Is it Cash or Card? National Health Insurance Scheme of Tanzania: A Decade and Half of Progress

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Abstract

This paper explores the perspectives of Tanzanians since the introduction of the National Health Insurance Fund (NHIF) a decade and half ago. It examines the key objectives of the program by evaluating the impact of this program in meeting the health needs of Tanzanians. The study addressed specific challenges posed by the program and experiences users have with the program. Study was undertaken in eastern Tanzania. Several respondents mentioned the easy access to better health provided by the scheme at a lower cost. Though several decried the poor quality of services and the rather limited options for accessing health care, most were of the view that Tanzania is on the right track in expanding health coverage to its citizens. As we better understand the role of social health insurance in Africa, the Tanzanian experience offers a window on how to expand health coverage to millions of Tanzanians.

Key words: Health Insurance, access, Tanzania,

Introduction

Access to health care has been a major challenge for virtually all African countries. The burden of manifold diseases has complicated Africa's attempt to extend affordable medical coverage to all its citizens. Several African countries have combined western (modern) and traditional health care systems as appropriate ways for meeting the health challenges facing the continent. A new sense of urgency arose in the early 1980s with a clear shift in health care financing. The World Bank Development Report of 1993, " Investing In Health," suggested that health improvement can be sustained through the "encouragement of market forces and competition in the health sector"(Zikussoka 2007:2)). Funding for the health sectors in most African countries has come from general tax revenues, donor support, and private out–of-pocket household expenditures (Quaye,2010).

Indeed, the cost of providing free care and dwindling financial resources have forced governments to consider alternative financing strategies (Quaye, 2010). While developing countries account for 84 percent of the world's population, 18 percent of the world's income, and 93 percent of the world's disease burden, they have contributed only 11 percent of global health spending (Schieber and Maeda, 1997). Regrettably, the "single largest source of financing for health services is out –of-pocket, which exceed 25 percent of total health care expenditure in more than 75 percent of Sub-Saharan countries"(Mcintyre et al.,2005).

In response to these circumstances, African governments have introduced three methods of health care

financing-- user fees, community health funding, and social health insurance. The negative family income effect generated by out-of-pocket medical payments has contributed to greater experimentation in health insurance. The 2005 World Health Assembly resolution on "Sustainable health financing universal coverage and social health insurance" made abundantly clear that social health insurance is the wave of the future. Not coincidentally, in the early 1990s, several African countries introduced, at the very least, some type of health care privatization. It has been suggested that the real reason for introducing in some parts of the developing world, private insurance options are the "widespread failure to provide insurance coverage that satisfies the needs and desires of citizens in developing countries" (Pauly et al, 2006:370). It must be noted that private financing has long existed in Africa in the form of private not-for-profit missions, faith-based organizations, private health practitioners, and traditional and complementary medicine practitioners in the informal sector (Schieber and Maeda, 1997). So why social health insurance?

As Zikussoka (2007:8) noted, "Social health insurance refers to compulsory contributions into a health fund, made by mainly those who are formally employed , in return for a health care benefit package covering them and their dependents." Simply put, social health insurance is defined as, " the reduction or elimination of the uncertain risk of loss for the individual or household by combining a larger number of similarly exposed individual or households who are included in a common fund that makes good the loss caused to any one member" (Criel, 1999:59). Risk pooling makes possible ordinary family's ability to afford the cost of health care. In situations where governments intervene to protect the most vulnerable groups such as patients with pre-existing medical conditions, or the poor and the aged, private insurance offers one of the major ways of achieving equity and access in health care

(Quaye, 2010). But the literature also suggests that private insurance can encourage insurance companies to engage in patient skimming and dumping. A major drawback for health insurance is the well- known concept of "moral hazard." Simply put, " Moral hazard occurs when members of a health insurance plan use services more frequently than they would have had they not been members " (Shaw and Griffin, 1995: 5). This can be offset for example by asking consumers to pay part of the costs of their health care through co-payments. The literature review suggests that among other barriers to free and universal access to health services is poverty. It has been argued that these countries are poor to provide care to marginalized groups and the difficulty the citizens may have in contributing into such a health insurance scheme (Pauly, 2006). Further studies have concluded that inferior tax systems, political inertia by governments and corruption associated with the payment of health services by health care providers have made it difficult for the wider segment of the population to benefit from such services. In a similar study done in Ghana, it was reported that , "Barriers to health care insurance enrollment and retention included :poverty, traditional risk-sharing arrangements which precludes people from enrolling and general dissatisfaction about health care providers' behavior and service delivery challenges" (Kotoh et al.,2018).

The Tanzanian experience with social health insurance provides valuable information about how not to introduce social health insurance in Africa. It is to the modalities of this effort that we now turn. We begin with a brief over view of health care financing in Tanzania prior to its introduction

of social health insurance.

Tanzania has a long history of state intervention in health care. From its socialist objectives in the 1960s, culminating in the Arusha Declaration of 1967, the directive by the government has been that, "Health services should be made available to all Tanzanians at no cost to the people "(Ministry of Health, 1994:18). This was followed by the nationalization of hospitals and a ban on private medical practice in 1977. However, as the Tanzanian economy faltered, so did revenues. At the urgings of the World Bank, the government re-assessed its approach to healthcare financing. User fees or cost sharing was introduced in July 1993 with mixed results. As well- documented by Mwabu et al., 2002, Criel, 1998 and Gilson, Russell and Buse (1997), user fees are highly regressive and have been associated with declines in attendance at hospitals and clinics. The negative income effect generated by out-of-pocket payments did contribute to greater experimentation in social health insurance as a financing strategy in Africa.

In Tanzania, the National Health Insurance Fund (NHIF) Act No. 8 of 1999 with Amendments Act No. 25 2002, Act No. 11 and Act No.2 provided the framework for creation of the National Health Insurance Fund . The specific provisions under this act were that the scheme was mandatory and covered government employees, spouses, and children or legal dependents not exceeding four family members and their contributions would come from both the government and the employee, each contributing 3 percent of the scheme. Among its objectives were, and still are, to:

- enable the government to have a stable basic contributory social health insurance scheme for public servants;
- expedite improvement of the health sector by having an alternative health care financing option that would complement the government health budget; and
- promote public-private partnership that would impact a competitive environment which would in the long run ensure overall improvement of health services with the aim of instituting health sector reforms in the country (National Health Insurance Fund, Tanzania , 2011:90).

As currently configured, health insurance in Tanzania remains fragmented and coverage is low (Borghi et al., 2013; Criel, Soors and Ndiaye, 2007).) There are currently four health insurance funds in mainland Tanzania. They are: National Health Insurance (under discussion in this paper) community health fund(CHF) , "a voluntary scheme for the informal sector in rural areas, offering citizens limited benefits in public lower- level facilities" (Borghi et al., 2013: 1), Social health insurance benefits(SHIB) and Tiba Kwa Kadi (TIKA) (NHIF, 2016) The NHiF membership has increased from 602, 955 in 2014 to 640,341 total beneficiaries in 2015 (National Health Insurance Fund, 2015). The current figures are that 763,000 Tanzanians are covered under the National Health Insurance Fund covering 3,472,000 beneficiaries .Combined with Community Health Fund, a total of almost 10 million Tanzanians beneficiaries are covered. The goal for 2020 is to scale this up to reach 50% of the entire Tanzanian population (National Health Insurance Fund, 2016)

According to Borghi et al., (2013: 10) "While NHIF coverage has been gradually increasing since

its introduction, CHF coverage has remained low due to weak management, poor understanding of the concept of risk pooling , and limited benefit package."

In meeting the health needs of members, the NHIF contracted for the services of government, faith-based organizations (FBOs), private hospitals, clinics, and dispensaries. The National Health Insurance Fund has accredited 6,185 out of 11,146 available health facilities in the country, amounting to 55% of total number of all health facilities in Tanzania National Health Insurance Fund, 2015).

As a health care financing strategy, very little is known about social health insurance schemes in Africa, but in an increasingly interdependent world, cross-national experiences with alternative health care financing options offer a rich field for analysis. It has been a decade and half since Tanzania experimented with social health insurance. While research has been done assessing the viability of the scheme, it has not been clear whether the SHI introduced to cover civil servants and those in other public sectors had worked or not.

Methods

This paper explores the perspectives of Tanzanians regarding the social health insurance program. We were particularly interested in assessing the benefits and challenges of NHIF. The study addressed the following questions:

- Is the current NHIF meeting the health needs of Tanzanians in terms of coverage, risk protection, and benefit management?
- How well-informed is the general population about the benefits and drawbacks of the scheme?
- What specific problems are encountered by users of NHIF?
- How can the services provided under NHIF be improved or expanded?
- What benefits does NHIF provide in promoting health care access in Tanzania?
- What experiences do users have with health care providers?

The data were obtained from a survey carried out in Dar es Salaam between March and May 2013 when the author was attached to the Sociology and Anthropology Department at the University of Dar Es Salaam as a Fulbright scholar. Additional data collection was undertaken in January through March 2014. The study was done in the Eastern Zone (Dar Es Salaam), Central Zone (Dodoma), and Northern Zone (Kilimanjaro). These locations were selected because they have a large concentration of government, private, and faith-based organizations health facilities and pharmacies with which the NHIF had contracted services. The sample areas were selected because of the availability of NHIF members. The sample was selected to purposely target those who use NHIF services. The questionnaires were distributed in offices, shops, households, and schools. The survey questionnaire was first developed in English and then translated with the assistance of a Kiswahili language instructor, to allow easy completion by respondents. The answers were then translated back into English from Kiswahili. Of the 250 questionnaires distributed, 200 were returned, yielding a response rate of 80%.

Table 1. Survey respondent demographics (n=200)

Gender	
Male	62%
Female	38%
Education	
Primary/Secondary	48%
Advanced College Degree	51%
Monthly Income	
0 – 61,000 TZ	29%
>61,000 TZ	50%
NHIF Membership	
NHIF Member	94.5%
Member for two years	45%
Member three-ten years	55%
Marital Status	
Single	42.5%
Married	37.5%
Divorced/Separated	20%

Apart from the socio-demographic section of the questionnaire, all were open-ended questions. This allowed respondents to give detailed responses.

Results

In this paper we wanted to ascertain the extent to which Tanzanians surveyed were familiar with the government social health insurance (SHI) system as currently configured. To assess that, we asked our respondents to define what they understood "social insurance" to be. Overwhelmingly, all our respondents demonstrated through their responses that they had a good understanding of social health insurance. Fifty-eight percent of our respondents defined SHI as a system that insures access to health care to members enrolled in the program. One respondent declared that SHI is, " state engineered health insurance scheme tenable mostly in public facilities and covering a range of health

problems." Another stated, "It is an insurance scheme that covers health expenses of its members based on their contributions." For another, "It is just a fund which helps government employees access health services, although some people are limited to low-quality services." Another respondent declared that," NHIF means liberation from health problems especially when one is bankrupt; it is a prepayment scheme which aims at pooling risks against the risk of bankruptcy." One respondent defined NHIF as "security for [my] health."

On the question, "What benefits does NHIF have in promoting health care access in Tanzania?", a majority of our respondents reported that NHIF is useful in cases of accidents as it allows individuals to have access to health services like reduced cost of diagnostic exams, x-rays ,and CT scans at Muhimbili and other private hospitals and clinics . As one respondent puts it, "Many people can access health care services through NHIF." NHIF is helpful, especially when we do not have money. It has the benefit of providing health services at a cheaper price." For another, the benefit of NHIF is that it has "facilitated health service access to many people. Costs have been significantly reduced if one compares the monthly contributions to the cost of services one receives. I think the benefits are much more than the problems associated with it."

Perhaps one respondent sums it best when he said, "The benefits of NHIF is promoting health care access to Tanzanians; it allows those who are members to get quality health services and it prevents overcharging for health services as this is forbidden. It also allows individuals to have access to medications (22% of respondents said this.) To the question, " Do you think the benefits of NHIF outweighs its problems?", the respondents were split . Sixteen and half percent stated that the system is oriented toward making a profit. Thirty-nine percent stated that they observed problems with NHIF, with fifteen percent reporting that NHIF is trying to fix the problems.

On the question, "What specific problems are encountered by NHIF users?" more than half of the respondents reported that they have had problems getting proper medications, depending on the type of card they had. Several pointed to the fact that some medical services are not covered by NHIF. Several also raised questions about their dealings with health care providers. They mentioned that some hospitals do not provide adequate services to NHIF users and some complained that they experience delays in getting health services, and for those who have gotten them, they reported receiving substandard health services. From the perspective of one respondent, "Users of NHIF have difficulty accessing specialist services. They have limited access to some medications, and that authorization process takes too long. Some mentioned payments to health care providers being delayed by the employer, making getting services from certain providers even more difficult.

Another respondent in answer to the question stated that, "Most of the hospitals discriminate against patients, depending upon the type of card they carry." As one put it," I am always limited in the type of services I get because I carry the brown card. To me, NHIF is providing services to many, but they are not equally provided. I once missed the service because the health center I went to complained that NHIF had delayed in paying them and as a result stopped providing the services until further notice." Twelve percent of the respondents reported that the services provided by NHIF are located very far from the community and thirty-seven reported providers' lack of health personnel

and medicine and equipment as major obstacles to effective utilization of NHIF services. Others mentioned the long process involved in accessing NHIF services and the lack of sufficient health care providers who accept NHIF users. For others, overcrowding of patients at health care centers are major problems as well. About using the brown or green card, one respondent responded by stating that , "I think it is morally and ethically wrong to say that green card holders access certain services and the brown card covers other services. It is my position that that is not proper. I have the green card and they deduct 3% from my salary, and brown card holders also contribute 3%. The amount of income that is taxed remains the same, so why do we have different services?" He goes on to argue that, "The fact of the matter is that if you go to some hospitals with the brown card, they refuse to treat you unless you have a letter from the Director General of the NHIF. I go to the dispensary and I know I am not being provided adequate health care service."

Another respondent indicated that when NHIF users approach the health facility, they are made to feel like they are "beggars" for health services. Some health facilities do not provide services to NHIF members and want to be paid in cash. The medicines prescribed are also often out of stock and one is forced to sign NHIF forms before treatment and some examinations are not covered by the scheme. From the perspective of another user, "Most of the health care I prefer does not accept the NHIF card. With those that do, there are many inconveniences, including providing undesirable medications, especially for children. "Another respondent indicated that, "In theory, with my NHIF card, I should be able to go to any health clinic for service, but the reality is different."

From the perspective of another respondent:

> First of all, NHIF is a hoax and a failure and not all hospitals have agreements with NHIF members. The best hospital in Dar is not even a provider of health services. Aga Khan hospital joined but pulled out as well. Another issue is the difficulty of capacity. They tell you, you can access health services anywhere but the fact is that these hospitals do not have the capacity to do so. For example, if you walk to a hospital in Singida, they look at you and say, "ha." They ask you, is it cash or card? There are problems with NHIF and that is why a lot of its members are disgruntled with NHIF and its services. I am disappointed with the scheme, how it is set up and the proposed benefits they tout as provided for their members."

However, a health economist stated that, "I think the idea of insurance is good because it tries to protect people against catastrophic illness. I am personally a member of NHIF." On the challenges facing users of NHIF, he reported that , "NHIF sets limits on what drugs they will pay for. In some of the hospitals you are also not allowed to see a specialist. You are required to see a primary care doctor, so people ask themselves why is that because we are paying a lot of money for care, but we are not getting the care we need."

In summary, the key points raised by respondents included the following: lack of prescribed medicines ; long process for using NHIF services; Lack of necessary and sufficient health care providers;

Lack of health care providers who accept NHIF users; and overcrowding of patients by health care providers that do accept NHIF cards.

Finally, when respondents were asked, "How best can NHIF services be improved?, overwhelmingly, all our respondents stated the need for customer choice in accessing health care. Forty-one percent of the respondents mentioned the need for improved and better quality care for NHIF users. Some suggested the need for making sure that health care providers are located close to the users. As one puts it," We need to make sure that on every street there is at least one health care provider who accepts the NHIF card." Some also decried the compulsory nature of the scheme and suggested that it should be voluntary and members should pay depending on the services they choose. One respondent in response to the above question stated:

> I contribute 60,000 shillings and ever since I signed on to it, I have not used the services. I will say that NHIF is a hoax and a failure to some extent. When the NHIF started in the early 2000s, there was a comparative advantage, such as helping people who could not afford treatment. However, lately the fund has failed to maintain itself. In so many respects, the fund has siphoned money from its members without giving them or their family's quality health service in return. NHIF has failed to live up to expectations. Dissolve it, form something new, or allow public servants to join private health insurance agencies.

On another point, one respondent stated that, "NHIF is good, but sometimes the scheme is not well-regarded by providers, so the queue may be long or some drugs denied on excuse of unavailability." The benefit of NHIF is that it has opened access for more people with modest incomes to get care in private facilities. For another respondent," NHIF has replaced the original policy of free access to all citizens; now one has to pay for insurance and still pay the usual government taxes. Those who cannot pay the insurance are left out." Others mentioned that [university] staff should not be forced to join NHIF. As eloquently described by one respondent, " We want the right to decide which health insurance is best for us on an individual basis.[Rather] we have been forced to join NHIF."

Discussion

This paper has explored the perspectives of Tanzania government employees on their experiences with National Health Insurance Fund. On a general level, most of the respondents believed that NHIF is providing a useful service in meeting the health needs of state workers. Several mentioned the easy access to better health services at a lower cost made possible by the introduction of the scheme. Some indicated that the scheme is further making it possible for greater number of Tanzanians to be able to access health care. The benefits of insurance, including fostering peace of mind for its users is a welcome relief, from the cash- and- carry system for some. Though several decried the poor quality of services and the rather limited options for accessing health care, most commented that if there were greater attention paid to health care providers, the scheme could be effective in attracting more users to the scheme. Some felt that NHIF should use some of its profits to pay health care providers in a timely manner so that these initial barriers can be overcome. Some questioned

the wisdom of prior-authorization for certain services and the degree of centralization in the prior-approval process. Others raised the fundamental question of equity with the use of the green and brown cards and questioned whether there is a danger in dividing the country into two classes and thereby creating and reinforcing two-tier systems of health care delivery systems in Tanzania. This is a concern that must be addressed by NHIF administrators.

Finally, in 2009, the NHIF assumed the primary responsibility of managing the community health fund in Tanzania. As the memorandum of understanding signed by NHIF, the Ministry of Health and Social Welfare in concert with the Health Sector Strategic plan stated that its objectives were to "harmonize NHIF and Community Health Funding (CHF) management operations by incorporating CHF management structures within NHIF, to improve efficiency, and supervision, to increase awareness of the CHF, and to increase coverage in line with universal coverage objectives " (Borghi et al.,2013:4). Preliminary studies done on this merger suggest that the approach is sound and will help attract more Tanzanians to the system. After all, Community Health Fund services are limited to the primary care level such as health centers and dispensaries, and these services can easily be accessed by Tanzanians living in rural communities. As one respondent puts it, "For those in rural areas, CHF is a good option for them. Actually it is a good option since without it, one will have to pay each time one accesses health care service." The major barrier facing CHF success is its low enrollment. Several reasons are presented: These include the quality of services provided under CHF, which some deem poor and of inferior quality, frequent shortages of drugs in most health centers and its voluntary nature. Yet a careful coordination of CHF with NHIF may have the potential to achieve the goal of universal coverage that Tanzanians are working hard to achieve. This is consistent with the Health Sector Strategic plan 2015-2020 in which the Tanzanian government "aims to improve the health of all ,especially those at risk, and to increase the life expectancy, by providing health services that meets the needs of the population" (Health Sector Strategic Plan, 2015-2020). The author is encouraged by a recent study exploring the coverage of National Health Insurance Fund to informal sector workers in Tanzania. In his study, Mwatawala (2018)observed that community awareness campaigns initiated by NHIF staff members has contributed to more users of NHIF by informal sector workers. As he rightly noted, reducing wait times at the service delivery phases, reduced premiums, addressing medicine shortages, training of staff on how to manage and relate to users and minimizing the need to seek approval for services will go a long way in reaching a greater number of Tanzanians . It is my hope that more research will be done to assess the modalities of integrating the two systems seamlessly to ensure greater access to health care by all Tanzanians.

Conclusion

Relatively little research has been done to assess the usefulness of social health insurance as a source of health care financing in Africa. While health insurance has been used extensively in Western countries, and it constitutes the major part of health care access, this has not been the case in Africa. For the past decade and half, several African countries have introduced social health insurance. While national health insurance schemes do not eliminate all the barriers to health care access, it nevertheless provides for low-income countries one effective ways of insuring the population of the country through individual and government contributions. After all, given the disease burden in Africa

and the limited resources of African governments, a broader vision of expanding health coverage through the private sector is long overdue.

This paper is limited by its small sample size and the lack of representation from other districts in Tanzania. By focusing mainly on respondents from Dar es Salaam, Kilimanjaro, and Dodoma areas, our sample cannot be said to be representative of Tanzanian society. A wider sample representative of Tanzanian society would yield valuable information for assessing the effectiveness of this scheme. Nevertheless, this is part of a broader study that is currently being undertaken by the author. As we better understand the role of social health insurance in Africa, the Tanzanian experience offers a window on how to expand health coverage to millions of Tanzanians.

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