landscape.** Document 5 considers the current suite of products in the Tanzanian microinsurance landscape. In addition, it unpacks trends in insurance distribution.
- 6. Health insurance dynamics.** Document 6 takes a closer look at the health insurance dynamics in Tanzania, given the unique features of the health insurance landscape.
- 7. Regulatory framework.** Document 7 considers the role of policy, regulation and supervision in building an inclusive insurance market by unpacking the key features of the insurance regulatory framework, as well as ancillary areas of regulation.
- 8. Understanding client needs.** Document 8 draws on focus group and demand-side survey research to better understand the economic realities, risk experience, coping strategies and knowledge and perceptions of insurance of the Tanzanian adult population. On this basis, it conducts a segmentation exercise whereby the target market is grouped into distinct segments and the profile of each is explored.

The series was designed so that readers can focus on the Headline Findings document, drawing on specific input documents for the evidence base and as per their area of interest.

The full series is available at: www.fsd.or.tz and www.finmark.org.za

The series has been submitted for review by the global Access to Insurance Initiative (www.access-to-insurance.org) and, upon acceptance and subject to further refinements, will also be published under the banner of the Access to Insurance Initiative.

HEALTH INSURANCE DYNAMICS: DOCUMENT 6 SYNOPSIS

Health insurance warrants special attention due to its unique nature and the important role it plays in the Tanzanian insurance landscape. It is the single biggest usage category and the best known and most needed product among the population at large. However, the rural and informally employed population still remain largely unserved.

Key findings

The Tanzanian health insurance landscape consists of five components:

- *National Health Insurance Fund (NHIF)*. The NHIF provides comprehensive care cover on a fee for service basis to all public sector employees and their families through a broad network of health service providers. Focus group research highlights user frustration with the system, causing many NHIF customers to buy private top-up cover.
- *National Social Security Fund (NSSF) Social Health Insurance Benefit (SHIB)*. The SHIB is available to private sector employees and operates on a capitation basis. SHIB enrolment is voluntary and is used by only 9.2% of NSSF members. Low usage is attributed largely to its relatively small network of healthcare facilities.
- *Community Health Funds (CHF) and Tiba kwa Kadi (TIKA)*. Rural CHF and their urban counterparts, TIKA, are public schemes administered by the NHIF requiring nominal annual membership contributions by users and operated on a capitation basis. They were set up to enhance access to healthcare for rural and informally employed individuals. Despite a relatively wide reach, they are fraught with challenges, including the fact that members only qualify for treatment at the facility where they are registered. Focus group research indicated considerable dissatisfaction with the system.
- *Private/NGO community-based health insurance funds*. In addition to CHFs and TIKA, there are also numerous private/NGO health insurance schemes that operate at the community level, outside of the formal insurance market, on a capitation basis.
- *Private health insurance*. Private health insurance is currently used only by the top-end, formally employed market. It provides comprehensive cover on a fee for service model.

Conclusion

None of the current offerings likely to meet microinsurance market needs at scale:

- State provision at national and community level reach a significant number of people, but face a number of challenges
- Demand-side research indicates that private/NGO community-based health insurance funds fulfil a valuable role, but they are estimated to reach only a small part of the population rely largely on NGO and donor support to be financially viable.
- There is still a significant untapped client base in private health insurers' traditional target market. Coupled with the fact that the industry is facing severe cost challenges, this means that it is unlikely to branch into the microinsurance sphere.

This creates a public policy imperative for finding a solution to the day to day healthcare needs of the poor and rural population, particularly by looking at ways in which the public and private community-based systems can be strengthened.

This conclusion also challenges the private insurance sector to consider innovative ways, outside of the traditional comprehensive care model, for expanding their reach.

1. Introduction: health landscape in Tanzania

This document provides an overview of the health financing landscape in Tanzania. We consider health insurance separately because: (i) it is the single biggest insurance category by number of users according to the 2009 FinScope figures; (ii) focus group discussions indicate that it is the most sought after insurance product in Tanzania and (iii) it has a unique set of role players in comparison to other insurance classes. Whereas the two main parties in other classes of insurance are insurers and distribution channels, the health insurance market also includes a service (healthcare) provider as key link in the value chain. In addition, government involvement in healthcare provision, subsidisation and social health insurance are important elements to take into account when building an understanding of the health insurance sector dynamics.

Improving healthcare indicators, but service network does not meet all needs yet. To better understand the health financing landscape in Tanzania, it is important to have an appreciation of the health sector within which it operates. Key health sector indicators show that there have been significant improvements in healthcare outcomes in recent years:

Indicator	1999	2004/05	2009/10	Change, 1999-2010 (%)
Infant mortality rate	99	68	51	-48.5
Under-five mortality rate	147	112	81	-44.9
Maternal mortality ratio	529	578	454	-14.2
Births in health facilities (%)	36	46	51	41.7
TB treatment completion rates (%)	81	82.6	88	8.6
Clinical staff per 10,000 population	4.3	4.6	4.9	14.7

Table 1: Changes in Key Health Sector Indicators, 1999 – 2010

Source: Tanzania Demographic & Health Survey (TDHS), 2010

Table 1 indicates that there has been an increase in clinical staff¹ over the last decade. Nevertheless, the World Health Organisation indicates that the health services network is still inadequate to meet the population's full healthcare needs. Especially in rural areas, numbers of service points, physicians and nurses are still relatively low according to international standards and there are challenges with medicine distribution and quality of care at the local level. In working towards universal health coverage, the Tanzanian government should ensure that the health services network is adequate to 'carry' the population (WHO, 2006).

Change in financing model creates out of pocket expenses. Prior to trade and economic liberalisation, healthcare services were solely financed by the national budget². In 1993 the Tanzanian government decided to introduce user fees as an additional financing source. This decision was made in light of an increase in treatment costs and the overall poor performance of the economy. Since the introduction of user fees, uninsured households are required to make out of pocket payments at healthcare facilities. Internationally, out of

¹ Clinical staff includes physicians, assistant medical officers, nurses and nurse-midwives.

² World Bank, 2011. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*

pocket expenditure for healthcare creates an equity concern as it limits the poor’s access to healthcare.

Significant government expenditure, but donors, consumers still carry the brunt. Government’s health expenditure as a proportion of total government expenditure (TGE) remained constant between 2002/03 and 2009/10, at approximately 7% of total government expenditures. Figure 1 shows that donors were the largest contributors to Total Health Expenditure (THE) in 2009/10, while public expenditures remained relatively constant at a quarter of THE. Although households’ out of pocket expenditures has declined from 2002/03 to 2009/10, it still represents nearly a third of THE:

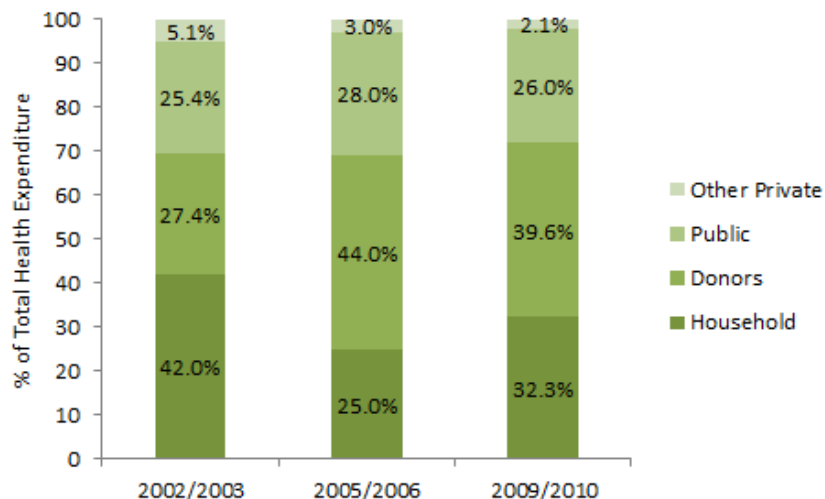


Figure 1: Total Health Expenditure (THE) according to financing source: mainland Tanzania³

Source: United Republic of Tanzania, 2010. *Tanzania Mainland National Health Accounts 2009/2010*.

National and social health insurance introduced to curb user burden, enable cross-subsidisation. In an attempt to protect vulnerable groups, the *Ministry of Health and Social Welfare* committed itself towards the expansion of health insurance in Tanzania. This has led to the introduction of the Community Health Fund (CHF) system in 1996 and the establishment of the National Health Insurance Fund (NHIF) in 2001⁴.

Public scheme targets included in broader government health policy. Government’s goal with regards to the strengthening of the health sector includes a number of enabling policies. These policies are articulated in various government documents, including the National Vision 2025, the Five Year Development Plan (2011/12–2015/16), the National Strategy for Growth and Reduction of Poverty (NSGRP-MKUKUTA II), and the National Health Policy and Health Sector Strategic Plan III 2009–2015 (NHSSP III). In order to achieve the goals of the NSGRP-MKUKUTA II, the health sector is tasked to improve the quality of life and social well-being of the population. As part of this, government is aiming to expand health coverage by state schemes to reach 45% of the population by 2015⁵.

³ Please note that similar National Health Accounts are not available for Zanzibar

⁴ United Republic of Tanzania, 2010. *Tanzania Mainland National Health Accounts 2009/2010*.

⁵ United Republic of Tanzania, 2010. *Ibid.*

In light of the health sector context, this note aims to evaluate how effective the government's health insurance schemes are in addressing the healthcare needs of the poor, and what role private insurers can play in the broader health financing landscape.

We start by looking at the health financing needs of the Tanzanian population. Thereafter the various players in the health financing market are introduced and unpacked in order to conclude on the extent to which they serve the health insurance needs of the mass market – currently, as well as potentially in future.

2. Demand-side indications: health is paramount

Health insurance single biggest insurance usage category. As shown in *Document 3*, FinScope 2009 indicated that 5.6% of the adult population had health insurance, amounting to nearly 1.2 million individuals. Though this is still only a small percentage of adults, it made health insurance the single biggest insurance category according to number of users (88.9% of those with insurance).

Health risks utmost in people's minds. *Document 8* indicates that health insurance is by far the best known and most desired – but also the most criticised – insurance product amongst focus group respondents⁶. FinScope survey results show that the bulk of the population regard health expenses as the biggest threat to their income. This is confirmed by the focus group research: respondents indicated that the most frequent, and at the same time most uncertain and urgent cost facing them, is paying for medical services.

Variety of coping mechanisms. Given the high cost and unexpected nature of illness and accidents, various financing mechanisms are used to pay for healthcare. These include contributions from relatives, loans, the sale of livestock and financial support from rotating savings schemes/merry-go-rounds and VICOBA⁷s. As the following quotes illustrate, focus group discussions highlighted the sense of urgency people felt in getting money together – through whatever means – to cover healthcare expenses:

“The first strategy is to ask for help from your relatives and close friends. Another strategy is that in case you do not have relatives or close friends to look to, then you have to sell something valuable in your possession or use that valuable item as collateral to borrow money from several sources”. (Group 3: non-insured men, Dar es Salaam)

“You have to help yourself. If you have nothing you have to ask for a loan, and through God's wishes when things get better you have to return the money. If you belong to a group, they can make some contributions for you. Sometimes when you go to hospital you are told to go with advance money otherwise nobody will take care of you. So the only option is to go and ask for a loan or if you have something worth a lot of money you put it as collateral just to get money to take a child to hospital”. (Group 17: non-insured women, rural Kilimanjaro)

“Actually most of the time, we are required to borrow money to take care of the health expenses, because they happen too suddenly.” (Group 9: non-insured men, rural Kisarawe)

⁶ As explained in *Document 8*, this diagnostic study benefits from a series of dedicated focus group discussions conducted as input to the study by Development Pioneer Consultants, Dar es Salaam. The full focus group report is available at: <http://www.fsd.or.tz/>

⁷ Village Cooperative Banks, also known as Village Savings and Loan Associations.

“If you have chickens at home you can sell maybe two just to make sure your child gets treatment. Sometimes even if one hundred shillings is missing, they will never treat you.”
(Group 17: non-insured women, rural Kilimanjaro)

Demand-supply mismatch. Does the current supply of health insurance meet client needs? These quotes suggest not. They illustrate the demand-side realities implied by gaps in health financing and the subsequent need for out of pocket expenses. They furthermore underline the imperative for finding a health insurance solution for the population at large.

Below, the existing health financing landscape will be analysed in order to identify the gaps in the market.

3. Supply-side: multi-faceted health financing landscape

Intricate set of role players in health financing landscape. The health insurance landscape is comprised of various components:

1. **State provision at national and community level** through the National Health Insurance Fund (NHIF), the National Social Security Fund (NSSF), Community Health Funds (CHF) and their urban counterparts, *Tiba kwa Kadi* (TIKA).
2. Various **private/NGO community-based** health insurance schemes that operate outside of the formal insurance market
3. **Private health insurance** provided by general insurers.

In addition to these public, private and community-based health insurance providers/funds, the health financing landscape also comprises direct state funding and donor support, as well as a multitude of healthcare service providers (surgeries, health centres, clinics and hospitals) at district and community level. Between all these financiers and service providers there are a number of service agreements and financing flows⁸. Furthermore, the institutional landscape includes the *Ministry of Health and Social Welfare* in a coordinating capacity, the *Social Security Regulatory Authority* as regulatory home for the NSSF, NHIF and, through the NHIF, the CBHs/TIKA, and TIRA as regulator of private health insurers.

The following diagram summarises the health financing landscape in Tanzania:

⁸ World Bank, 2011. Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note.

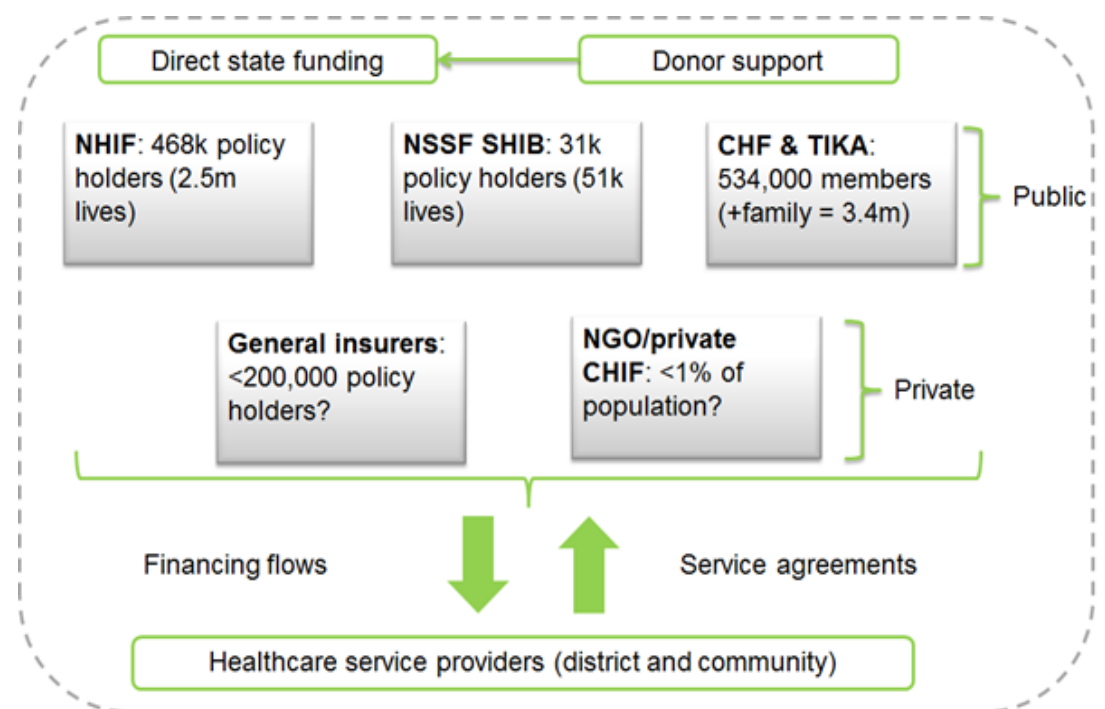


Figure 2: Health financing landscape

Source: authors' representation based on various sources

Within the health insurance space, different schemes apply different payment provider methods (see Box 1) that can result in conflicting incentives for the various actors in the health system⁹. The NHIF and private health insurance use a *fee for service* model, whereas the SHIB and community-based schemes apply some form of *capitation* model:

Box 1: Capitation versus fee for service models¹⁰

Under a **capitation** model, healthcare providers are paid a fixed amount per beneficiary enrolled to them, for a specific period of time. Healthcare providers are remunerated regardless of whether or not the beneficiary utilizes services during that time.

Seeing that remuneration is not determined by the 'type' of procedure, healthcare providers are incentivised to contain the cost of treatment. Such models therefore have the potential to be more cost-effective than fee for service models (see below). The downside of this, however, is that healthcare providers tend to 'under provide' in order to benefit more from the fixed amount per beneficiary, or to provide lower quality of service. Thus intensive quality control measures are required to make the capitation model work effectively.

Under the **fee for service** model, healthcare providers are compensated at an established rate for treatment on a per-patient, per-service basis. This potentially creates an incentive for doctors to increase the supply of services, as they stand to gain financially from doing so. There is extensive international evidence, at both national and micro levels, of the link between increased utilisation and

⁹ Broomberg, J. & Price, M.R. The impact of the fee-for-service reimbursement system on the utilisation of health services. Part 1. A review of the determinants of doctors' practice patterns. *Department of Community Health, University of Witwatersrand, Johannesburg.*

¹⁰ Alex Drosses, 2002. *Health Economic Analysis. Fee for service vs. Capitation.*

the fee-for-service payment system¹¹. Thus healthcare providers tend to ‘over treat’ patients under this model.

In terms of access to services, the capitation model typically limits patients to a single or specified group of healthcare providers, while the fee for service model typically allows beneficiaries to choose from a large network of healthcare providers.

Below, the features and reach of each of the three categories of health insurance providers, as well as the particular challenges facing them, are considered in turn.

3.1. State provision at national and community level

Table 2 outlines the main features of each of the three state schemes:

Prepayment scheme	NHIF	NSSF – SHIB	CHF/TIKA
Number of lives covered	2.5 million beneficiaries (468,611 policy holders) ¹²	51,300 beneficiaries (31,000 policy holders)	3.4 million beneficiaries (531,154 policy holders)
Coverage	Principal members, their spouses and up to four children and/or dependents	Principal members, their spouses and up to four children	Principal member, spouse and children below the age of 18 years
Target market	Formal public sector	Formal private sector & parastatal	Informal sector
Enrolment basis	Compulsory	Voluntary	Voluntary
Premium Range	6% of basic salary, 3% employer, 3% employee	Part of 20% NSSF contribution, half employer, half employee	Agreed by community members, annual premium typically range between TZS 5,000 - 15,000; doubled by matching grant from Health Basket Fund
Premium collection method	Payroll deduction and submission to NHIF	Payroll deduction and submission to NSSF	Collected at health facility level, remitted to district
Payment method	Fee for service	Capitation & some fee for service	Capitation/state-subsidised
Benefit package	Full range of services ¹³	Broad range of services ¹⁴	Public primary healthcare & some hospital services
Facility coverage	Over 5,500 health facilities	264 facilities	Typically the facility where subscriber is registered

¹¹ Broomberg, J. & Price, M.R. *The impact of the fee-for-service reimbursement system on the utilisation of health services. Part 1. A review of the determinants of doctors’ practice patterns.* Department of Community Health, University of Witwatersrand, Johannesburg.

¹² National Health Insurance Fund (NHIF). *Fact Sheet Inside NHIF: 2001-02 to 2010-11.*

¹³ Registration fees, basic diagnostic tests, outpatient services including medications and investigations, in-patient care (fixed rate per day per level of health facility), surgery, spectacles, physiotherapy, optical services, dental services, retirees health benefits, medical/orthopaedic appliances

¹⁴ Outpatient services include consultations, basic & specialized investigations, drugs under the National Essential Drug list, simple procedures; in-patient services include accommodation, consultation with a Medical Officer or specialist and basic investigations.

Prepayment scheme	NHIF	NSSF – SHIB	CHF/TIKA
Regulatory oversight	SSRA	SSRA	Administered by NHIF

Table 2: Key features of state schemes: NHIF, SHIB & CHF

Source: NHIF, 2010. Actuarial & Statistical Bulletin as of 30th June; World Bank (2011)

As mentioned in Section 1, state schemes have been designed with the aim of improving availability and accessibility of healthcare to all groups of people in the country. Below the key features of the existing state schemes will be discussed in more detail in order to determine whether they currently succeed in this goal.

National Health Insurance: relatively wide reach, but limited to public workers, questions on quality

Caters for civil servants. The NHIF was set up in 2001 in recognition of the need to use social insurance as a financing tool to achieve effective cross-subsidisation towards the goal of universal coverage. It is compulsory for public sector workers only, though there are plans to extend coverage to the full formally employed market and even the informally employed market in future (NHIF consultation, 2012). As shown in Table 2, about 2.5 million individuals (including main members, spouses and children) are currently covered. Although there has been substantial growth in NHIF membership in the last 10 years, it still represents less than 5.8% of the total population¹⁵.

Managed under a fee for service model. As shown in Table 2, the NHIF covers main members, their spouses and up to four children and/or dependents. Premiums are equal to 6% of a member’s salary – 3% is deducted from a member’s salary and remitted to the NHIF, and the remaining 3% is contributed by the member’s employer, i.e. the government. Healthcare providers are remunerated on a fee for services basis and members must be treated at one of the 5,500 accredited healthcare providers in the NHIF’s network.

Focus group discussions highlight user frustrations. A discussion on compulsory health insurance through the NHIF provoked strong reactions from focus group respondents. Despite some positive responses, the NHIF was also heavily criticised:

“It has benefits. Instead of using cash you get the service without paying - they will deduct from your salary. For example I delivered my first child in a private hospital and I didn’t pay anything, so the benefits are there.” (Group 16: compulsory insured women, rural Kilimanjaro)

“Let me say the majority has health insurance because we are forced by the institution that we are working for because it is being deducted from our salaries. If it were voluntary to sign up probably some of us wouldn’t be there, so it’s compulsory, you must sign up.” (Group 16: compulsory insured women, rural Kilimanjaro)

¹⁵ Based on the CIA World Factbook’s total population estimate for 2011, which is the latest available population estimate.

One of the problems is that of **limited awareness** with regards to health cover. Some respondents indicated that they were not aware that they have health insurance until they realised money is being deducted from their salaries. Furthermore, respondents are not aware of what is included in the benefit package:

“I just found it in my salary slip that there is money deducted for insurance so we had no idea about it. They started deducting in 2009 and later we realize that there is health insurance.” (Group 4: compulsory insured women, Dar es Salaam)

“I think they should tell us all the services which are part of the health insurance and others which are not, instead of us going there and wasting time.” (Group 16: compulsory insured women, rural Kilimanjaro)

Another issue raised by the focus group respondents is their perception that the NHIF **segregates members by rank**, and rank determines what is covered and who is given first priority. Though it is logical for a system to have different benefit tiers based on the size of contributions, focus group respondents experienced it as going against their ingrained appreciation of social equality (referred to by one respondent as “Mwalimu Nyerere’s perspectives”):

“Health insurance discriminates people by giving people cards with different colours. Some of the classes of these cards give no freedom to be treated for some diseases.” (Group 19: non-insured men, rural Kilimanjaro)

“There is a problem that we face concerning health insurance as it segregates people because there is a green card, and a red card and a brown card. For us who have red cards we are separated from the rest. We wait for a long time before we see the doctors so it’s a big challenge. Others who have green cards are given first priority, while we don’t have the same scale when it comes to deductions in our salaries maybe.” (Group 4: compulsory insured Female women, Dar es Salaam)

“I once faced the same challenge when I went to KCMC because I preferred to be hospitalized in a private ward. It was not possible because I was not using the green card so I had to sleep in a normal ward because I had no savings at that time. My relative too had cancer and it was not possible for her to be treated using the red card so she had to use cash although she was relying on health insurance.” (Group 16: compulsory insured women, rural Kilimanjaro).

“There are some hospitals, if they see you with health insurance cards they get annoyed and won’t give you any service. Yet separation of the same Tanzanians in provision of health services is very common in our hospitals. This is social stratification and against Mwalimu Nyerere’s perspectives. Please, tell these insurance companies to remove this segregation.” (Group 7: compulsory insured men, rural Kisarawe)

Furthermore, focus group participants explained that compulsory health insurance would not cover all their expenses, necessitating them to incur **out of pocket expenses**:

“For example when you go to hospital for certain medical check-ups they tell you directly that you can’t use your health insurance. You need to contribute some amount of money for treatment, you can’t just rely on health insurance only.” (Group 4: compulsory insured

This may indicate potential demand for “top-up” cover. Industry consultations confirm that a substantial proportion of NHIF clients obtain additional health cover from private insurers.

Focus group discussions also pointed towards **inefficiencies within the system’s design** and expressed the need for an option to change the list of beneficiaries when your spouse is also part of the NHIF:

“I have been told to list four close relatives, which are my wife and three of my children. But now my wife does the same, so I find that we are paying for each other. I would have personally preferred that it increases the number of people that we can list to be catered for in this scheme regardless of our blood relationship.” (Group 12: compulsory insured men, urban Kilimanjaro – Moshi)

Low claims/loss ratios validate consumer complaints. An analysis by the World Bank¹⁶ shows that there has been an increase in total premium income paid out as benefits by the NHIF, from 2.2% in 2001/02 (its first year of operation) to 23.4% in 2009/10. Although the loss ratio has steadily increased, 23.4% still represents a poor value proposition for members if one considers that only a quarter of what people have paid in premiums is paid out in benefits; the rest is either used to cover admin costs or it goes to reserves.

High levels of unused reserves. The NHIF’s latest annual report shows that it has more than TZS 300 billion in investments and reserves. At current expenditure levels this represents approximately 15 years’ worth of claims¹⁷. The high levels of unused reserves held by the NHIF imply that they have the financial capacity to pay out more in benefits and if the NHIF was administered more efficiently, consumers would have less out of pocket expenses.

Quality of healthcare services hampered by cumbersome reimbursement procedures. In addition to consumers’ negative experiences, public healthcare providers expressed their frustration with the NHIF’s reimbursement procedures. Not only does this influence healthcare providers’ attitudes towards NHIF patients negatively, it also weakens facilities financially and therefore affects the quality of services¹⁸. This is confirmed by focus group discussions:

“I remember one day my child was sick and had to take him to Umbwe hospital and they told me that they can’t treat my child simply because the government has not paid these [hospitals] for such a long time so we are no longer providing services for health insurance people. So I asked them why the advertisement is still there that they treat health insurance people? They insisted that the government hasn’t paid and they can’t run their hospital under loss.” (Group 16: compulsory insured women, rural Kilimanjaro)

“The main complaint about health insurance is that they get very poor services from the hospitals they go to because of possessing a health insurance card.” (Group 2: voluntarily

¹⁶ World Bank, 2011. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*.

¹⁷ *Ibid*.

¹⁸ USAID, 2011. *Tanzania health system assessment: 2010 report*.

National Social Security Fund (NSSF) caters for the private sector, but limited reach

In 2006, Government introduced a Social Health Insurance Benefit (SHIB) to the NSSF as part of its efforts to expand healthcare financing to the bulk of the Tanzanian population¹⁹.

Low enrolment rates. The SHIB is one of the seven benefit categories of the NSSF and, as indicated in Table 2 (page 7), offers private sector workers a relatively broad services package. Although enrolment with the NSSF is compulsory, registration with the SHIB is voluntary and only 9.2% of NSSF members are currently registered. Low enrolment rates can, amongst others, be attributed to the relatively small network of healthcare facilities with SHIB accreditation (only 264, versus the more than 5,500 facilities accredited by the NHIF) and the fact that enrolment requires a separate procedure.

Managed on a capitation basis. In contrast to the NHIF's fee-for-service model, the SHIB is managed on a capitation basis (refer to Box 1, page 5, for an explanation). Some facilities, especially in Dar es Salaam, refuse to work on a capitation basis and the NSSF has special fee-for-service agreements with these facilities²⁰.

Community Health Fund (CHF) & Tiba kwa Kadi (TIKA) cater for the mass market, but fraught with challenges

Demonstrates government's commitment to healthcare for all. The CHF and TIKA²¹ system was introduced in 1996 as part of government's attempt to increase the poor's access to healthcare²². As shown in Table 2 (page 7), the CHF is the only state scheme that caters for the informally employed market, which represents the bulk of the Tanzanian population.

Designed as an alternative to user fees at point of service. The district is the centre of the CHF activities. Members of a community join on a voluntary basis and agree on annual premium themselves, typically between TZS 5,000 (about USD3.2)²³ and 15,000 (USD 9.6), which is doubled by a matching grant from the national budget. In order to qualify for matching grants from government, districts are required to raise TZS 5 million (USD 3,218) or more per year²⁴. Those who cannot afford the membership fee can theoretically benefit from an exemption policy²⁵. Relatively low user fees imply that the CHF is not run on insurance principles – the community contributions cannot feasibly be expected to cover the costs of full healthcare provision.

¹⁹ NHIF Actuarial and Statistical Bulletin of 30th June 2010.

²⁰ World Bank, 2011. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note*

²¹ TIKA is the urban form of CHF. For simplicity's sake, we shall only refer to CHF for the remainder of the document. All references to CHF will also include TIKA.

²² Consortium for Research on Equitable Health Systems (CREHS), 2007. *Community Health Funds in Tanzania: A literature review.*

²³ All exchange rate conversions in this document based on the three-month average TZS/USD exchange rate up to 12 September 2012 obtained from www.oanda.com

²⁴ World Bank, 2011. *Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note.*

²⁵ Kamuzora and Gilson as cited in World Bank, 2011

Fraught with challenges. As is often the case with voluntary state schemes, the CHF faces a number of problems, including a poor provider structure and the fact that members only qualify for treatment at the facility where they are registered. The efficiency of the CHF is further hampered by limited management capacity and the absence of proper data²⁶. There are reports of members opting not to renew their initial membership due to poor quality of healthcare and poor staff attitudes. The following focus group respondent did not have a positive experience with the CHFs:

“I have the health insurance provided by the district council. We pay 5,000 but sometimes you can get sick without being given medicine. You are told to buy.” (Group 7: compulsory insured men, rural Kisarawe)

Can state schemes solve the health cover demand-supply mismatch? The three state administered schemes already reach a significant number of people, but they face a number of challenges. Furthermore, the NHIF and the SSIB just reach the formally employed and do not address the microinsurance demand versus supply mismatch suggested by the focus group findings. The CHF-TIKA system does play in the low-income, informally employed space, but indications are that these funds cannot currently fulfil people’s full health insurance needs, a situation that is unlikely to change in the near future. They also still do not reach the population at large.

3.2. Private/NGO community-based schemes

Cater for the low-income, informally employed market. Private community-based schemes aim to strengthen the informally employed market by providing access to quality healthcare at affordable prices²⁷. Most of these schemes are sponsored by religious groups or NGOs. What sets them apart from other health financing mechanisms is the fact that there is no formal insurance mechanism involved. Like the SHIB and CHF, these schemes tend to be managed on a capitation basis, which implies that the fund carries no risk internally and all the risk is shifted onto the providers.

Still limited reach. Only about 36 community-based health schemes are registered under the Tanzania Network of Community Health Funds (TNCHF)²⁸. Because they are not formally regulated, it is difficult to estimate the number of schemes. Consultations suggest that there are hundreds, if not thousands, such schemes. Nevertheless, they would seem to have limited reach among the population at large. Enrolment is voluntary and a 2011 USAID study estimated that they cover less than 1% of the population²⁹.

Below we consider one example, namely the Kilimanjaro Native Cooperative Union (KNCU) health plan, as a case study to explain how such schemes tend to work in general.

²⁶ World Bank, 2011. *Ibid.*

²⁷ World Bank, 2011. *Ibid.*

²⁸ USAID, 2011. *Tanzania health system assessment: 2010 report.*

²⁹ USAID, 2011. *Ibid.*

MicroEnsure, in partnership with the PharmAccess Foundation, have launched a health financing scheme serving members of KNCU, a coffee farmer’s cooperative³⁰ in the Kilimanjaro area in the North of Tanzania:

Scheme	Kilimanjaro Native Cooperative Union (KNCU) Health Plan
Policyholders	5,000
Target market	Members of the KNCU in the Kilimanjaro area of North Tanzania
Enrolment	Each cooperative votes on whether or not it should take out the health plan. If more than 50% of the people say yes, the whole group is enrolled into the health plan
Premium Range	Each member pays an annual premium of TZS 12,000, while a further payment of TZS 28,500 is funded by PharmAccess.
Premium collection	Premium is deducted from the proceeds of their coffee sales.
Payment method	Capitation
Benefit package	The program offers full outpatient services and inpatient maternity cover
Facility coverage	13 Primary healthcare providers in the Kilimanjaro region, members select one provider (but have the option to change if they have a problem).
Regulatory oversight	None

Table 3: Features of the Kilimanjaro Native Cooperative Union (KNCU) Health Plan

Source: www.microensure.com and industry consultations

As the KNCU case study shows, most of these schemes enrol groups of people who share common characteristics (in this case coffee growers), rather than individuals³¹. In the case of KNCU, each cooperative votes on whether or not it should take out the health plan. If more than 50% of the members vote yes, the whole group is enrolled and the premium is deducted from the proceeds of their coffee sales. Each member pays an annual premium of TZS 12,000 (approximately USD 7.7), while a further payment of TZS 28,500 (approximately USD 18.3) is funded by PharmAccess.

Managed on capitation basis. The fund has a service level agreement with local healthcare facilities to service members. It is therefore run on a capitation rather than fee for service basis. As mentioned in Box 1, payment methods that transfer financial risk to healthcare providers have greater potential to incur additional costs than fee for service models. This type of care is suited primarily to high-frequency, low value outpatient services (i.e. more predictable) and limited in-patient needs³². It is therefore unlikely to be sufficient in itself to cover all households’ medical service needs.

Donor dependence. The KNCU health plan furthermore shows that these schemes typically rely heavily on donor subsidisation. Industry consultation revealed that private schemes are required to subsidise premiums in order to compete with the heavily subsidised CHF. It is claimed that subsidisation has undermined the payment culture in Tanzania and dislocated market prices.

³⁰ KNCU is a union of coffee growers comprising 67 cooperatives with around 1,000 families per group.

³¹ World Bank, 2006. *Health Financing Revisited: A Practitioners Guide*.

Valued by customers. Focus group respondents who have voluntary insurance through KNCU mainly gave positive feedback³³:

“For example if I get sick I use the health insurance. You can go to hospital and get treatment for 40,000 while you only contribute little money for your health insurance.” (Group 15: voluntarily insured men, rural Kilimanjaro)

The conversation below shows that uptake was triggered by an awareness campaign. Respondents furthermore emphasised and valued the fact that it is voluntary to register:

“But it should be known that you are not forced to allow them deduct some amount from your cash. It should be your willingness. And we pay in instalments. For example if you are supposed to pay 30,000 per year you can pay 20,000 then 10,000. (Group 15: voluntarily insured men, rural Kilimanjaro)

R: How did you hear about it?

A: It came as you are doing, they came here and talked to us.

G: They did door to door mobilization.

R: What was the process?

G: They called all members of KNCU and conducted an awareness creation campaign until people decided to join.

R: How many can access services from your insurance?

G: The whole family, though you can be alone.

A: I don't have children who use this insurance, I'm using it with my grandchild.

R: What happens if you are ten in the family?

A: All of them would get health services by using that insurance.

R: How much are you paying?

B: 12,000 TShs per year”. (Group 15, voluntarily insured men, rural Kilimanjaro)

The only negative aspect that was mentioned in relation to the KNCU health plan is the fact that coverage is limited to the area/facility where you are registered:

“For instance we are staying in Maida and I signed up for insurance there, but if I want to go to Marangu for treatment they will never accept me, simply because I am from Maida. I have to use my personal savings to sign up for a new insurance from Marangu in order to get treatment. That's a big challenge”. (Group 17: non-insured women, rural Kilimanjaro)

From a consumer's point of view, voluntary health insurance at the community-level seems like a better value proposition than compulsory insurance through the NHIF:

“Yes, actually in the villages where we stay people have voluntarily joined health insurance schemes that are offered by coffee cooperatives and district councils. I have to say these

³³ The desk-based case study was complemented by a dedicated focus group discussion with KNCU members.

other health insurance schemes offer far much better services than what the national health insurance offers". (Group 12, compulsory insured males, urban Kilimanjaro – Moshi)

Operate outside of regulatory framework. Private/NGO community-based schemes are not currently subject to any prudential or market conduct regulation or supervision as, in practice, they are regarded as outside the ambit of the Insurance Act. Market players argue that these schemes should be regarded as ‘health services supply agreements’ rather than insurance, seeing that they are managed on a capitation basis, which implies that the fund carries no risk internally and all risk is shifted onto the providers.

Can private/NGO community health insurance funds solve the health cover demand-supply mismatch? Private community-based schemes work for customers, but only reach a small part of the population and, importantly, rely on NGO and donor support to be financially viable. This is the case even for the KNCU model, where a global microinsurance broker-administrator experienced in designing and implementing efficient systems is involved. Does this mean that the market mechanism – by itself – simply cannot feasibly reach the bulk of the population?

3.3. Private health insurance

Introduction of private health insurance in 1990s. As mentioned in the Section 1, the period since 1993 has seen big changes in Tanzania’s health financing landscape. This has included the introduction of private health insurance schemes – the only health cover provision model regulated under the Insurance Act and supervised by TIRA. Currently the private health insurance market is constituted by general insurers that provide health as a class of policies, of which two (AAR and Strategis) writes health insurance only and four³⁴ do health as one component of their general business³⁵. Between them, Strategis and AAR account for more than 80% of all health insurance gross premiums (see Table 4):

	Gross premiums written: 2010 (TZS million)	Premium growth: 2009-2010	Market share: 2010
Strategis	23,387	59.1%	51.9%
AAR	13,391	34.7%	29.7%
Total health industry	45,057	57.4%	

Table 4: Gross premiums written and market share of health-only insurers

Source: TIRA Annual Insurance Market Performance Report for the year ended 31st December 2010.

Health insurance a growth driver of general insurance at large. In 2010, health insurance contributed 18% to total general insurance premiums in Tanzania and, as discussed in Document 4, the strong growth in the general insurance market can largely be attributed to the exceptional premium growth in the health insurance market (see Table 4).

³⁴ Heritage (5.38%), Jubilee (4.53%), Momentum (8.36%) and Milembe (0.11%). Percentages refer to percentage of total premium for each insurer represented by health insurance.

³⁵ Tanzania Insurance Regulatory Authority. Annual Insurance Market Performance Report for the year ended 31st December 2010.

Significant scope for further growth in client base. Private health insurance traditionally targets the formally employed and high-income individuals. The total private health insurance client base is estimated to be no more than 200,000 principal members³⁶, while the number of people formally employed in the private sector is approximately 1.4 million³⁷ – this implies that there is still room for substantial expansion in private health insurance. However, industry consultations indicated that challenges in the industry are limiting growth (see below).

Broad service package. Private health insurers offer a wide range of insurance packages – including both retail and corporate packages. Below, we consider the main features of an entry level family plan by Strategis as example of how private health schemes typically work:

Underwriter	Strategis Insurance Tanzania Limited
Name of product	Afya
Target market	Middle to higher income earners
Enrolment basis	Voluntary – either individual sign-up, or employer sign-up of whole employee group
Premium Range	Annual premiums range between TZS 331,000 (about USD 213) and TZS 949,000 (USD 611) (depending on number of persons covered).
Coverage	The main member and the immediate family. Dependants over the age of 18 will be covered if studying full-time and dependant on the main member.
Premium collection method	Cash, cheque, electronic money transfer
Distribution	Brokers, agents and in-house sales staff
Payment method	Fee-for-service
Benefit package	In-patient services include: ICU, theatre, consultation, treatment, physiotherapy, emergency medical expense, etc. Outpatient benefits include: general and specialist consultations, x-rays, laboratory tests, casualties, maternity. Depending on the number of persons covered per policy, annual inpatient limit ranges between TZS 6,000,000 (USD 3,861) and TZS 12,000,000 (USD 7,722) and annual outpatient limit ranges between TZS 500,000 (USD 322) and TZS 1,000,000 (USD 644).
Facility coverage	360 healthcare providers, distributed throughout Tanzania

Table 5: Key features of entry level health insurance package: Strategis

Source: Strategis website (<http://www.strategistz.com>) and industry consultations

Comprehensive benefit package comes with a price tag. As shown in Table 5, private health plans offer a comprehensive range of benefits, but premiums are relatively high in comparison with the public and community-based health schemes discussed above. Similar to the NHIF, providers are paid on a fee for service basis and members have to go to an accredited healthcare facility to receive health services. Industry consultations indicated that the fee for service model is difficult to manage due to the rising cost of healthcare services in Tanzania. Thus health insurers must increase premiums in order to stay ahead of rising healthcare costs.

³⁶ Please refer to *Document 3* for an explanation of how this figure was derived.

³⁷ Tanzania Integrated Labour Force Survey 2006

Market research recognises value of private health insurance. Though most Tanzanians are not in a position to afford private health insurance, they do recognise the benefits thereof. For example: one of the focus group respondents was covered by health insurance through his mother’s employer when he was young, a service he was very happy with. Another respondent emphasised that some health insurance products can be very beneficial:

H: “May I please tend to differ a bit with the guy who said all the insurance services in Tanzania are disorganized, when I was young I was enrolled in my mom’s health insurance that was being deducted in her salary by the research company she was working for and I can say that there was no time nor will there be any other that I will enjoy quality health services like I did under the health insurance scheme that was being offered by her company. It helped us a lot because even when we had no money, the health insurance guaranteed us health services. So I think what really comes into play is who is offering you that insurance, because insurance has now become a business, and different people are starting their own insurance companies as a way to create wealth for themselves and nothing else.”

K: “I would like to support my fellow colleague on what he has said, for example I have got my brother who works for Coca-Cola company and the company offers him a health insurance which affords to visit hospitals that I can never even dream of stepping my foot in their compounds.” (Group 2: voluntarily insured men, Dar es Salaam)

Higher than average loss ratios for health-only insurers. Table 6 below shows a clear increasing trend in loss ratios for both Strategis (from 67% in 2009 to 78% in 2010) and AAR (from 63% in 2009 to 77% in 2010), as opposed to an increase from 55% to 59% for the entire general insurance industry. Industry consultations revealed that high loss ratios can partly be ascribed to the increasing cost of healthcare services and the fact that insurers have little bargaining power. Health insurers furthermore struggle with fraudulent claims. The fact that management expenses are decreasing, implies that health insurers attempting to streamline operations in order to cope with increasing loss ratios are reaching sufficient scale to ‘carry’ their overheads. The combined ratio³⁸ shows that health insurers are more or less breaking even.

	Loss ratio		Management expenses to Net Premium Earned		Expense ratio		Combined ratio	
	2009	2010	2009	2010	2009	2010	2009	2010
Strategis	67%	78%	42%	29%	34%	19%	101%	97%
AAR	63%	77%	19%	13%	28%	23%	91%	100%
General insurance industry	55%	59%	42%	42%	44%	43%	99%	102%

Table 6: Private health insurers: ratio analysis, 2009 & 2010

Source: Tanzania Insurance Regulatory Authority. Annual Insurance Market Performance Report for the year ended 31st December 2010.

³⁸ Calculated by adding the loss ratio and the expense ratio.

Can private health insurance solve the health cover demand-supply mismatch? The analysis of the private health insurance market shows that: (i) there is still a significant untapped client base in the traditional, formally employed health insurance target market; and (ii) the industry is facing severe cost challenges. The combination of these two factors means that it is highly unlikely that the low-income/microinsurance population will become a feasible target market for private health insurers.

Options to extend private sector reach. There are three scenarios whereby the health insurance market could potentially grow its client base at scale, each with its own set of challenges:

- *Fixing the fee for service model in the comprehensive care market.* In the middle to upper end of the income spectrum, there is a need for comprehensive private health insurance, which is currently run on a fee for service model. This type of cover is more focused on secondary/tertiary/in-patient cover. By its nature, these are low volume, high cost services and hence particularly insurable. However, as discussed above, there are several problems experienced in this market. Overcoming these challenges may enable the private health insurance industry to increase its reach further into the formally employed sector.
- *Entering the outpatient cover market.* On the lower-income end of the spectrum it may not be feasible to provide comprehensive medical cover. A fee for service model would simply not be affordable to the microinsurance target market. For this market, insurers would need to look to and learn from the community-based primary managed care solution. Here the challenges however include willingness to pay, effectively managing provider quality and finding the right client aggregators to work with. Learning from the NGO sphere shows that, without donor involvement, at least upfront, this may be a tall order.
- *Providing sum assured benefits based on health triggers.* A third option, not currently found in Tanzania but gaining prevalence elsewhere, e.g. in South Africa, is the so-called hospital cash plan or hospitalisation cover. This is basically a type of term assurance that can be provided by life or general insurers whereby the trigger is hospitalisation or diagnosis of a pre-determined disease or condition. There is no direct link between the cost of medical treatment and the pay-out received. This represents health cover in “bite-sized” pieces, not enough to cover all medical expenses, but at least relevant cover that will help a household to cope with the financial shock represented by medical expenses.

4. Conclusion

Current health financing landscape fails those who need it most. Despite the government’s best efforts, the substantial health cover needs of the rural, informally employed population remain largely unserved. The private health insurance market, based on its current model, is unlikely to play a complementary role in serving the health insurance needs of the low-income market. Private/NGO community-based schemes seem best placed to fulfil this role, but are challenged in a number of respects to reach scale. This creates a public policy imperative for finding a solution to the day to day healthcare needs of the poor and rural population, particularly by looking at ways in which the public and private community-based systems can be strengthened. At the same time, this conclusion challenges the private

insurance sector to consider innovative ways, outside of the traditional comprehensive care model, for expanding their reach.

Regulatory implications. There is no single regulatory body with authority over all health financing activities and the private community-based health schemes currently operate outside of any regulatory oversight. This situation raises the question of “what is insurance” in the health space and, hence, what TIRA’s jurisdiction and role is. This will be an important question for TIRA to engage with (see *Document 7* for recommendations in this regard). As a first step, explicit dialogue is called for between the policymakers and regulatory authorities in the health financing landscape on the topic of providing for the health risk cover needs of the Tanzanian population at large.