Health insurance cover is increasing among the Tanzanian population but wealthier groups are more likely to benefit

By August Kuwawenaruwa & Josephine Borghi

Key points

- Health insurance coverage in Tanzania is gradually on the increase.

- Richer groups are covered by a wide range of health insurance schemes while poorer groups are covered by the Community Health Fund/TKIA.

- Insurance increases the intensity of outpatient care use especially for those aged between 5 and 50 years and influences where people go for care, diverting people from informal drug shops to formal care.

- Increasing the availability of affordable insurance options for poorer groups and ensuring greater consistency in the benefits offered across schemes would help to improve health system equity.

Background

This policy brief arises from the Strategies for Health Insurance for Equity in Less Developed Countries (SHIELD) project launched in 2006 and concluded in 2010. The aim of SHIELD was to critically evaluate existing inequities in health care in Ghana, South Africa and Tanzania and the extent to which changes in health care financing mechanisms can address equity challenges.

In Tanzania, there is growing commitment to the expansion of health insurance to achieve a ‘universal health system’, whereby all those needing care can access affordable services. This paper outlines the current health insurance schemes in Tanzania. It looks at how health insurance schemes are designed in terms of contributions and benefits offered, and how coverage is spread across different socio-economic groups. Finally, this paper indicates how health insurance is impacting on the use of health care services, and makes recommendations for improved tailoring of insurance to meet the goal of universal coverage.

Health insurance schemes in Tanzania

Table 1 outlines the five types of health insurance schemes in Tanzania. The largest scheme, the National Health Insurance Fund (NHIF), was set up in 2001 as a mandatory scheme, offering a comprehensive benefit package for public servants. The scheme is currently reaching out to members of the private formal sector. The NHIF is administered by an independent body answerable to the Ministry of Health and Social Welfare.

In this context, retail census assessed the impact of the program on availability of ITNs in commercial outlets. By 2010, ITN use by pregnant women and children under five years of age reached 57% and 64% respectively (TDHS, 2010).

Sample of a CHF membership card
Another scheme, the Social Health Insurance Benefit (SHIB) was formed in 2005 as an independent body within the National Social Security Fund (NSSF), which is one of the largest pension funds in the country. It offers health insurance to NSSF members. NSSF members contribute 10% of their gross salary to the NSSF, and this is matched by their employer, with total contributions equalling 20% of their salary. The SHIB contribution is drawn from the overall NSSF contribution to reimburse services used by SHIB scheme members. To benefit from the SHIB scheme, individuals have to register with the scheme and complete an enrolment card, which can be provided by their employer.

There are also a range of private health insurance schemes. Strategis and African Air Rescue (AAR) are among the largest private insurance schemes. The formal sector is most likely to benefit from private health insurance when offered by their employer.

For the informal sector, the Community Health Fund (CHF) is the largest scheme operating in rural districts. In 2009 a similar scheme, the Tiba Kwa Kadi (TIKA), began operating in certain urban councils. The CHF/TIKA was initially administered by the Ministry of Health and Social Welfare (MOHSW). Since 2009, the NHIF has taken over the management of the CHF/TIKA, initially for a three-year period.

There is also a range of small scale micro-insurance schemes (such as Chawana) operating across the country, although coverage with such schemes is very low and financial sustainability is a concern (Jamu et al., 2009).

Table 1: Insurance schemes in Tanzania

<table>
<thead>
<tr>
<th>Insurance Scheme</th>
<th>Eligibility</th>
<th>Contribution rate</th>
<th>Benefit package</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Health Insurance Fund (NHIF)</td>
<td>Mandatory for public servants and covers up to 5 dependents. Currently opening up to other members of the formal sector.</td>
<td>6% of gross salary, split between employer and employee</td>
<td>Inpatient &amp; outpatient care from public and accredited faith-based &amp; private facilities &amp; pharmacies.</td>
</tr>
<tr>
<td>National Social Security Fund (Social Health Insurance Benefit - SHIB)</td>
<td>Mandatory for private and parastatal employees and covers up to 5 dependents.</td>
<td>No earmarked contribution, reimbursement funds taken from NSSF contributions</td>
<td>Outpatient and inpatient care up to TZS 80,000 at selected facilities. Members have to sign up in order to receive benefits.</td>
</tr>
<tr>
<td>Private Insurance Schemes (e.g. Strategis and AAR)</td>
<td>Voluntary, often tied to employment – individual cover.</td>
<td>Various depending on benefits.</td>
<td>Various packages typically including outpatient and inpatient care.</td>
</tr>
<tr>
<td>Community Health Fund (CHF)</td>
<td>Rural – voluntary, household enrolment for a couple and their children under 18 years.</td>
<td>Between TZS 5,000-20,000 per year/household</td>
<td>Primary level public facilities. Limited referral care in some districts</td>
</tr>
<tr>
<td>Chawana, as example of micro-scheme</td>
<td>Market vendors, individual enrolment</td>
<td>TZS 50 / person / day</td>
<td>Private outpatient care plus transport to a referral facility and up to TZS 10,000 referral costs</td>
</tr>
</tbody>
</table>

Methodology

A study was conducted by IHI in three urban councils: Morogoro, Ilala and Kinondoni and four rural districts namely Mbulu, Singida, Kigoma and Kilosa. Information on outpatient and inpatient health care utilization and health insurance status from 2,234 households was collected. Researchers interviewed 1,686 beneficiaries of the National Health Insurance Fund, 3,324 members of the Community Health Fund, 196 members of the Social Health Insurance Benefit (SHIB) scheme, and 173 members of private health insurance schemes. They also interviewed 6,748 non-insured individuals. Apart from the data generated by SHIELD, there is no other publicly available national data on the use of health care services for members of different health insurance schemes and for uninsured individuals. Such data are not routinely compiled for the CHF or the SHIB. While such data are available for NHIF members, the figures are not disaggregated by age group or by income. It was not possible to assess data availability among private insurance schemes.

Health insurance coverage in Tanzania

Health insurance cover has been gradually increasing among the Tanzanian population since its introduction over a decade ago (Table 2). Data collected as part of the SHIELD project in 2008 suggest that national coverage was around 9% in this year.

Counting CHF membership cards in a dispensary in Singida district
More recent figures released by the Ministry of Health and Social Welfare during its 2011 Technical Review Meeting suggest that around 17.1% of the national population are insured by the NHIF/CHF/TIKA: 7.3% by the NHIF, 9.8% by the CHF/TIKA (Ally, 2011). A further estimated 1% is insured through the remaining schemes (SHIELD data), resulting in an estimated 18.1% total national coverage.

The Health Sector Strategic Plan III sets a target of 30% health insurance coverage across the population by 2015. In order to achieve such coverage the NHIF has estimated the number of households to be enrolled each year in every district/region. CHF coordinators have been directed to meet the targeted number of households per annum.

Table 2: Estimated expansion in health insurance cover over time

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Covered by Insurance</th>
<th>NHIF members</th>
<th>CHF/TIKA members</th>
<th>Other schemes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>8.5 %</td>
<td>3.4%</td>
<td>4.0%</td>
<td>1%</td>
</tr>
<tr>
<td>2011</td>
<td>18.1%</td>
<td>7.3%</td>
<td>9.8%</td>
<td>1%</td>
</tr>
</tbody>
</table>

SOURCE: SHIELD Household Survey Data 2008; Ally 2011

Which socio-economic groups are covered by health insurance?

There is wide variation in health insurance coverage by socio-economic status. Unsurprisingly, health insurance cover is higher among the rich. The 2008 SHIELD household survey data indicate that 13.5% of the richest groups were insured compared to 4% of the poorest groups (Table 3). The figures from the more recent Tanzania DHS (2010) suggest a similar distribution of coverage by wealth group1 (Table 3).

Table 3: Overall insurance coverage by wealth group

<table>
<thead>
<tr>
<th>Wealth Group</th>
<th>SHIELD %</th>
<th>TDHS %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>2nd poorest</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Middle</td>
<td>5.8</td>
<td>4</td>
</tr>
<tr>
<td>2nd richest</td>
<td>9.6</td>
<td>7</td>
</tr>
<tr>
<td>Richest</td>
<td>13.5</td>
<td>15</td>
</tr>
</tbody>
</table>

Richer groups were covered by a wide range of health insurance schemes, whereas poorer groups were only covered by the CHF/TIKA (Figure 1).

Figure 1: Health insurance cover, by wealth group

Which health care services are used?

Health care use varies depending on whether a person is insured and the type of insurance coverage they have. Outpatient utilisation rates for NHIF members are generally higher than those of CHF/TIKA members (Table 4). Apart from two age groups (0 to 4 years and over 50 years), the uninsured have much lower rates of outpatient utilisation than those with some form of health insurance.

Utilisation rates are likely to be higher for uninsured individuals who are either very young or very old because of the exemption policy which indicates that care should be provided for free to such individuals in public facilities.

Table 4: Annual outpatient utilisation rates, by age group and type of health insurance scheme

<table>
<thead>
<tr>
<th>Age Group</th>
<th>NHIF</th>
<th>CHF/TIKA</th>
<th>Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>2.9</td>
<td>4.3</td>
<td>3.1</td>
</tr>
<tr>
<td>5-14</td>
<td>2.3</td>
<td>2.1</td>
<td>1.1</td>
</tr>
<tr>
<td>15-49</td>
<td>2.8</td>
<td>2.3</td>
<td>1.2</td>
</tr>
<tr>
<td>50+</td>
<td>5.2</td>
<td>2.5</td>
<td>2.9</td>
</tr>
</tbody>
</table>

SOURCE: SHIELD Household Survey Data 2008

In addition to increasing the use of services among its members, health insurance also affects where people go to seek outpatient care. Insured individuals are generally less likely to seek care at drug shops than the uninsured (Figure 2). However, there are differences across insurance schemes:

- CHF members are much more likely to use public primary health facilities and less likely to go to faith-based health providers than the uninsured in rural areas.

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1 However, the Tanzanian DHS classification of insurance was ambiguous, combining social security as well as a variety of non-mutually exclusive insurance scheme categories (such as insurance through employer and private insurance). Hence, a breakdown of coverage by type of scheme was not possible. Furthermore, data were only captured for adults aged 15-49, so coverage among children and the elderly was excluded.
• NHIF members in urban areas (NHIF U) are more likely to use private providers and public hospitals, whereas those in rural areas (NHIF R) are more likely to go to public primary and faith-based facilities.

• SHIB and private insurance scheme members (not shown in Figure 2) are more likely to use private providers.

Figure 2: Impact of insurance on where people go for outpatient care

Legend: NHIF R= NHIF members in rural areas
       NHIF U= NHIF members in urban areas
       Unins R= uninsured population in rural areas
       Unins U=uninsured population in urban areas

SOURCE: SHIELD Household Survey Data 2008

Conclusions

Health insurance cover is gradually increasing among the Tanzanian population since its introduction over a decade ago. However, wealthier groups working in the formal sector are more likely to benefit from this development than poorer groups.

The diversity of schemes, in terms of contribution rates and benefits offered, means that the effect of insurance is inconsistent, both in terms of the amount and nature of services received by members.

What is clear is that insurance is generally increasing the intensity of outpatient care use and also influencing where people go for such care, diverting people from drug shops to formal care. CHF members are more likely to use public primary care than their non-insured rural counterparts, consistent with their benefit package.

Despite equal contributions, NHIF members in urban areas use a much wider range of outpatient care than those in rural areas.

Policy implications

The findings from this research have implications for health policy in Tanzania:

■ Data on the use of health care services are highly valuable for resource planning and insurance scheme management as this helps to identify possible system abuse, and alert providers to system overload. It would therefore be useful to address the lack of publicly available data of this nature.

■ Increasing the availability of affordable insurance options for poorer groups and ensuring greater consistency in the benefits offered across schemes would help to improve health system equity.

■ The inequity in service availability between urban and rural areas should also be taken into account when setting premiums for schemes, and parallel efforts should be made to increase provider choice for those living in rural areas.

References


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This publication can also be accessed online from www.ihi.or.tz and other SHIELD reports are available from: http://web.uct.ac.za/depts/heu/SHIELD/reports/reports.htm.