Who is covered by health insurance schemes and which services are used in Tanzania?

Background

This brief arises from the SHIELD (**S**trategies for **H**ealth **I**nsurance for **E**quity in **L**ess **D**eveloped **C**ountries) project, which was initiated in 2006 and ended in 2010. The aim of SHIELD is 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 meet the goal of providing a 'universal health system'. A universal health system is one that provides financial protection from the costs of health care and access to needed health care for all Tanzanians. This policy brief outlines the current health insurance schemes in Tanzania, looks at how the schemes are designed in terms of contributions and benefits offered, and how coverage is spread across different socio-economic groups. Finally, the brief indicates how health insurance is impacting use of health care services, and makes recommendations for improved tailoring of insurance to meet the goal of universal coverage.

To assess how health insurance cover varies by socio-economic status and how it impacts health care utilisation, researchers from the Ifakara Health Institute (IHI) collected information on outpatient and inpatient health care utilization and health insurance status from 2,234 households (12,201 individuals) in 2008 as part of the SHIELD project.

Households were interviewed in 3 urban councils (Morogoro, Ilala and Kinondoni) and 4 rural districts (Mbulu, Singida, Kigoma and Kilosa). Researchers interviewed 1,686 members of the National Health Insurance Fund, 3,324 members of the Community Health Fund[1], 196 members of the Social Health Insurance Benefit (SHIB) scheme, 173 members of private health insurance schemes and 6,748 non-insured individuals.

Counting CHF membership cards in a dispensary in the Singida district

Main features of health insurance schemes in Tanzania

Table 1 outlines the five types of health insurance schemes in Tanzania.

For the formal sector, the largest scheme is the National Health Insurance Fund (NHIF). The scheme was set up in 2001 as a mandatory scheme for public servants and offers a wide benefit package. 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. The Social Health Insurance Benefit (SHIB) scheme was formed in 2005 as an independent body within the National Social Security Fund (NSSF), which is one of the largest pension funds, and offers health insurance to NSSF members.

[1] Including districts where the benefit package was limited to primary care and districts which had extended the benefit package to cover some costs for referral care

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Table 1: Insurance schemes in Tanzania

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

NSSF members contribute 10% of their gross salary to the NSSF, which 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.

The private formal sector can also join a range of private health insurance schemes (Strategis and African Air Rescue (AAR) are among the largest private insurance schemes).

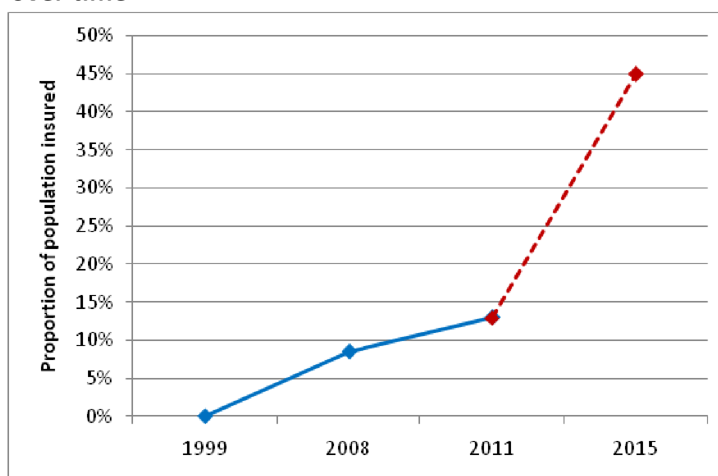
For the informal sector, the Community Health Fund (CHF) is the largest scheme operating in rural districts. In 2009 a similar scheme began operating in certain urban councils: the Tiba Kwa Kadi (TIKA). Until recently the CHF/TIKA was administered by the Ministry of Health and Social Welfare (MOHSW). Since 2009, the NHIF have taken over the management of the CHF/TIKA for a 3-year period. There are 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 a concern (Jamu et al., 2009).

How many people are covered by health insurance in Tanzania?

Health insurance cover has been gradually increasing among the Tanzanian population since its introduction over a decade ago (Figure 1). Data collected as part of the SHIELD project from 2008 suggest that national coverage was around 9% in this year. More recent figures released by the NHIF suggest that around 13% of the national population are insured: 5.8% of the population are insured by the NHIF, 6.6% by the CHF (NHIF, 2010) and an estimated 1% are insured through the remaining schemes (authors' estimation).

Recent policy announcements indicate an intention from the Minister of Health to increase these coverage rates to 45% by 2015 (Figure 1).

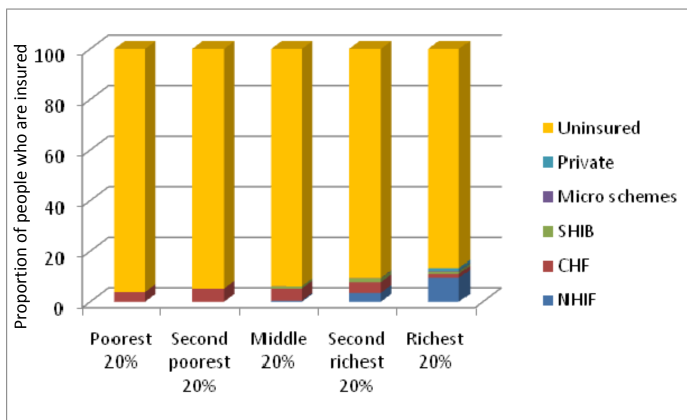
Figure 1: Estimated expansion in health insurance cover over time



Which socio-economic groups are covered by health insurance?

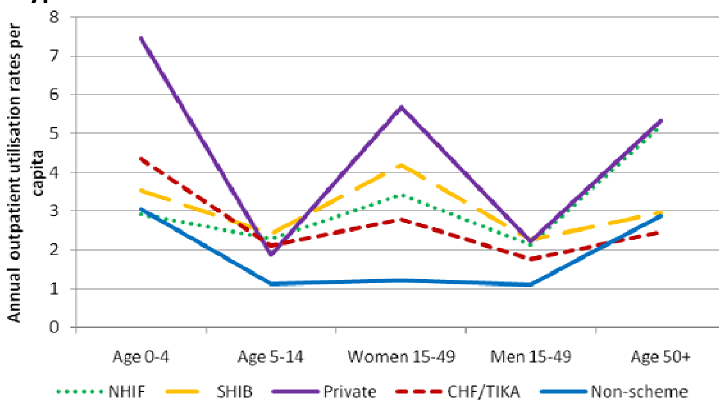
There is wide variation in health insurance coverage by socio-economic status. Health insurance cover is higher among the rich: in 2008, 12% of the richest groups were insured compared to 4% of the poorest groups. Richer groups were covered by a wide range of health insurance schemes, whereas poorer groups were only covered by the CHF (Figure 2).

Figure 2: Health insurance cover, by income group



SOURCE: SHIELD Household Survey Data 2008

Figure 3: Outpatient utilisation rates, by age group and type of health insurance scheme



SOURCE: SHIELD Household Survey Data 2008

Which health care services are used?

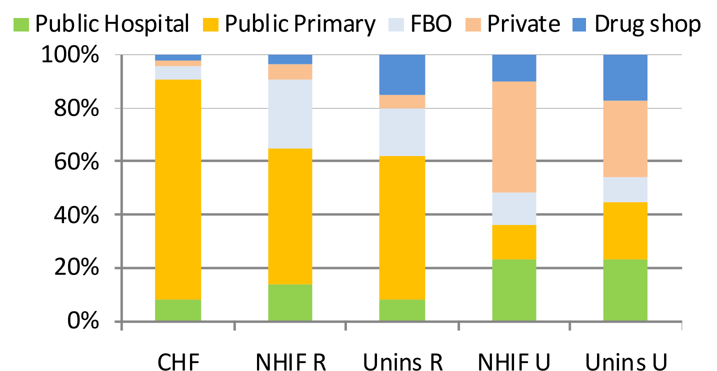
Health care use varies across insured and uninsured groups. Outpatient utilisation rates for schemes targeting the formal sector (private insurance, the NHIF and the SHIB scheme) are generally higher than those of CHF/TIKA members (Figure 3). Apart from two age groups (0 to 4 years and over 50 years), the uninsured have much lower rates of outpatient utilisation than other groups. Utilisation rates are likely to be higher for uninsured groups who are either very young or very old because exemption policies in public facilities promote free care for these groups.

12% of the richest groups are insured compared to 4% of the poorest groups

In addition to increasing the use of services among its members, health insurance also affects where people go to seek outpatient care. For example, insured individuals are generally less likely to seek care at drug shops than the uninsured (Figure 4). 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
- 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 4) are more likely to use private providers.

Figure 4: Impact of Insurance on where people go for outpatient care



NOTE: 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

Box 1

A lack of publically available data on the use of health care services:

Apart from the data generated by SHIELD, there is no other publically available national data on use of health care services for members of different health insurance schemes and for the uninsured. 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.

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 informal 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.

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- SHIELD reports are available from: http://web.uct.ac.za/depts/heu/SHIELD/reports/reports.htm

This policy brief forms part of the research completed for the SHIELD (**S**trategies for **H**ealth **I**nsurance for **E**quity in **L**ess **D**eveloped **C**ountries) project. SHIELD aims to critically evaluate existing inequities in health systems and to examine the extent to which mechanisms to provide financial protection can address these inequities in Ghana, SA and Tanzania.

SHIELD: Strategies for Health Insurance for Equity in Less Developed Countries

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Visit the SHIELD website: http://web.uct.ac.za/depts/heu/SHIELD/about/about.htm
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