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Tanzania Health Insurance Regulatory Framework Review

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Executive Summary

Main recommendations

- Make sure that current policy objectives – achieving universal coverage, social health protection, good governance and cost-containment – are reflected in the relevant legislative documents, and provide the requisite legal tools, reflecting the chosen policy options and the institutional consequences of those options.

- Consider reducing the fragmentation of the health financing legislation which reflects the current fragmentation in health financing and in governance and oversight of the health financing and insurance systems.

- Develop an explicit policy on competition in health financing to close the current gaps in legislation and to prevent the possibly negative side effects for Tanzania citizens of such competition in the event that the Government of Tanzania (GOT) opts for a competition-based model of health financing. The model ultimately chosen will have consequences not only for health financing practise, but also for the relevant legislation.

- Consider the establishment of an independent accreditation body for external assessment and gradual improvement of the quality of care of all health services providers, regardless of their sources of financing.

- Plug the identified gaps in single enactments which can be done without embarking on any big policy changes. The latter can be included in the development of a planned National Health Financing Strategy. During this development process, it will be possible to focus on specific areas of interest and make detailed recommendations. After national adoption of the strategy, new legislation will have to be drawn up.

1. Introduction

In Tanzania health insurance and related legislation is technically sound, the various enactments and their respective regulations adequately covering the different forms of health insurance and health service delivery in the country. However, as in any other dynamic country, principal laws and their more detailed regulations need to be adjusted to changing policies, taking into account developments in society, new or evolving international treaties and jurisprudence. Laws developed over time, sometimes without reference to one another, and dealing with particular issues such as, health financing and health insurance, can easily devolve into a regulatory patchwork that may no longer reflect the actual policy objectives of a national Government. Current legislation codifies existing policies, as it should, but if policies change, legislation needs to change with it, reflecting current policy objectives.

This study aims to provide information to the Tanzanian stakeholders on the extent to which current law reflects policy objectives, and to contribute to the further development of a comprehensive and coherent regulatory framework for health insurance in Tanzania. The study can also be used as input for the planned Health Financing Strategy. A key purpose of the study is to identify issues and principles relating to regulation and regulatory institutions, comparing them to the regulatory *status*

quo, and to present options for revising that regulation, including revision to facilitate the effective alignment of funding streams.

2. Policy objectives

The GOT wants to achieve social health protection (SHP) objectives. These include universal coverage of the population, equity in financing of health services, equal access to health care and the prevention of impoverishment. Existing health insurance law and regulations have been developed over time and in a fragmented manner, catering for different categories of society. The schemes regulated by these laws offer different packages of health services benefits, have different contribution regulations (percentage-based, flat fees and copayments), and different systems for accreditation of providers. They also have different systems for payment of health facilities, are governed by different regulatory bodies with different approaches, report to different ministries, and have different enrolment policies (mandatory or voluntary). As a result, current health insurance and adjacent law, does not reflect government objectives.

3. Governance

As the health sector has developed, the approach to governance of the health sector, health insurance and health-care financing has also evolved. The same can be said of the approach to governance of public finance. While the government endorses principles of good governance, such as clear responsibility definition, transparency and accountability in operations, these principles are not yet fully reflected in health insurance law and regulation. Overlaps in responsibility exist, resulting in duplication of effort and inefficiencies.

4. Cost containment

The GOT is committed to containing publicly funded health-care costs, and would like to have at its disposal legal instruments that are effective in supporting the efficient implementation of insurance and insurance-financed health care across the board (see section 5 of this summary).

5. The review: process

The P4H team of consultants has used the above-cited policy objectives, principles of good governance and cost containment as a yardstick in reviewing the existing body of health insurance legislation, along with the statutes that govern the health sector and health services delivery. The same is true of their review of more generic laws, such as laws governing public finance. The core elements considered are: a) technical quality; b) compliance with generic laws (not contradicting other specific laws); c) utility in achieving the stated objectives of the law; d) utility in achieving overall GOT health sector and societal objectives; e) degree to which laws take into account societal values; and f) extent to which laws leave as much opportunity as possible to self regulation.

The legislation that has been reviewed and/or referred to in this report has been listed in the literature list, annexed to the report.

The team has also conducted stakeholder interviews to gain insight into current practice; to learn about perceived problems with the implementation of the current laws; to see to what extent the current regulation impedes policy objectives and to identify key areas for amendment.

The achievements of the Tanzania health system, its health insurance systems and their actors warrant substantial praise. This report is undertaken to focus on possibilities for further improvement in the regulatory environment for health insurance and health insurance implementation with a view to improving access to necessary health services. The intention is to point out the gaps and loopholes and suggest ways to close them.

Walking a fine line

The team had to walk a fine line. Pointing out strengths, weaknesses, opportunities and threats in the current legislation may easily give the impression that the team seeks to advise on policy, or pass judgement regarding the implementation of mandates of different bodies. This is not the intention. That said, the team stands behind its observations regarding the regulatory aspects of the current system and the challenges it faces. Although the team has looked into institutional issues, it did not undertake an institutional assessment; the aim was to examine the underlying regulatory aspects. Besides the more general issues covered, the team also paid attention to technical aspects, and took note when issues of clarity arose.

In order to walk the chosen line, the team has limited itself to conditional statements along the lines of: "in case the GOT wants to do X, then regulations should be established or current ones amended". If MOHSW, SSRA and other stakeholders accept the frame of reference adopted, they may support much of the analysis and many of the proposals for updating and amending the current legislation or establishing new legislation.

The report starts with a description of its background, the approach to the review and a summary of the current situation in health insurance, including references to earlier reports on health financing. It ends with options for a regulatory framework, some possible institutional consequences and a conclusions and recommendations section.

6. The review: findings

The ***main observations*** arising from the review are:-

A. Policy topics

1. The current ***policy concept*** of social health protection is not reflected in the legislation. There is therefore a need to update the legislation in this regard with particular reference to the following issues:
    a. ***No equal access***. Those with mandatory and private health insurance have easier access to more services without a risk of impoverishment than people enrolled in Community Health Funds (CHF) and other informal sector health insurance schemes or people with no insurance at all. A common basic health services benefits package

(BBP) is not universally implemented, although such a package has been proposed[1]. As regards the budget-funded benefits, priority-setting is left to the Councils and there is no guarantee that all the money intended for health services is indeed spent on them. Benefits provided as a part of health insurance scheme[2] reach only a part of the population.

b. ***No equity*** in p*a*yment into the health system. Voluntary private and community insurance schemes charge a variety of different flat fees, mandatory social health insurance charges, wage dependent, and percentage-based contributions, the latter being at different levels. Out of pocket payments (OOP) are an important component of health-care ***funding,*** but they do not contribute to equity in financing the system.

c. ***No universal coverage***. Despite tremendous efforts by the GOT and ministries, most people in the informal sector continue to be excluded from coverage owing to low enrolment in the insurance schemes targeting such populations.

2. ***Fragmentation***. As with the health finance system in general and health insurance in particular, the legislation covering these areas is fragmented. There is no unified or even harmonized system of regulation covering the different forms of health insurance that uses comparable governance regulations or the same body/organ for regulation and oversight.

   a. The National Social Security Fund (NSSF) and its Social Health Insurance Benefits (SHIB) program report to the Ministry of Labour (MOL), while conforming to the NSSF Act and its regulations and schedules.

   b. The National Health Insurance Fund[3] (NHIF) reports to the Ministry of Health and Social Welfare (MOHSW) and is regulated by the NHIF Act and subsidiary legislation as well as the SSRA Act with respect to "non-technical" health matters.

   c. Both the NSSF and NHIF are subject to oversight by the Social Security Regulatory Authority (SSRA) established under the SSRA Act[4], which in turn reports to the MOL.

   d. Private health insurers are regulated/governed by the Tanzania Insurance Regulatory Authority[5] (TIRA), established by the Insurance Act and reporting to the Ministry of Finance (MOF). This Act does not, however, provide for any health insurance-specific regulations.

   e. CHFs, through their respective Councils, report to the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) and are regulated by the CHF Act[6]. MOHSW, PMO-RALG and NHIF attempt to improve efficiency in operations by giving HIF responsibility for the CHF administration[7], keeping the option of further regulatory and practical steps open.

[1] Ministry of Health. National Package of Essential Health Interventions in Tanzania, January 2000

[2] Benefits package is in this review defined not only in terms of medical interventions but also in terms of copayments and other conditions for access to services.

[3] Established under the National Health Insurance Fund Act,1999 [Cap. 395 R.E. 2002].

[4] Established under the National Social Security Fund Act, 1997[Cap. 50 R.E. 2002].

[5] The Social Security (Regulatory Authority) Act, 2008, No. 8 of 2008

[6] Established under the Insurance Act, 1996 (repealed and replaced by Act No. 10 of 2009) [Cap. 394 R.E. 2002].

[7] Under a a tripartite Memorandum of Understanding among these three institutions due to expire at the end of this year unless renewed. It is one of the documents reviewed for and appended to this report.

f. Health maintenance organizations (HMOs) and medical benefits management organizations (MBMO's) are not subject to oversight by anybody in the health sector.
g. MOHSW vertical disease programs exist next to health insurance-financed services of mainstream health care provided by the five tiers of the health services system. Furthermore, a devolved political system, which is not yet fully implemented, has mandates in health financing next to the MOHSW vertical programs and insurance-paid benefits. Although the benefits regulations of NHIF and NSSF-SHIB exclude MOHSW-financed services (next to other explicitly mentioned medical interventions and diseases), demarcation problems exist, burdening providers. This was noted during the focus group discussion with hospital representatives and arises when, for example, a hospital treats a patient for cancer (budget financed) and the patient has other diseases at the same time.
h. The regulatory framework in Tanzania has not been designed to regulate common functions across organizations; rather, it is designed to regulate the bodies/agencies themselves.

3. Explicit policies regarding ***competition in health insurance*** do not exist. At the moment, NHIF has a monopoly in the formal public sector, while in the formal private sector, private health insurers, NSSF, and (as of 2010) the NHIF compete for members. In the informal sector, some micro schemes compete with CHFs. The lack of a specific policy and regulatory framework on competition makes it difficult to deal with the possible adverse side effects of competition and hence may not advance the GOT's SHP objectives. Topics to address in regulation include risk selection and risk rating by insurers. The absence of such regulations could possibly lead to reduced access to health insurance and thus to reduced health care. As a direct consequence there would be a reduction in access equality and an increase in inequity in financing.

   Competition in health finance also requires dedicated regulation and oversight. Should the GOT desire to prevent risk selection and use competition to advance efficiency and focus on the client, it may want to establish a risk equalization schedule. To do this, considerable efforts are required to create a suitable HMIS infrastructure, to enforce the provision of reliable data and to have oversight mechanisms in place that enforce compliance. The current regulations would obviously have to be amended to allow for such instruments.

   The SSRA Act is in line with the implicit GOT policy regarding the stimulation of competition among insurers as there are only formal criteria to register or deregister insurers. However, the SSRA cannot prevent insurers from risk rating individual contributions, from excluding certain services to the insured based on pre-existing diseases and from refusing coverage. In other words this Act is not explicitly intended to promote equity in financing, equal access to insurance and to health services and to prevent or reduce impoverishment; although, it can "f*acilitate extension of social security coverage* " (s 5 (k)). So, SSRA may want to consider establishing rules governing competition in the health sector which would mitigate or prevent the negative aspects of competition.

B. Regulators

4. **SSRA** is a rather new but potentially very useful regulatory authority for social security related insurance schemes.
    a. However, it does not cover all health insurance schemes, such as private schemes, HMO's and MBMO's.
    b. The SSRA Act is not specifically oriented toward health insurance. But since it is a framework law, regulations based on this Act can provide for health insurance specifics.
    c. SSRA has no mandate regarding cost containment and promoting quality assurance in health-care services delivery. Although SSRA does not directly deal with health-care providers, it could support the focus of NSSF-SHIB and NHIF in these areas and play a coordinating, regulatory and supervisory role, thus making sure that members get value for money.

5. ***TIRA*** is focused on insurance in general and as such covers private health insurance. However, there are some grey areas between what is covered in this Act and in the SSRA Act and between the mandates of TIRA and SSRA - as regards HMOs, for example. Furthermore, the TIRA Act does not allow for establishing requirements for private health insurance as regards benefit packages, etc. Is therefore recommended that the TIRA Act explicitly refer to private health insurance as a second (voluntary) tier supplementing the first tier of social health insurance which is regulated under the SSRA Act. The reverse should be done in the SSRA Act. Given the established expertise of TIRA in technical insurance matters and financial management, it would be advisable for there to be coordination and cooperation between TIRA and SSRA. Such coordination could be based on a memorandum of understanding (MOU) or on amendments of the two Acts.

C. Insurers

6. Although ***NSSF*** is mandatory for formal private sector workers[8], enrolment in its SHIB program is not. Funding for the SHIB program comes from the general NSSF contribution (which, however, is not disaggregated to indicate what portion, if any, in percentage or proportion, counts towards the SHIB program).
7. The ***NHIF Act*** does not allow for flexible contribution rate setting to enable adjustments according to need. NSSF, on the other hand, does not charge health insurance-specific contributions.
8. The NHIF Act (Section 36 (2)) does not allow for the maximizing of financial reserves. It is therefore recommended that the GOT consider operationalization to protect NHIF members from being either overcharged or having unnecessarily limited benefits.

[8] And, as an alternative choice among other social security schemes that have no SHIB programs, it could be said to be mandatory for public sector workers not covered under any other scheme

9. Beside the fact that ***benefits***[9] are dissimilar in social health insurance (SHI), contracts with services providers and payment schedules also differ. A fee for services (FFS) contract is implemented by NHIF and a capitation fee is paid by NSSF to every registered provider for services. This burdens providers with having to run different administration systems. It may also create bias/double standards in the treatment of patients, because of the possibility of maximizing profit by "under providing" for those members who are covered by the capitation scheme and "over providing" for those under fee for service.
10. Criteria and a generally accepted method for ***determining fee amounts*** are lacking, raising questions among providers that have no negotiating power in the system as well as among health insurers that are required to justify their payment levels. A dedicated forum with participation of all relevant stakeholders backed by supportive expertise might be worth considering. The ongoing service costing study may provide a good starting point.
11. NHIF and NSSF operate their own ***accreditation systems*** with different standards. The recent MOHSW Tanzania Quality improvement Framework in Health Care 2011-2016 (October 2011) makes no reference to the existence of SHI or to the possibility of using SHI legislation and SHI contracts as a tool for implementing the MOHSW quality assurance and quality improvement policies.
12. NSSF and NHIF have their own ***conflict resolution mechanisms.*** A generic health insurance ombudsman could serve both SHI and private health insurance in an advisory role, regardless of the differences in BPs. SSRA could also opt for such an ombudsman function provided that SSRA could also deal with private insurance, CHFs and other community-based schemes. There is a possibility that this would generate a considerable workload and capacity requirements, especially if the insured became aware of such a possibility. A dedicated patients' rights Act could serve as a legislative vehicle to support such a development.
13. Health insurance regulation can be a great tool for guaranteeing access to health services, which makes it a valuable health policy instrument. The NSSF and NHIF Acts provide for this through the benefits-in-kind system and the contracts with providers. The **Insurance Act** does not, its focus being mainly on general protection of consumers of insurance against fraud and insurer insolvency and on regulating the insurance market. Private health insurance is insurance to cover financial losses in case of financial damage. Health policy considerations do not play a role in this private sector.
14. None of the health insurance schemes takes account of the need to ***cross-subsidize*** other schemes, aiming at more equity overall in financing the health sector.
15. NHIF and NSSF make creative use of their reserve funds by ***providing loans*** to health-care providers (called advance payments for which an administration fee is paid). The funds could actively use this facility to ensure the equitable distribution of health technologies. However, a national health facilities planning system, which could guide investments and loan policies, does not exist. MOHSW requirements for standard equipment, related to the type and level of facility, can provide guidance. NHIF and NSSF are not involved in any of the ***investment decisions*** of MOHSW but do have to pay (part of) the operating costs. Although this may not

[9] Benefit package understood as the entitlement to health services of which the services can be described by either using a system of positive and/of negative lists, indicate the provider from whom the services need to be received, the location where the services will be offered and the conditions for access, such as existing medical need, referral, co-payment, pre-authorization, etc.

be perceived as an urgent problem because of the need for providers to comply with MOHSW standards and because of the more than sufficient reserves of NHIF and NSSF, this situation may change and the current regulation does not provide for this. This is not just a matter of financial considerations, quality of care is also important. Planning and concentrating ***high tech and high risk interventions*** improves the chances of achieving better health outcomes and greater efficiency. Legislation in this area could therefore be considered.

D. Governance

16. Generic regulation provides for conflict-of-interest avoidance rules and the declaration of assets/wealth for high level officials and public servants. This promotes ***good governance***. However, other critical positions of responsibility should also be identified in health insurance and regulatory bodies, where the risk of inappropriate use of funds exists, and subsequent legislative action may need to be taken.
17. The system of financial ***auditing*** of public insurance is straightforward and guided and overseen by the National Audit Office (NAO). Although NAO has started "value for money" auditing in the health sector, it has not yet done so in SHI. There is no legal obligation to do this. Coordination with SSRA in this regard would need to be developed and most of the activities could be left to SSRA, under the oversight of NAO.

More detailed reviews and options for amendment are provided in Chapter IV.2.

7. Towards an adjusted framework for the health insurance sector

Based on the discussed yardstick for legal review, after amending or endorsing it as the reference framework and taking into account the review findings, a more specific framework for health insurance could be established. In developing this framework, several policy aspects need to be taken into account.

1. **Competition**.

At some point a choice will probably need to be made between a competition-based system and a single-payer system. Important considerations regarding this choice include:

A. Competition in social health insurance: The main argument for a competition-based system is its supposed positive effect on efficiency (in care delivery and administration) and client focus. If the GOT wants to pursue this option, there are two possibilities: a simple variant, in which competition is allowed between the public insurers; and a more complex version in which competition is allowed between public and private insurers willing to accept Government conditions.

Depending on the version adopted, while at the same time seeking to advance the GOT's SHP objectives, regulation may be considered that:

1. Guarantees access for every citizen to insurance;
2. Avoids risk selection;

3. Avoids risk rating;
4. Creates a level playing field for insurers -
    a. To ensure that insurers accept all people as members, irrespective of their health status and health risks,
    b. By establishing a basic benefits package that would need to be implemented by all insurers,
    c. By establishing a financial equalization mechanism,
    d. All supported by an adjusted health management information system (HMIS);
5. Allows insurers to compete on efficiency in services delivery and client orientation. This presupposes the regulation of:
    a. Autonomous health-care providers (public and private),
    b. A level playing field for private and public health services providers, requiring a system for payments of investments to prevent public providers having an advantage over private ones where their investments are funded out of the Government budget,
    c. Selective contracting with providers (public and/or private),
    d. Bankruptcy of hospitals;
6. Has unified regulation, supervision and auditing;
7. Has an independent accreditation system for providers of health services;
8. Adjusts institutional mandates and the capacity of insurers and regulatory/supervisory/auditing bodies;
9. Institutionalizes value for money auditing.

B. No competition in social health insurance: If the GOT decides not to pursue a competition-based model, but instead prefers a ***single payer*** system, at least for the time being, while at the same time setting SHP objectives, and striving for cost containment, quality assurance and client orientation, then regulation could be considered that:

1. Formulates one basic benefits package (BBP) or different packages that is/are exclusively covered by the public insurer. Different packages can be considered dependent on geographic availability of services. As a consequence, different levels of contributions could also be considered. However, different BP's and contributions should be seen as a temporary and transitional phase towards the introduction/implementation of a universal BP.
2. Has a mechanism allowing sufficient funding through mandatory, paid income-dependent contributions of public and private, formal and informal sector residents, Government budget transfers (to cover the poorer segments of the population) and income dependent copayments.
3. Restricts private insurers to voluntary, supplementary insurance and prevents opting out of the public system.
4. Unwinds and integrates the current systems of NSSF, NHIF and CHF into the indicated public insurer and allows for a transition period and transitional arrangements.
5. Adjusts the regulatory/supervisory/auditing body and its capacity to assure compliance of the single payer with the changed regulatory environment, to ensure the efficiency and the client orientation of the public insurer.

6. Has an independent accreditation system to work for all providers, irrespective of their health services and ownership status.
7. Increases the autonomy of providers in the public system to allow them to allocate their resources so as to become more efficient and strive for quality of care.
8. Allows for competition between public and private providers.

Please note that the above are just the headlines regarding competition.

Regardless of the GOT's choice regarding a competitive or non-competitive model of financing, it will need to continue to play a significant role in subsidizing the poorest segments of the population, who might otherwise be left out.

The system for the public provision of health care would need to be improved in the competitive model in order to facilitate the efficient placement of insurers across localities and to ensure equity in access for the insured. Rural areas would most probably be underserved by insurers because of the poor health-care provision network.

2. Accreditation

When rethinking the regulatory framework for health insurance in the wider context of a health financing strategy, the GOT may also want to reposition the responsibility for accreditation. This is currently done separately by NHIF and NSSF-SHIB programs, a situation that probably gives rise to duplication and puts a strain on providers. What is more, MOHSW is also engaged in the implementation of its quality improvement strategy and cooperating in the "certification towards accreditation" program. It is therefore recommended that the mandating of accreditation of all health services providers to an independent body (state agency or NGO) be considered and adjustments made to the NSSF and NHIF Acts and related subsidiary legislation accordingly. The modalities would need to be worked out, but MOHSW, NSSF and NHIF could still opt for a position in the Board of such an accreditation body in which other stakeholders could also participate, such as representatives of LGA's, private insurers and associations of health facilities and health professionals. In this way, a new body could cater for all health facilities irrespective of their funding sources. It would also be more efficient. A participatory approach could lead to better uptake of quality assurance by all stakeholders and especially the providers. Insurers could still refer in their contracts with providers to the need for accreditation and continue with their provider performance review.

3. Adjustments

The findings point to several areas that could benefit from the adjustment of regulations that create clearer responsibilities, lines of management, instruction and reporting. Better, institutionalized coordination between stakeholders would also help. The use of memoranda of understanding would be an 'in-between' solution.

The table in Chapter V.D, provides the main decisions to be taken. It indicates also the actor in charge and the specific legislation to be considered for amendments, dependent of the chosen options and decisions made.

4. Towards a health financing strategy

The GOT might further consider defining its vision and policy with regard to actors such as MOHSW, MOL and PMO-RALG in the operation of the health insurance system in Tanzania. Depending on the choices made, it is in a position to enhance the effectiveness and efficiency of the actors, and to tune the current legislation to better reflect policy.

Key considerations include:

- A competitive or non-competitive insurance model?
- The implementation of a national basic benefits package by SHI only or by SHI and PHI on equal terms?
    - In case SHI only, PHI will be left with offering a voluntary supplementary package?
- The contribution system
    - Income based?
    - Flat rate?
    - Combined?
- One or more funding pools?
    - If more than one pool: cross-subsidization between pools to increase equity in funding?
    - Government budget transfers?
- One Minister in charge of health insurance (albeit in consultation with other relevant ministries) or more ministers?
    - If the latter, who has the lead and/or how to coordinate?
- One or two regulatory bodies?
- One national accreditation system or several (per insurance scheme)?
- Establishment of a forum to discuss and advise about fee schedules and levels?
- Complementary regulation:
    - Establishing a national health services provider planning and licensing system?
    - Giving special attention to high-risk/high-tech interventions?
    - Giving autonomy to public hospitals
    - Providing for competition between public and private providers (on equal terms) or seeing private providers as additional and only to be used if the public system is not capable or available?

Legislation enacted in a timely fashion would support the implementation of the GOT's strategy by creating, for example, universal access to services, financial and institutional capacity to fund the services more equitably, increased administrative efficiency and oversight capacity to prevent the derailing of the health insurance system.

Failing to implement legal reform, even without any other changes, may lead to unregulated competition between insurers, leaving the poor behind, and to inadequate governance of health financing.

5. Institutional consequences

Depending on the GOT's decisions, the mandates of institutions will need to be adjusted and capacities tuned to accommodate changed responsibilities and tasks. This concerns the public and,

possibly, private insurers, the regulators and, probably, the health sector providers which may have to adjust their management and administration. Providers would be especially pressured to adjust if they were granted greater autonomy, and if they had for contracts from the public and private insurers.

A parallel development worthy of consideration would be to make accreditation the mandate of a separate body which could cater for all health providers regardless of the way they are financed.

9. Conditions

In order to achieve successful reform in the way health insurance is organized, especially if the preferred option is a competition-based model, certain conditions for achieving the GOT's policy objectives will need to be set. These include: (a) the establishment of a risk equalization system between different insurers and, related schemes, (b) the strengthening of capacity for supervision and auditing of insurers, and the establishment of an up to date health management information system supported by good internet connectivity.

International experience shows that it takes considerable effort, detailed health services consumption data per social stratum, and robust institutional capacity to achieve a workable system of risk equalization between health insurance schemes. Experience also shows that where this cannot be achieved, there is a great risk that a competition-based model will unravel, with the poorest and the sick suffering most.

6. Next steps

These findings and briefly outlined options may be fed into the development of a Tanzania health financing strategy, a strategy that would lead to concrete choices which can subsequently be codified in legislation. It should be noted that not all of the identified shortcomings in the existing legislation are interconnected. Meanwhile several gaps and issues can be dealt with without making far-reaching decisions on the health insurance model. These include the accreditation system, autonomy for public health-care providers, and the establishment of a platform to discuss fee schedules and levels. Finally, a number of suggestions are included that are aimed at clarifying or strengthening existing Acts and Regulations.

List of abbreviations

Admin	Administration
Art.	Article
APHTA	Association of Private Hospitals Tanzania
BBP	Basic Benefits package
BOT	Bank of Tanzania
BP	Benefits package
Cap	Chapter (of the Laws of Tanzania series)
CBHF	Community based health fund
Cf	Conform
CHF	Community Health Fund
CHSB	Council of Health Service Board
CMO	Chief Medical Officer
DG	Director General
DPP	Department of Policy and Planning
EAU	East African Union
FBO	Faith Based Organization
FFS	Fee for service
GBS	General Budget support
GIZ	German International Cooperation
GOT	Government of Tanzania
GTZ	German Technical Cooperation
HMIS	Health Management Information System
HMO	Health maintenance organization
HSF	Health Services Fund
HSSP III	Health Sector Strategic Plan III
LGA	Local Government Authority
MBMO	Medical benefits management organization
MCDEG	Ministry of Community Development and Gender
MKUKUTA	Mkakati wa Kukuza Uchumi na Kupunguza Umaskini Tanzania
MMAM	Mpango wa Maendeleo wa Afya ya Msingi
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MOLE	Ministry of Labour and Employment
MOU	Memorandum of understanding
MSD	Medical Stores Department
MTEF	Medium Term Expenditure Framework
NAU	National Auditing Office
NB	Nota bene (note well)
NGO	Non government organization
NHA	National health accounts
NHIF	National Health Insurance Fund
No	Number
NSSF	National Social Security Fund

OOP	Out of pocket payment
P4H	Providing for Health
P4P	Pay for Performance
PER	Public Expenditure Review
PhD	Dr. Of Philosophy
PMO-RALG	Prime Minister's Office-Regional Administration and Local Government
POPSM	President's Office, Public Service Management
PPP	Public Private Partnership
P/pp	Page/gages
Prof.	Professor
R.E.	Revised edition
S./Ss.	Section/sections
SDC	Swiss Development Cooperation
SHI	Social Health Insurance
SHIB	Social Health Insurance Benefit
SHP	Social health protection
SSRA	Social Security Regulatory Authority
SSRAA	Social Security Regulatory Authority Act
TIKA	Tiba kwa Kadi (Treatment by card), the urban Community Health Fund
TIRA	Tanzania Insurance Regulatory Authority
TOR	Terms of Reference
TZS	Tanzanian Shillings
VAT	Value added tax

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I. Introduction

The Tanzanian health system is financed through a mix of health financing sources from Government (GOT), Local Government Authorities (LGAs), Development Partners (Basket Fund and Project Funds), Social Health Insurance (SHI), Community Health Funds (CHF) / Tiba kwa kadi (TIKA), and community/micro- and private health insurance (PHI). There are different rules and regulations for the different pre-payment schemes and other funding agents, resulting in different levels of access to services at different prices for different population groups.

Social insurance

The two formal public SHI providers are the National Health Insurance Fund (NHIF) and National Social Security Fund (NSSF). They offer members relatively broad service packages with access to all levels of care in return for income-based premiums, reimbursing providers for their services. The voluntary CHF/TIKA, usually referred to as the third public SHI scheme, is a flat user-fee prepayment scheme that allows access to primary level and in some Councils to District Hospital services. The CHF's do not reimburse claims for services provided but supplement the district budget, through which health facilities can benefit from contribution to CHF.

Private Insurance

Besides those public approaches, there are also several private health insurance companies operating on the Tanzanian market as well as a large number of smaller micro-health insurance schemes that partner with private providers. There is also a multiplicity of stakeholders involved in the SHI sector, ranging from various Ministries and donor organisations to local and international NGOs and even private companies, working on different programmes and projects under the SHI umbrella for over 10 years now.

Expanding health insurance

While insurance schemes currently only finance a small part of the health sector with the major share being provided through input-based Government budgets, their contribution is growing. Meanwhile, the Government's Health Sector Strategic Plan III aims to "enhance complementary financing" to provide 10% of the health sector budget by 2015. Alignment of funding streams is thus an important issue.

Regulation

Every public health insurance scheme has its own legislative foundation. The private schemes are considered as insurance schemes, and are regulated by the Insurance Act, and overseen by the Tanzania Insurance Regulatory Authority. The public schemes are regulated and overseen by the Social Security Authority which started its work in 2011 and is established under its own Act. The Authority also covers other social insurance schemes such as those for pensions and disability. These different authorities and insurers report to different ministers/ministries. Observation of this gradually grown patchwork of legislation and implementation practices has raised the question of revision of the health insurance regulation, firstly during the National CHF Best Practices Workshop

of 2007, held in Dar Es Salaam. As a result, a first consultation on this topic was carried out in 2008, financed by GTZ and SDC. This provided an overview of fields of regulation for health insurance and focused on proposals for a future structure of the health insurance sector in Tanzania. With this focus, it provided an important impetus for a discussion of further reforms in health financing. However, the fragmented nature of the health insurance sector regulation continues to be a problem.

Health financing strategy & regulation

Because MOHSW, together with other stakeholders, is in the process of preparing a mid- to long-term Health Financing Strategy, which is part of the Health Sector Strategic Plan III work plan, a review of the regulatory aspects of health insurance, oversight authorities and related regulation is opportune. It is expected that the planned Strategy will provide guidance on the future structure of the health insurance sector (social and private) in Tanzania and on the regulatory issues that need to be addressed and institutions that may need to be reformed or built.

The MOHSW and the Social Security Regulation Authority have, therefore, requested The international Providing for Health (P4H) Initiative to support a health insurance regulatory review as part of its support for the development of a Health Financing Strategy for Tanzania, inviting a team of national and international consultants to assist in this endeavour.

Purpose of review

The review aims to inform the Tanzanian stakeholders regarding the further development of a comprehensive and coherent regulatory framework for health insurance in Tanzania. As an input to the Health Financing Strategy, the purpose is to identify issues and principles for regulation and regulatory institutions, comparing them to the regulatory status quo, and providing options for reform and compliance with HP objectives. Due to its importance to the Tanzanian Health Financing Strategy, the focus will be on Social Health Insurance institutions (i.e., NHIF, NSSF, and CHF), although private health insurance issues will also be integrated into the analysis. The study will also describe possible regulatory options for an effective alignment of funding streams.

Once the Health Financing Strategy is developed and accepted, and a course for sector reform is agreed on, the focus can shift to formulating a specific framework for the Health Financing option selected.

Terms of reference: objectives & tasks

Building on the 2008 report "Consultancy for Situational and Needs Assessment on setting up a Social Health Insurance (SHI) Regulatory Framework for Tanzania", the current review is expected to:

a. Provide a comprehensive and updated overview of all health financing regulation; this shall include a brief discussion and review of the relevance and significance of health insurance regulation in Tanzania; and a discussion of the different types of regulation, including the possible role of self-regulation;

b. Identify areas in which regulation is needed to govern health insurance (social and private) in line with the health sector objectives as stated in the HSSPIII in the context of a mixed health-financing system (i.e., tax and contribution funded), and to facilitate the move towards the goal of universal coverage and social health protection, namely, ensuring access

to necessary health care for all without the risk of catastrophic health expenditure. This should include an analysis of the goals and principles guiding such regulation. The review endeavours to elaborate comprehensively on the different topics that relate to insurance.

c. Conduct an analysis of regulatory, oversight and enforcement bodies (including but not limited to: MOHSW, SSRA, TIRA, BOT) to determine current regulatory and oversight responsibilities, their functioning (e.g., strategic decision making and oversight of implementation) and the links and relation between these bodies; gaps; unclear and potential areas of conflict in the aspects identified under point a;
d. Based on the above analysis, provide options:
    - For establishing a regulatory framework which will reflect the principles established under point b, and which will be conducive to the acceleration of the transition towards universal coverage and social health protection, i.e., addressing critical issues regarding equitable, effective and efficient resource generation, pooling, use of resources, entitlements/benefits, purchasing arrangements and service provision and Exemplify the previous point by describing how regulation would, necessarily, need to differ for a competitive insurance market and a single-payer model in order to reflect the principles established under point b, taking into account the level of administrative capacities for each model;
    - For a clear, comprehensive and efficient allocation of regulatory and oversight responsibilities to existing or newly established bodies;
    - For addressing issues of gaming and avoidance behaviour with regard to regulation;
    - For strengthening alignment of health insurance schemes with other health financing mechanisms (especially input financing) and reducing the complexity of the health financing system.
    - On how to integrate regulatory reform options effectively into the Health Financing Strategy.

The full text of the terms is attached (Annex 1)

Below is a description of the approach the team agreed upon during the Inception meeting on 9 December 2011, followed by a summary of previous findings and recommendations regarding health financing and insurance. This is followed by a description and review of the current situation in health finance and health insurance and their many aspects, including regulation, then a discussion of the principles and goals of legislation of health financing and health insurance, acting as a frame of reference for a more in-depth review of principal enactments and related regulations. Options for alignment are then described, followed by institutional requirements or consequences, conclusions and recommendations as well as conditions for realization of provided options.

II. Approach

The team undertook three missions, after the initial desk review, one in December, 2011, and then in January and March, 2012. The second mission coincided with a medical doctors strike, due to which several planned meetings could not take place. During these missions, the team members undertook joint law reviews and interviewed stakeholders.

Document review

Given the number of reviews and GOT documents already published, the team has focused on those issues not yet reviewed or elaborated upon; it is this effort to break new ground that constitutes the added value of this review. Nevertheless, the team has also reviewed other documents in order to better understand and interpret the current regulation scenario as well as to identify regulatory gaps and to provide options for improvement and alignment. Not all the documents reviewed are quoted and referenced in footnotes, but they are all included in the attached literature list (Annex 2).

Reviewed documents provided general country background on: political, social and cultural aspects; the country's economy and overall governance; important policy documents on development in general, health sector development on health financing and earlier surveys and reviews. Reviewed documents also provided information on legal documents, generic and health sector matters, and health finance and health insurance specifics. Annex 2 provides an overview of reviewed legislation and other regulatory documents.

Interviews

Interviews were conducted with officials and staff of MOHSW, Ministry of Labour and Employment (MOLE), Ministry of Finance (MOF), Ministry of Community Development and Gender (MOCDEG), PMO-RALG, Local Government Authorities (LGAs), social partners and other stakeholders. Most of the interviewed institutions were sent a letter in advance with a list of topics, in order to facilitate the discussions. The interviews were conducted in order to learn about the problems institutions were facing when implementing the regulations and to what extent the current regulations are conducive to achieving SHP objectives, cost containment and good governance.

Site visits

Visits were made to several public and private hospitals, and a health centre. Team members met management and staff not only to see the premises, but to discuss their relations with public and private insurers, with ministries and local authorities, and to learn about issues that may have arisen in relation to the regulatory and oversight aspects of health insurance, and in relation to health-care providers (public and private) and to LGAs.

Workshops

An inception workshop was held at the beginning of the first mission to discuss the approach and the proposed table of contents of the final report. These were both accepted by the audience, representing MOHSW and SSRA as well as other main stakeholders. (Some notes are attached in Annex 3)

A focus group meeting took place with representatives of public and private health facilities to obtain information about their side of health insurance contracting, claims review, accreditation, investment funding and loan provision (thus far loans have only been provided by NHIF although NSSF is starting this option). Short notes of this meeting are attached (Annex 4).

During its 3rd mission, the team presented its initial draft, firstly, to MOHSW and SSRA (See Annex 5 for list of attendants) and, secondly, to the wider audience of stakeholders (see Annex 6). The comments made during these meetings have been taken into account in the final report.

See meeting schedule, with persons met and sites visited in Annex 7.

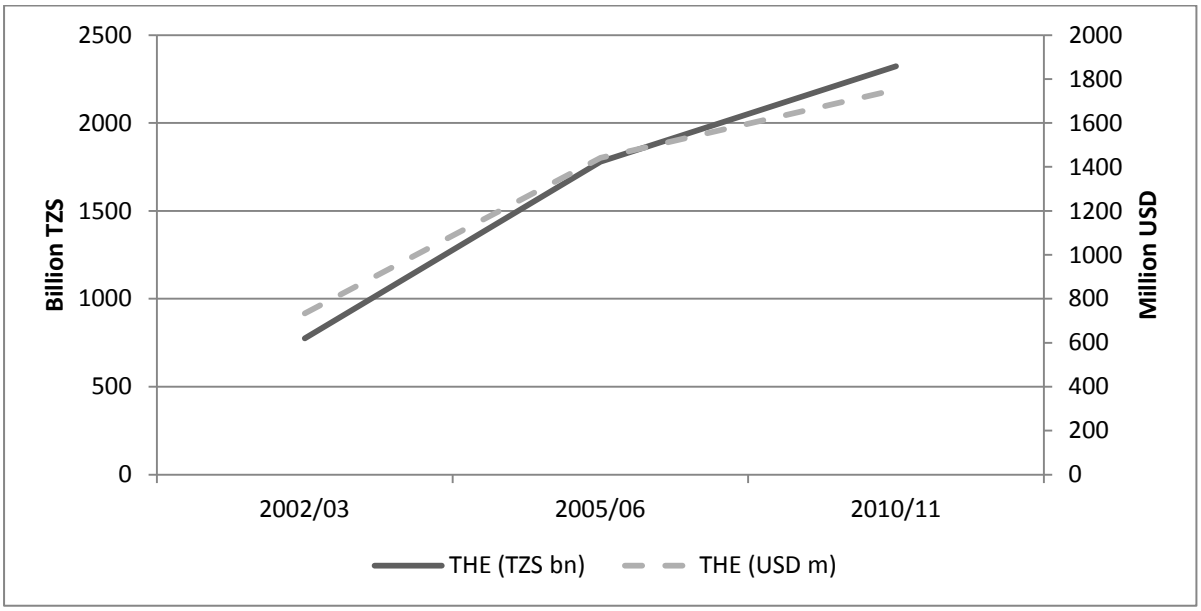
The next chapter provides a description of the current health financing and health insurance system in Tanzania combined with information from recent reviews.

III. Current Situation of health financing and health insurance

1. Total financing

Total health-care financing increased almost threefold between 2002/03 and 2010/11. The current estimates from the NHA shows that total health sector financing amounts to approximately 2,323 billion (USD $1751 million) Tanzania shillings (Figure 1).

Figure 1: Total Tanzania Health Financing Envelope



Source: NHA 2010/11 draft (MOHSW, forthcoming)

2. Sources of financing

The health financing system in Tanzania is composed of many different financing sources, including OOP payment, donor funding, general taxation and health insurance. These sources differ in terms of revenue collection, risk pooling, purchasing mechanisms, and benefit package as shown in Tables 1 and 2.

Table 1: Characteristics of different health financing schemes in Tanzania by health financing function

Source	Collection	Pooling	Purchasing
Out-of-pocket	In public facilities, user fees operate from primary facilities to referral level. The fees are differentiated with the level of health care, with low fees at primary level and higher at referral level. Currently user fees are paid by those who are not enrolled in a prepayment scheme and are also paid for some of health-care services which are not covered by the prepayment schemes. There are exemptions from user fees in public health facilities for priority population groups including: under-five children; pregnant women and for selected diseases/conditions, e.g. chronic illness, AIDS, TB and leprosy. Furthermore, the poor are officially to be exempted from payments. However, in practice, it has been difficult to clearly and uniformly define and classify the poor to qualify for exemption. This has been left to communities. User fees are collected by health facilities and deposited into the CHF account in the case of primary facilities, while at the hospital level, fees collected go into the health services fund	No risk pooling	Individuals choose the facility at which they access care based on the ability to pay; and pay at the point of service
Taxation	Funds are collected from direct (income) and indirect (consumption) taxes. The former is mandatory and directly deducted from income earned, while the latter is voluntary, as one can avoid paying tax if one does not consume a taxable product. The amount of income tax paid varies with the income level while, for consumption tax, the amount of tax paid varies with the volume of consumption; although for the latter, the amount of tax paid for the same commodity is the same for all individuals regardless of income	At the national level, the TRA and MOFEM pool all tax revenue from specific tax sources into one basket as domestic tax revenue; hence, both the rich and the poor contribute to the same pool.	Health services are mainly purchased from public facilities; hence, automatic accreditation. Some not-for-profit and private facilities are also designated as district and referral facilities in areas without public facilities under special arrangements whereby the Government covers part of the operational costs. Services are paid for through annual budget allocations after a comprehensive budgeting process that covers primary facility level to referral level. Health workers are paid through salaries, per diems and allowances
Donors	Grants and loans issue from external fund sources, including bilateral and multilateral donors. The amount of funds collected depends on donor country financial position, together with the fulfilment of various commitments and conditional packages agreed between the donors and the recipient country. The funding from donor contributions is not assured and cannot be counted upon.	Two pools exist for this financing source. The MOFEM pools funds allocated by donors through the GBS while the second pool consists of the funds from donors which are specifically earmarked for health care (Basket funding). The latter is pooled by the MOHSW but also with supervision from the MOFEM.	Purchase of service arrangements is similar to general taxation; however, a large proportion of funds for the purpose is mainly used for development activities and implementation of vertical programs such as TB, HIV, and immunization.
NHIF	Cover under the National Health Insurance Fund is compulsory for all public servants. Premium contribution is 6% of employee's salary equally shared between the	NHIF maintains a single pool and covers public employees together with their dependants not exceeding 5 per one member. The scheme also	All public health facilities are automatically accredited to provide services to NHIF members. A special procedure is followed to accredit private and not-for-profit facilities.

Source	Collection	Pooling	Purchasing
	employer and the employee. Contributions are automatically deducted from the payroll and submitted to NHIF. The National Health Insurance Fund is an independent/autonomous body which is responsible for the management of the scheme.	covers the retired member public servants and their spouses but excluding other dependants. NHIF currently covers about 6.1% of the population. There is risk pooling and cross subsidisation within the members only as the lower income households pay a relatively smaller contribution than the higher income households.	Payments to providers is through FFS , whereby providers submit their claims for payment to NHIF and the Fund pays the provider within a period of sixty days. The money paid to public hospitals is deposited into the Health Service Fund, while the amount that is reimbursed to primary facilities (dispensaries and health centres) enters into the Community Health Fund and is used according to the direction of the district health plan.
NSSF	Members of NSSF compulsorily contribute 20% of their salary (equally shared between the employee and the employer) and part of this contribution is used to provide for social health insurance benefit (SHIB). Collection of these contributions is the responsibility of NSSF which is a legally established body.	The NSSF has only just started and there is no information available to assess coverage, but it is expected to operate like NHIF. By targeting private sector workers, the potential scope of coverage is much larger	Members are supposed to register with one facility from which they and their dependants will access health-care services. Payments to the facilities is on a capitation basis.
CHF	The scheme is administered in the informal sector in rural areas under the management of district councils. Contribution to this scheme is voluntary. The rate is decided within the community and varies from one council to another. Majority of the councils contribute a flat rate of between TShs 5,000-15,000. Members' contributions are matched by a 100 % grant from the basket fund. The CHF contributions are collected at facility level. NHIF currently oversees CHF operations, a task which was previously carried out by the MOHSW.	CHF was expected to cover a wider range of the population since around 80% of the population in Tanzania is in rural areas, but the average enrolment rate is less than 10%, although more than 90 % of the councils have been sensitized to start CHF. The contribution level (flat rated) is the same for all. Contributions are made mostly by the poor in the informal sector. Thus there is no cross-subsidisation between the poor and the less poor. Furthermore, each council operates in isolation from the others, and so there is no cross-subsidization across districts/councils.	Members are supposed to register with one facility where they will contribute and access services for a minimum of one year. All public facilities are accredited to provide services to CHF members. Payments for services in public facilities are based on budgeting since CHF funds are part of district/council revenue which needs to be budgeted. Accredited non-government facilities are supposed to claim from the district/council the costs incurred by treating the CHF members
CBHFs	These are established at the initiative of different communities which share common socio-economic characteristics. Contribution is voluntary and determined by the members. CBHF schemes have their own way of managing the funds.	Each CBHF scheme operates its own small pool and there is no cross-subsidization across CBHF schemes.	The majority operate like CHF, whereby an identified facility is used to access health care for the whole year. Payments are based on FFS.
PHI	Private health insurance mainly covers the private firms and a few wealthy individuals. Premiums are risk rated.	Separate small pools operate for each private insurance scheme. So there is no cross-subsidization. There is limited cross-subsidization between the sick and the healthy.	Accreditation of facilities is based on the agreement between the provider and the insurance scheme. Payments to providers are mainly on an FFS basis.

Table 2: Characteristics of different health financing schemes in Tanzania by other criteria

Source	Benefit Package	Benefit incidence	Financing Incidence	Regulator	Issues on Regulation
Out-of-pocket	Depends on the ability to pay	Those with higher income have more choice and enjoy more benefits	Mainly the poorest bear the burden of OOP payments. So the payments are regressive	MOHSW, PMORALG	
Taxation	Budget allocations comprehensively cover inpatient and outpatient services as well as curative, promotive and preventive services.	All individuals benefit from general tax allocation through budget allocations. However, effective benefits vary across localities and facilities owing to differences in availability. Since most of the hospitals and referral facilities are concentrated in urban areas, the least poor might be enjoying higher benefits from the high cost inpatient and outpatient services. Delays in disbursements of drug funds limit availability, especially in primary facilities in rural areas. So the least poor benefits more than the poorest.	All taxes are progressive overall with the exception of a few specific taxes. For example, excise taxes on kerosene, cigarettes. Income taxes are overall more progressive than consumption taxes. VAT and Import duties are the least progressive tax sources. If	MOF and TRA for national tax levels, and PMORALG for local if government taxation. All amendments in taxes must also pass through Parliament for approval.	
Donors	Similar to general taxation	All individuals benefit	The burden of this is borne by the citizens from donor countries, except in the case of loans which bear interest, where the burden is borne by the tax payers in Tanzania as in domestic general taxation.	MOFEM, MOHSW, Development partners committee	
NHIF	NHIF offers both inpatient and outpatient care as part of its benefits package. However, it has specific spending limits for inpatient care as determined by the board. Any amount in excess of the fixed expenditure is paid by the beneficiary in an attempt to counter consumer moral hazard. The fund does not cover services which are freely provided by the Government under exemption policy such as treatment for TB, HIV, immunization, cancer, etc. Treatment abroad is not offered by NHIF (and also not by the GOT.	This scheme benefits only those who are contributing, that is to say people who are generally speaking less poor then those who are working in the informal sector and the unemployed. However, with the current initiative whereby the Fund advances loans to the facilities to purchase equipment and supplies, the funds indirectly pay for the non-members as well. The quantification of the distribution of such benefits has not been empirically explored. However, charges are lower than at private providers.	The financing incidence analysis shows that contribution to this fund is progressive, the less poor contributing higher proportions of their incomes than the poorest	MOHSW, The parliament when it comes to amendments,	

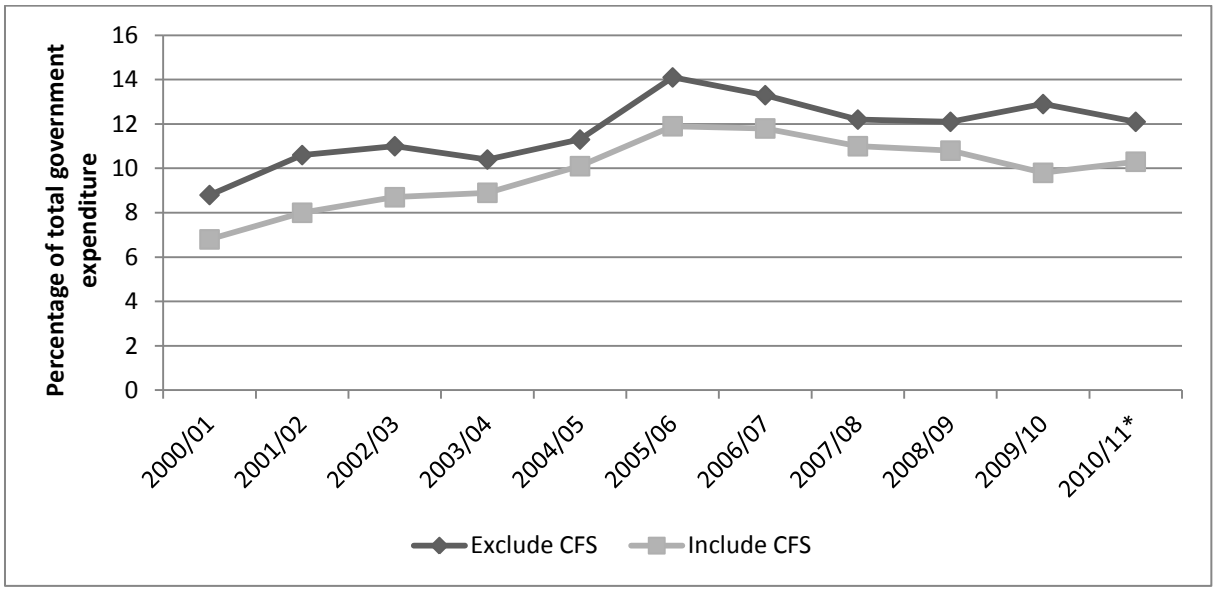
Source	Benefit Package	Benefit incidence	Financing Incidence	Regulator	Issues on Regulation
NSSF	The SHIB covers a wide range of services for both inpatient and outpatient services but its availability to a member is limited to the member's selected facility. As in the case of NHIF, the scheme excludes services which are freely provided by the Government.	This scheme benefits only those who are members of NSSF and who have registered with SHIB.	There are many similarities between members of SHIB and NHIF since both work in the formal sector. Hence the distribution of financing incidence is assumed to be progressive as well.	SSRA	
CHF / TIKA	The CHF access to health care for its beneficiaries is only limited to outpatient services from primary health-care facilities. However, a few councils have expanded the benefit to include hospital services although the guidelines do not allow this.	Mainly the poorest benefit from this service. However, due to the limited availability of services in primary rural facilities, the functional access to services is a problem, limiting the affected members' capacity to benefit.	Contribution to CHF/TIKA is regressive because the pool is only comprised of the poor while the poorest do not contribute to this scheme.	PMO-RALG / MOHSW	
CBHIs	There is a variation of benefit package provided by the CBHF schemes.	Assumed to be similar to CHF.	Assumed to be similar to CHF.	Registrar of NGOs.	
PHI	Varies with the premium level and the members' choice. There is no specified minimum benefit package across schemes.	Private insurance benefits only the members who are wealthy individuals.	Contributions are assumed to be progressive as such schemes target wealthy individuals.	TIRA, Registrar of Companies	

Source: Mtei, Mulligan et al. (2007); The World Bank (2011)

2.1 Public financing

Public financing consists of general taxation and donor support to the health sector through general budget support or basket funding (Table 1). The share of total public spending allocated to the health sector has been increasing over time (Figure 2), but remains below the typical level for developing countries. The 12% of total Government expenditure, which is the amount allocated to health care in 2010/11[10], is still below the 15% Abuja target, agreed by African countries[11]. The Government recently committed to achieving the 15% public funding level as soon as possible[12].

Figure 2: Public health-care financing as proportion of total public expenditure



Source: PER2005, PER2008, Various MOF budget speeches

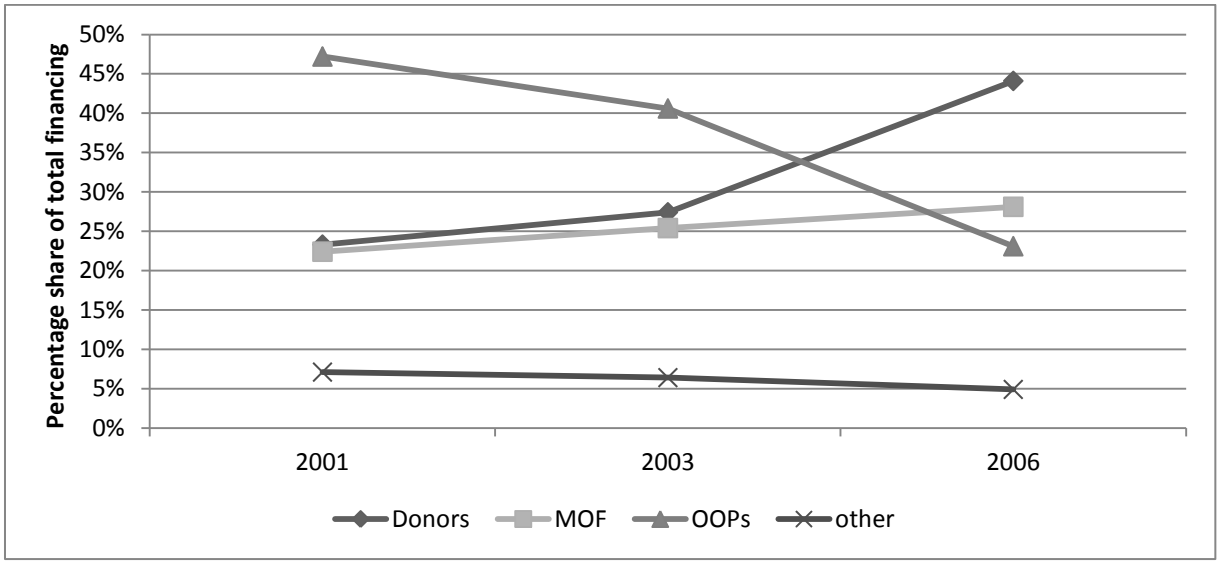
While general taxation and donor funding contributed a slightly similar proportion of total financing in 2001 and 2003, there was a significant increase in the proportion of financing coming from donor funding in 2006 (Figure 3). Donor financing as a proportion of total financing has almost doubled over a period of less than ten years.

A comprehensive analysis of the incidence of different tax sources and other financing sources has been undertaken in previous studies[13]. Overall, ***general taxation*** is considered to be the most equitable financing source as it pools funds from all individuals, with the less poor contributing a higher proportion of their income, while each individual benefits from this financing source regardless of how much s/he contributes. **Value added tax** (VAT) is the major source of tax revenue, accounting for about 34% of total tax revenue in 2010/11[14]. Previous analysis shows that 98% of the

[10] MOHSW, Health Sector Public Expenditure Review 2009/2010. Dar es Salaam, Tanzania, 2011.
[11] Organization of African Union Abuja Declaration on Hiv/Aids, Tuberculosis and Other Related Infectious Diseases: OAU/SPS/ABUJA/3, 2001
[12] MOHSW, Health Sector Strategic Plan III. Dar es Salaam: MOHSW, 2008
[13] NHIF, Action Plan for CHF Operations 2009-2012. 2009
[14] World bank, Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note, Dar es Salaam: The World Bank, 2011.

poorest segment of the population, and 100% of the less poor paid VAT in 2005.[15] ***Donor funding,*** which is also a significant source of financing in Tanzania, shares characteristics with general taxation, except that the burden is borne by the tax payers in the donor countries, unless of course the funds come in the form of interest paying loans , in which case the burden is borne by the Tanzanian tax payer.

Figure 3: Contribution of different financing sources in total health-care financing



Source: NHA 2008.

Further, varying degrees of inefficiencies have been observed in the allocation of public funds, especially for drugs, in addition to the inefficiency in the performance of salaried staff (including absenteeism) allocated to various public health facilities[16]. The observation has shown that public resources allocation, distribution of drugs, enforcement of regulations and contracts do not reflect the needs across different geographical locations. There are also delays in the approval and delivery of budgeted Government funds, which contributes to the poor provision of health services across districts[17].

2.2 Out of pocket payments

OOP payments are direct payments incurred by households and individuals when accessing health services (Table 1). This financing source plays a significant role in total health-care financing. However, Figure 3 shows that its share in total financing has been diminishing over time probably because of the increase in public funding. It also shows that the proportion of OOP payment decreased from about 47% in 2001 to approximately 23% in 2007.

OOP payments are considered to be the most inequitable financing source, with benefits being determined by how much each individual pays, and the poorest bearing the greatest burden (Table 1). In addition, OOP payment does not pool risk across the ill and the healthy. OOP payment is also

[15] World bank, Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note, Dar es Salaam: The World Bank, 2011

[16] National Audit Office, A Performance Audit Report on Management of Primary Health Care: A Case Study of Health Centres ,Dar es Salaam: National Audit Office (NAO), 2008.

[17] ibid.

responsible for pushing a significant proportion of the population into poverty. It is estimated that about 4% of the population is driven into poverty as a result of paying OOP for health care[18].

2.3 Health insurance

The introduction of health insurance is part of the health sector cost sharing policy in Tanzania. Health insurance is also a prepayment mechanism that allows for a reduction in the risk of catastrophic payment and impoverishment inherent in OOP payments for health care made at the point of service and at the moment of use. Health insurance is also argued to be an important funding mechanism in generating sustainable revenue to the health sector and improving access to health care especially for the most vulnerable populations[19].

The Health insurance system in Tanzania is fragmented, with three ministries (MOHSW, MOL and PMO-RALG) having their own schemes, implemented by different, not always cooperating and sometimes competing, insurance institutions, even in the area of social mandatory insurance. This state of affairs could delay the Government's intended objective of achieving universal coverage.

There are two major insurance schemes in Tanzania, namely, the ***National Health Insurance Fund*** (NHIF) covering public servants and the ***Community Health Fund*** (CHF) covering the informal sector. There are also several other small insurance pools, including ***Social Health Insurance Benefit (SHIB) under the National Social Security Fund*** (NSSF), private insurance and several micro insurance schemes (Table 1). Details regarding specific health insurance schemes situation is provided in the following sections.

The contribution of insurance schemes in total health-care financing is insignificant, amounting to about 4%[20]. This is a result of low enrolment. Although NHIF covers most public servants, these constitute only a small part of the population. **Community insurance** could cover all residents categorized as working within the informal sector. However, only a small proportion of such workers is covered. Health insurance schemes are currently estimated to cover about 15% of the total population[21]. Various factors contribute to the limited expansion of community health insurance in Tanzania, including the lack of supplies and drugs in public facilities, limited awareness of the importance of health insurance, weakness in the management system, and poverty. The GOT is committed to expanding the role of health insurance in Tanzania, and its overall objective is to achieve national health insurance coverage of about 30%, and to ensure that insurance-based financing accounts for about 10% of total health-care financing by 2015[22].

Previous analysis of the incidence of health insurance contributions shows that premiums paid into formal sector health insurance schemes is progressive (the relatively richer individuals contribute more of their income than the poorest), while informal sector insurance schemes are regressive (the poorest individuals contribute a higher proportion of their income than the less poor).

[18] MOHSW, Health Sector Public Expenditure Review 2009/2010. Dar es Salaam, Tanzania, 2011.
[19] Health Sector Strategic Plan Iii. Dar es Salaam: MOHSW, 2008
[20] Mtei, Gemini and Josephine Borghi, An Assessment of Health Care Financing Progressivity in Tanzania,Dar es Salaam: Ifakara Health Institute, 2010
[21] Humba, Emmanuel "Pioneering Social Health Insurance in Tanzania: The Case of the National Health Insurance Fund (NHIF)," Improving access through effective health financing UBS training and conference centre, Basel, Switzerland: Swiss TPH, 2011
[22] MOHSW, Health Sector Strategic Plan Iii. Dar es Salaam: MOHSW, 2008.

Generally, formal sector insurance schemes – National Health Insurance Fund (NHIF), National Social Security Fund Social Health Insurance Benefit (NSSF-SHIB) and private insurance - tend to cover higher income categories and provide a more comprehensive package of benefits to their members than do informal sector schemes (Table 1). With regard to informal sector schemes, there is no cross-subsidization between the poor and the rich; and since the poorest individuals tend to suffer more illnesses compared to the least poor, there is limited cross-subsidization between the healthy and the ill, which is often cited as one of the core strengths of insurance systems designed to achieve universal coverage.

3. Details about specific Health Insurance Schemes situation in Tanzania[23]

3.1. National Health Insurance Fund (NHIF)

The NHIF is a mandatory public servants' insurance scheme which began operations in July, 2001. The scheme covers health insurance costs for the contributing employees, their spouses and up to four children or legal dependents. The scheme is managed by the board of directors, appointed by the Minister of Health.

Membership

About 2.5 million people are currently members of NHIF, which is approximately 5 % of the total population. There is only one risk pool to cover all NHIF members. In order to increase the membership pool, the NHIF has extended its coverage from central Government civil servants only, to retired public employees, police, prison staff, immigration officers, and fire and rescue service staff members, as well as to all employees in the public sector (parastatals, agencies and statutory bodies) covered by the definition in the HNIF Act of "public servant"[24]. It has allowed subscribers to pay extra for insuring family members beyond the numbers included in the basic package. NHIF is also exploring mechanisms to enrol the private formal sector. The GOT has continued to make amendments to the NHIF Act, aiming at increasing NHIF coverage to more categories of residents such as ward executive leaders. The current statistics show an average membership growth rate of 11.3% each year.

Contributions

Members contribute 6 % of their salaries per month, equally shared with the employers, in the form of premiums. Contributions are directly deducted from the employees' salary and remitted to the NHIF.

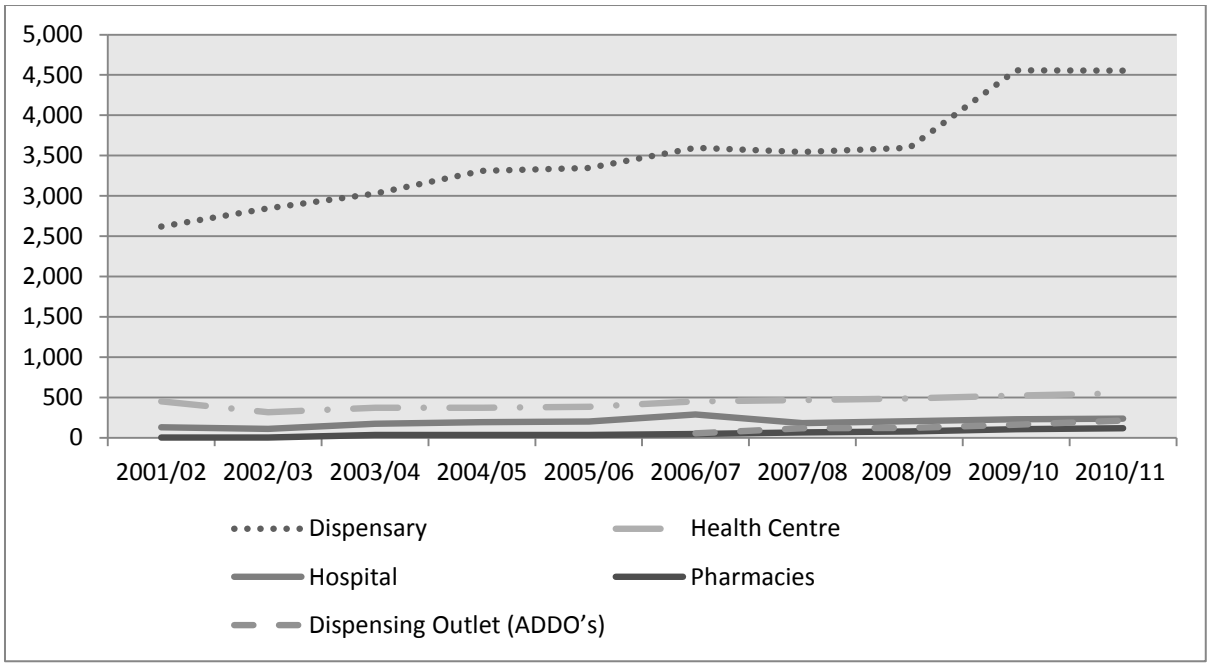
Benefit Package

The benefit package is characterized by a combination of positive and negative lists. The NHIF offers a wide range of benefits, including basic diagnostic tests, drugs, outpatient services, inpatient services, and minor and major surgery, with a list of exceptions. The Minister of Health has the mandate to exclude services from the package. Services provided by disease control programmes of the MoHSW (e.g. HIV/AIDS, TB, childhood vaccinations) are also excluded from the package. This package is available to all members of the NHIF. Certain conditions apply, such as the use of NHIF accredited facilities (public and private), the need for referral and medical care provided in compliance with current standards.

[23] The text in this section draws heavily from Lankers and others (2008, 21–22).
[24] Section 3 of the Act.

The benefit package is delivered by NHIF accredited facilities. All public providers are accredited, regardless of quality, while private providers must follow specific guidelines to qualify and to enter into a service agreement with NHIF. The accreditation criteria include the following: (a) availability of human resources, equipment, and facilities in accordance with MOHSW guidelines; (b) acceptance of a formal program of quality assurance prescribed by the NHIF; (c) acceptance of NHIF standard payment mechanisms and fees; (d) adherence with NHIF referral guidelines; (e) acceptance of reporting requirements; and (f) recognition of the rights of the patient. As of June 30, 2011, a total of 5,673 health facilities (69.2% of all health facilities in Tanzania) were accredited to provide services for the NHIF members (Figure 4). About 80% of the accredited facilities are dispensaries, 10% health centres, 4% hospitals and 6% pharmacies and drug dispensing outlets.

Figure 4: Growth of number of NHIF accredited health facilities



Source: NHIF

While there is only one list of covered health services and interventions, the NHIF has two types of membership cards. 'Standard' cards are brown, 'Leaders' cards are green. Green card holders get fast-track access to services and can directly access referral facilities, as well as some high quality hospitals such as Aga Khan, Hindu Mandal, Regency and TMJ Hospitals. Everyone with a basic salary above TZS 1,140,000 is eligible for a green card. Between 2001 and 2012, green card membership has grown from 1% to 4%. The management of NHIF is in the process of harmonizing all membership cards to allow access to the same benefit package for all its members.

Provider payment

Providers are paid for these services on an FFS basis through a reimbursement / billing system; health facilities provide the service, submit a claim to the NHIF, the NHIF assesses and verifies the claim, and pays after approving. In total, 406 different services are listed for NHIF reimbursement, including Caesarean sections which are listed as major surgery. There are more than 600 different reimbursement rates for drugs and medical supplies. Private health-care providers may be contracted based on individually negotiated reimbursement rates if no public provider is available.

Finances

Premium contributions account for the largest proportion of total NHIF revenue and have been increasing over time, in line with the increase in membership. Investment return is another significant source of revenue. NHIF income has been growing strongly since the start of the scheme, both due to membership growth, and members' income growth.

Total payments for health services has been growing for the past 10 years, but are still quite low at 23.4 % of total NHIF revenue in 2009/10[25]. Total claims reimbursement account for about 2 % of total national health expenditure. Administration costs have also increased from 8.4 % of total revenue in 2004/05 to 12 % in 2009/10. "*There has also been significant growth in investment income, from just 4 % of total income in 2002/03 to 23 % in 2007/08, although it declined to 17 % in 2009/10. In 2008/09, this investment income exceeded the amount spent on benefits. If this income stream can be maintained, it could be used to help improve the level of benefits for NHIF members*"[26]. NHIF also uses its revenues to advance payments to accredited providers as a ***loan for investments*** in necessary medical equipment and facility rehabilitation. Providers are supposed to pay 10% of the total "loan" requested as an administration cost for the same. In FY 2010/11 about TZS 1.4 billion was disbursed as a loan for medical equipment, and TZS 986 million for facility rehabilitation. Loan advancement is perceived to be a motivation for more facilities to seek NHIF accreditation.

The Memorandum of Understanding between NHIF-PMORALG-MoHSW on CHF. Recently, the NHIF has been tasked with providing administrative, coordination, and technical assistance support to CHFs within the 12% administrative costs of the Fund. This support has included the development of a CHF action plan and inclusion of CHF issues in the second NHIF Strategic Plan (2010–15).

2.3. National Social Security Fund7[27]

The Social Health Insurance Benefits (SHIB) program is part of the seven benefits provided by the NSSF. It was established in July 2006 to provide health insurance cover for the employees of the private sector contributing to this pension scheme.

Membership

Although membership in NSSF is mandatory for formal private sector employees, enrolment to the SHIB is voluntary and members are supposed to register and secure an identity card before being covered. At the moment, about 10 % (about 50,000 individuals) of total NSSF members have registered with the SHIB. In total there are about 74,000 beneficiaries of SHIB, which includes principal member dependants. Various factors contribute to this low enrolment rate. These include private sector employers offering their own health benefits arrangements to their employees, if and lack of public knowledge about the scheme. In addition, there is a widespread belief among members that being an SHIB members may lead to a reduction in pension. Furthermore, there is a lack of accredited health facilities in some areas, which also acts as a disincentive to enrolment. NSSF pensioners are also entitled to membership in the SHIB, but they are supposed to contribute 6 % of their gross pension as premium to the scheme. The NSSF is currently reviewing its health-care financing strategy and examining approaches for increasing the uptake of the SHIB in order to increase enrolment.

[25] World Bank. Tanzania Health Policy Note, P. 16

[26] World Bank. Op cit. P. 16

[27] The text in this section draws heavily from Lankers and others (2008, 21–22).

Contributions

There is no separate premium contribution to SHIB, and members' access to health services is financed by their 20% contributions to the NSSF, which are collected through payroll deduction (Mtei and others 2007, p 35).

Benefit Package

The NSSF SHIB benefit package includes the majority of outpatient services, such as consultations, basic and specialized diagnostics, simple and specialized procedures, and drugs on the National Essential Drug List. It also includes standard inpatient services like hospital admission (overnight stay), consultations, simple and specialized procedures, and referrals to a higher level and to specialized hospitals.

The benefit package is delivered in 264 health facilities accredited to provide service for SHIB members. The provider network is therefore very limited, although the concentration of NSSF members in urban areas reduces the need for accredited facilities. The current small number of accredited facilities could also be due to resistance of service providers because of the capitation mode of payment used by NSSF (see below).

Provider payment

In contrast to the NHIF, the SHIB uses a capitation model to pay accredited health providers. This approach requires the members to pre-select and register at a single facility from which health care will be sought. The facility is then paid a flat amount per member per year to provide services. There is no specific basis for determining the level of capitation, but NSSF has started to request cost information from the providers in order to adjust its fee schedules. Some facilities, especially in Dar es Salaam, refused to take capitation, and NSSF made special FFS arrangements with those facilities. Higher level facilities, which provide referral care, are reimbursed on an FFS basis.

Finances

SHIB finances are included in the general accounts of NSSF. It is therefore difficult to assess the financial situation of the SHIB itself.

2.4. CHF/TIKA (Community Health Fund and TIKA [Tiba kwa Kadi])[28]

The Community Health Funds (CHFs) were established as an alternative to user fees at the point of service. The idea is that district residents (usually informal workers and farmers) can join a CHF on a voluntary basis and can get access to health care without paying user fees. The MOHSW, PMO-RALG and the NHIF provide regulatory oversight to CHF/TIKA.

Membership

As of January 2012 there were 108 districts that had a functioning CHF out of a total 133 districts (NHIF, 2012). By September 2011 a total of 573,000 household were registered with CHFs, representing around 3,438,000 members out of an estimated population of 42.6m in 2010/11, around 8.1%. The Health Sector Strategic Plan III sets a target of 30% for CHF enrolment for 2015.

Membership growth, according to various assessments[29] reflects a variety of management-related

[28] The text in this section draws heavily from Lankers and others (2008, 23-24).

factors, inability to pay, limited understanding of insurance, and a limited benefit package.

Contributions

Members pay flat rate contributions, which are between TShs 5,000 and TShs 20,000 per household per year. Those who cannot afford the membership fee can benefit from an exemption policy. The Council is tasked with meeting the shortfall in funds. This policy is only working to a limited extent.[30]

The funds raised are paid to the Council and are doubled by a "matching grant" from the national budget (Health Basket Funds). The NHIF tends to get the money late or, and sometimes gets less than the required amount.

Benefit package

The benefit package is determined locally at the Council level and typically includes all services provided at the primary care level, that is to say out- and in-patient services offered at dispensaries and health services. The inclusion of services at the District Hospital is at the discretion of the Council; some Councils include services there to make the benefit package more attractive, some do not in order to limit the costs to the Council. In some cases, other services are offered with donor support, such as HIV/AIDS-related services.

Provider Payment

The CHFs do not pay providers. The membership contributions and the matching grants go into the cost-sharing account of the Council and typically become part of the Council's health budget that is spent in accordance with the Comprehensive Council Health Plan. There is typically no connection between payments to health facilities and either the number of services provided to CHF members or the amount of CHF members enrolling at a specific facility.

Finances

Total income from CHFs is estimated to be between TShs 1bn[31] and TShs 3bn[32]. With this, it provides only a very small part of total sector financing, i.e. less than 0.7%.

The Memorandum of Understanding between NHIF-PMORALG-MOHSW on CHF.

Recently, the NHIF has been tasked with providing administrative, coordination, and technical assistance support to CHFs within the 12% administrative costs of the Fund. This support includes the development of a CHF action plan and the inclusion of CHF issues in the second NHIF Strategic Plan (2010–15).

The NHIF has developed a CHF Action Plan (2009–12) that outlines the way the increased collaboration between the NHIF and CHF/TIKA is going to work, and notes several advantages, including: (a) providing an entry portal for wider health insurance coverage; (b) providing a cost-effective coordination mechanism for CHF/TIKA at the national level; (c) promoting the harmonization of services and claims mechanisms; (d) facilitating the extension of coverage to the informal sector; (e) providing professional management of CHF/TIKA revenue; and (f) facilitating the portability of services (Tanzania Nation Health Insurance Fund 2009a, 13–14). Specific interventions

[29] Kamuzora and Gilson, Mtei and Mulligan Op Cit
[30] Kamuzora and Gilson. Op Cit 2007, 4
[31] PER 2010
[32] World Bank. Health Financing Policy Note

mentioned in this plan include: reviewing CHF benefit packages; registration and collection mechanisms; introducing claims management and information systems at the CHF level; undertaking capacity building of CHF operations; promoting increases in user fees to encourage CHF membership; and establishing a Risk Equalization and Reinsurance Fund[33].

The NHIF management has shown an interest in adopting the Rwandese model in building a sustainable CHF that is affordable and mandatory for everyone, unlike the current household payment system.

2.5. Nongovernment non profit (micro-insurance)[34]

Most of micro-health insurance schemes in Tanzania are run by religious groups, informal groups, and rotation schemes that serve a given number of voluntarily enrolled members who contribute an agreed amount to cover for unforeseen contingencies. Micro-insurance schemes such as VIKOBA, UMASITA (Tanzania Informal Sector Community Health Fund) and VIBINDO (the umbrella organization of informal sector operators in the Dar es Salaam region) seek to strengthen informal sector communities by providing better access to health care, improved quality of care and by seeking ways to promote comprehensive health-care services at affordable prices. Micro-insurance for health care is still in its infancy. Most of the schemes enrol groups rather than individuals (for example, all market vendors are required to join), but each group operates as a separate risk pool, causing potential financial sustainability problems.

A few initiatives have been started in Dar Es Salaam. The first, organized under VIKOBA is affiliated to the social economic initiative through entrepreneurship (VIBINDO) and was facilitated by the International Labour Organization through small business operators in the second half of the 1990s. This initiative has remained small, with very low rates of registration and renewal of membership. VIBINDO covers about 1,102 people out of about 40,000 VIBINDO society members. The VIBINDO benefit package includes primary health-care services, reproductive health-care services, some referral services, minor surgery, and limited hospitalization. The second initiative, registered by UMASIDA, is now known as UMASITA. UMASITA had up to 40,000 people enrolled, although it recently stopped functioning as a result of issues related to revenue collection and management, service utilization, and continuity of enrolment. While active, the UMASITA benefit package included: maternal and child health; voluntary counselling and testing; and treatment of common diseases such as malaria, pneumonia, diarrhoea, and sexually transmitted infections. Surgical services are provided at Government facilities, and the user fee is paid by the scheme. Neither scheme requires a copayment[35]. A third scheme, initiated by the Anglican Health Network, had a goal of registering 40,000 people within the first six months of operations and going nationwide within three years.

One of the key problems contributing to the low uptake by the population is the general lack of knowledge of the concept of insurance and of the fundamentals of insurance operations. There is also a failure to explain these fundamentals in simple terms in the local context where the majority live of target groups that would be interested. Another major issue is the lack of financial

[33] NHIF 2009a, 17–18

[34] The text in this section draws heavily from Lankers and others (2008, 21–22).

[35] McIntyre et al. Op Cit. 2008, 24–25

sustainability because such schemes operate separate risk pools and suffer from cost escalation[36].

Private for profit health insurance

Private health insurance was allowed as a part of health sector reforms in the mid- to late-1990s, and became popular with most private companies. According to company representatives, in the last few years, membership in Private Health Insurance has been between 100,000 and 150,000 members. This number represents only a small percentage of the overall population of Tanzania, i.e. less than 0.3%.

Since 2005, gross premium revenues have increased by an estimated 380%, amounting to TShs 156 bn. Meanwhile, claims expenditure at the four health-only insurers has risen by more than 100% per year on average, to reach about TShs 24bn in 2010.[37] On average, premiums represent an estimated 8 % of payroll.

Interviewed representatives noted two factors for the lack of growth of private health care in Tanzania. First, the poor level of health care in many parts of the country. Second, the high solvency requirement that does not differentiate between a general insurer and a health insurer and has acted as a barrier to many of insurers to cover health risks. There is a technical committee among the Association of Tanzania Insurers working with the Tanzania Insurance Regulatory Authority (TIRA) to formulate different solvency requirement regulations for health insurers that will take into account the huge liquidity requirement imposed on health insurers to meet medical claims.

Different private micro-insurance schemes have been started in Tanzania, most recently a scheme under the sponsorship of PharmAccess, and with the initial participation of a private health insurer (Strategis). With substantial financial support, this programme has been able to overcome a number of challenges faced by other micro-insurance schemes such as quality of care and management processes. Nevertheless, sustainability without donor support remains a challenge.

[36] Jamu et al. Op Cit. 2009, 32

[37] TIRA annual reports, various editions

IV. Regulation review

1. Frame of reference for review

It is helpful in reviewing a set of laws to draw up a frame of reference within which the review takes place. In this report the frame of reference is primarily comprised of the goals and principles of law-making and regulation, and, to a lesser extent, the standards of law-making, i.e. what makes for a good law. Finally it takes into account the goals and objectives of the Tanzania Government based on the official documents, considered in conjunction with internationally/universally endorsed best policies and practices.

1.1. Goals and principles of regulation

Principle: is defined in this report as the point of departure or starting point, in this case for legislation.

Goal: is defined as something to be achieved, in this case by means of legislation. Goals, aims and objectives are seen as synonyms.

Standard: besides goals and principles it is also useful to use criteria, in this report defined as a frame of reference for good law-making.

Values: Preceding a discussion about goals and principles are values, e.g. the value of human life and its protection, the value of trust, the value of equality in rights, the value of solidarity, the rule of law, the value of self-determination and the value of privacy and confidentiality. Values can differ from country to country, and also within countries, and are thus the subject of debate.

Norms: Values are different from norms. Norms are the operationalization of values. Norms are fixed and can be used as thresholds to trigger action, e.g. a standard operating procedure in nursing or medical care or a blood alcohol level above which people are categorized as driving under the influence and risk the loss of their driver's license or worse. The value from which the alcohol limit is derived is respect for other people's lives, health and goods.

Some values are promoted as universal, such as the values included in human rights. The endorsement of values is reflected in a country's principles, goals and standards of law-making, as well as in their implementation. So, the following descriptions are also subject to debate, but may be useful as a point of departure to reach explicit agreement on laws governing health insurance and health services ad their delivery.

a. Principles for health insurance and related laws, including laws that deal with governance of the health sector, are:

- Mitigating unpredictable and unbearable risk: Offering the possibility of mitigating unpredictable and individually unbearable financial risks for people when in need of health services which are essential to protect them against illness, injury, handicap and avoidable death through coverage provided by a prepayment financing scheme which can be tax or contribution based or characterized by mixed financing. This is the very basis of health insurance which has already been applied for a long time in many countries and is also endorsed by Tanzania.

- Containment of cost: The need for cost containment of health services, especially when paid for out of scarce public monies. Mandatory health insurance contribution revenues are also seen as public funds. Wage based charges impact labour costs and therewith formal private sector and international competitiveness.
  Although health services also can be seen as an economic activity for which no limit needs to be set as with other economic goods that people want to purchase, there is no real market for health services since patients are not free to shop around for the best services and lowest price because of the often urgent nature of health-care consumption. Patients also have too little knowledge to decide for themselves what medical intervention they need (information asymmetry). That is why countries regulate the practice of health services to prevent their population (and health workers) from engaging in dangerous health practices, and from having to shoulder unnecessary health-care costs.
- Prevention of inefficiencies: The need to prevent inefficiencies in the delivery of health services and health financing. This is related to the previous principle. However, preventing inefficiency is not only of economic interest, but also a matter of quality of care. Inefficient care can harm the patient by exposing him or her to protracted waiting periods or unnecessary treatments which most of the time have negative side effects.
- Protection from fraud: The need to protect people and institutions from fraud. Such protection is generally afforded by the country's legal system but it is of particular importance in health care because of information asymmetry and the urgency of consumption of medical services.
- Prevention of abuse of public resources: The need to prevent abuse or misuse of scarce public resources as regards the organization and financing of health services (administration costs).
- Fairness: Fairness in all matters concerning health administration/management and health insurance matters including regulation, dispute resolution, etc .
- Proportionality: This should be carefully observed when applying sanctions and punishment.

b. Standards for law making in health finance/Insurance and health services

Laws are ***meant to achieve something*** in society: "*When we make law we have in mind very practical aims, we don't want only leave a written message of our intention and will, we want create concrete situation of the public life in accordance with our intention and will. Therefore the necessary follow up of the legislative and normative activities is the concrete application of the law we made to the real life, to the living experience of our society in view of obtaining the compliance with it by the destinataries of the legislative and normative acts*." [38] Another definition sees *"LAW is that which systematically impels conduct*."[39]

Both descriptions imply that laws should influence individual and institutional behaviour or actions of persons and legal entities in society.

[38] Bartolo, Sergio. Good law making principles. Report for a Meeting of the European Commission for democracy through law (Venice Commission).Strassbourg. 1 July 2010.
http://www.venice.coe.int/docs/2010/CDL-UDT(2010)016-e.pdf

[39] Luce Robert. Legislative principles. The history and practice of law making by representative government. The Riverside Press Cambridge. Boston 1930

Furthermore, laws should:

- Be written with an eye on interpretation for practical implementation purposes and thus take into account the social and legal environment in which the laws will have their role;
- Be written in univocal, unambiguous language commonly used in local legal practice, although as much as possible in common language, readable by the average citizen;
- Be enforceable;
- Not contradict the National Constitution, generic and specific laws (subject to acceptable exceptions), and international treaties to which the country is a signatory;
- Have clearly formulated rights and obligations/duties;
- Include a clear objective or general intention, a distinct subject, and a description of the institutions tools and procedures required to achieve the objective of the law;
- Require accountability and include sanctions;
- Either include in specific legislation a clause or clauses to prevent conflicts of interest and requiring asset/wealth declaration for all officials and crucial staff of public organizations involved in health financing, or refer to common (generic) law[40] in the specific health insurance legislation;
- Be implementable as regards available financial and other resources and institutional capacity etc;
- Minimize the need for complaints, appeals, arbitration and court procedures, i.e. minimize the burden on the judiciary;
- Be gender neutral/sensitive;
- Be disability sensitive;
- Non-discriminative as regards race, religion, ethnicity, etc ;
- Balancing Individual freedom versus protection of the collective (e.g. weighing individual choice with the need for overall cost containment; in enforcing solidarity in health insurance; and in enforcing quarantine of people with dangerous infectious diseases);
- Provide opportunities for stakeholder participation in the processes of decision making (in an advisory capacity) in all matters involving stakeholder/public interest.

c. Goals

Which health sector and health financing goals and objectives should be achieved by a specific law is ultimately up to the law making body; in Tanzania it is Parliament. However, the GOT has, in several documents, expressed its goals as regards the development of the health sector, including health financing and social security, which are instrumental in achieving overall health sector goals. These goals include:

- "...increasing access to health services, based on equity and gender-balance needs; improving the quality of health services; strengthening the management of the health system; and developing policies and regulations of human resources for health and social

[40] I.e., The Public Leadership Code of Ethics Act (Acts No. 13 of 1995 & 5 of 2001). However, this code of conduct is restricted to the top functionaries and is not applied for lower level functions which can also be critical for e.g. a health Insurance organization or a regulatory body, for example as regards staff dealing with investments, Financial administration, auditing, procurement etc. Although not all possible crucial positions can be summed up or perhaps even imagined as regards future ones, an instruction to a board of a government agency to establish, implement, periodically review and adjust and publish the generalized results would be advisable.

welfare coherent with Government policies. .... Increase financial resources through complementary financing by 10% of total budget by 2015/16. .....Equitably allocate essential medicines, dental diagnostics, medical supplies and equipment to all public health facilities.[41]

- making sure "...health services are available and accessible to all the people in the country (urban and rural areas)" including drugs, reagents and medical supplies and infrastructures."[42]
- providing accountable, responsive, effective and efficient leadership in public services ensured;
- ensuring equity of access to public resources and services; [43]
- widening the scope and coverage of social security services to all citizens;
- instituting a mechanism for good governance and sustainability of social security institution through establishment of a regulatory body;
- ensuring greater transparency and involvement of social partners in the decision making with respect to social security institutions;[44]
- providing appropriate provisions for the realization of a person's right to work, to self education and social welfare at times of old age, sickness or disability and in other cases of incapacity...;[45]
- providing for reciprocal agreements with other countries for the transfer of social security benefits across nations;[46]
- liberalizing the social security sector, such that "while the existing mandatory social security institutions shall operate and compete among themselves Social Security Services shall be fully liberalized"[47]

The MOHSW health financing strategies are also formulated as objectives:

- "Reduce the budget gap in the health sector by mobilising adequate and sustainable financial resources;
- Enhance complementary financing for provision of health services, increasing the share in the total health budget to 10% by 2015;
- Improve equity of access to health services;
- Improve management of complementary funds raised at local level;
- Increase efficiency and effectiveness in use of financial resources."[48]

MOHSW also wishes to achieve universal coverage through health insurance, by reducing OOP payment, and by enrolling the poorest in insurance schemes[49].

[41] Tanzania National Five Year Plan 2011/12 – 2015/16.
[42] Ministry of Health. National Health Policy. October 2003
[43] The National Strategy for growth and reduction of poverty II has similar goals on improving governance and accountability NSGRP II, issued by the Ministry of Finance and Economic Affairs July 2010,
[44] The National Social Security Policy. Ministry of Labour, Youth Development and Sports. January 2003
[45] Constitution of Tanzania, Article 11 (1), quoted from National Social Security Policy. Ministry of Labour, Youth Development and Sports. January 2003
[46] National Social Security Policy. Ministry of Labour, Youth Development and Sports. January 2003
[47] National Social Security Policy. Ministry of Labour, Youth Development and Sports. January 2003
[48] MOHSW. Health Sector Strategic Plan July 2009 – June 2015
[49] MOHSW. Health Sector Strategic Plan July 2009 – June 2015

Not only specific health sector and health financing related goals matter, but also goals related to public finance, governance and the rule of law[50]:

Table 3: Goals of Governance and the rule of law

Goal	Strategic Intervention	Key Output/Target for 2015
To mobilise public efforts and opinion towards zero tolerance of corruption, improved and strengthened leadership and governance systems.	• Strengthen legal and institutional framework for democracy, rule of law and good governance by: • Sustainably curbing corruption at all levels; • Strengthening Good Governance by enhancing transparency, accountability and ethical behaviour of Government staff and enhancing public awareness and partnerships in the prevention and combating of corruption; • Enhancing Operational capacity of governance institutions; • Strengthening mechanism for accountability and sanctions on implementation; enforcement and compliance with legislative, policy, regulatory and operation rules; • Fully installed and operationalized National ID system by 2015. • Ensure broad participation and promote gender equality.	• The global rank of Tanzania in the World Bank Doing Business survey decreased to below 100. • Tanzania's percentile rank in Rule of Law indicator and the Control of Corruption indicator (both in the World Governance Indicator) increased from their current level 40 and 40.5 respectively to 60. • In June 2016, 40% of the population have an ID card (i.e. 19.3 Mio Tanzanians), implying a distribution of 18,000 ID cards per day between July 2012 and June 2016.

Overarching goals: The picture that emerges from the above can be summarized in three overarching goals:

1. Achieving universal coverage of the population with social health protection, i.e. universal access to necessary health care without running the risk of catastrophic health expenditure and with equity in financing.
2. Achieving a sustainable, effective, efficient health-care and health financing system, providing essential care of good quality.
3. Achieving good governance in the operations of the health sector and its financing system, meaning well defined responsibilities, transparency and accountability in institutional set up and operations.

[50] Tanzania National Five Year Plan 2011/12 – 2015/16. The National Strategy for growth and reduction of poverty II has similar goals on improving governance and accountability NSGRP II, issued by the Ministry of Finance and Economic Affairs July 2010,

1.2. The basis for the health insurance regulation review[51]

In its review the consultant team has constantly referred to the above-cited principles and standards of health sector and health financing related law-making, analysing the extent to which the current legislation effectively and efficiently supports efforts towards the realization of the Government's goals and objectives for the health sector and its governance.

Not only have laws been reviewed one by one using this frame of reference, but the relevant body of laws and the objectives, institutions, tools and processes these laws regulate have also been examined, with a view to evaluating consistency, and possible overlapping or conflicting regulations. The review has also sought to evaluate the effectiveness and efficiency of operation, looking for opportunities to realign and reduce unhelpful complexity, redundancies and inefficiencies, and to create synergies.

It needs to be noted that the consultants have not reviewed the actual performance of health financing institutions and insurers. This was not part of their mandate. However, they have been made aware of performance issues and barriers to good performance and have used these observations to inform their review of the regulatory aspects of these issues. This report does not, in any sense, constitute a judgement on the current institutions, and its description and analysis should not be read as such.

1.3. Topics

In applying the aforementioned frame of reference, the following topics, derived from the Terms of Reference, have been considered:

- Coverage of the population, including enrolment procedures and criteria; enhancing pro-poor and informal sector enrolment; mandatory or voluntary in character; geographical restrictions and cross-District and cross-border cooperation;
- Resource generation, effectiveness and efficiency;
- General Government and local government budget, donations, taxes and contributions as sources of funding; equity and cross subsidization; overlap, conflicting aims and effects on services provision;
- Pooling of resources, including cross subsidization and equalization between financing schemes; reserve fund requirements and management, profits;
- Benefit packages, including common elements and differences, reflecting essential health service needs and supporting effectiveness and efficiency in service delivery;
- Copayment. Modalities, procedures and administration;
- Health services providers; selection; and selection criteria, including accreditation and quality grading of health facilities; contracting; investment decisions; payment schedules and investment funding; reimbursement claims review; multiple financiers and conflicting incentives; dual practicing;

[51] The used yardstick has elements similar to the assessment framework for legal review as used by the Dutch Council of State (see annex 8). See: http://www.raadvanstate.nl/the_council_of_state/

- Organization and management; mandate; capacity requirements; good governance; participation of member representatives; management support systems; access for providers and insured to health financing organizations;
- Administration, effectiveness, efficiency and its costs;
- International cooperation (treaties);
- Collaboration and synergies between schemes as regards their management and instruments;
- Competition in service provision and insurance markets;
- Regulation of health financing schemes; government, ministries and agencies;
- Oversight and auditing; registration of insurance schemes and requirements;
- Monitoring, evaluation and adjustment of schemes and regulations;
- Laws that are complementary to health financing laws; regulating the provision of health services by health professionals and allied health professions and by health-care facilities (public and private); regulating public finance and auditing; generic laws and international treaties; regulating quality of care, of drugs, equipment and supplies.

Hereafter follows the review of the various laws by the consultant team on the basis of the above mentioned considerations.

2. Observations

The above-cited frame of reference has been used to systematically scrutinize the actual legal documents governing public and private health insurance and related Acts and Regulations. It is not used simply to checkmark the features of the legal documents being considers but to point to those aspects that are important for achieving the Governments objectives, and which would most likely figure in the deliberations of a health financing strategy.

Overall the review of the legal framework reveals that the current patchwork of Acts and Regulations is not conducive to achieving the SHP, cost-containment, universal quality improvement and client focus objectives.

The observations on the reviewed laws and regulations follow, starting with the broad, principal observation, and then going into more detailed findings, discussing the laws and subsidiary legislation, while also raising questions where texts have remained unclear to the review team.

2.1. Main Observations

The ***main observations*** arising from the review are:

A. Policy topics

1. The current ***policy concept*** of social health protection is not reflected in the legislation. There is therefore a need to update the legislation in this regard, among others.
    a. ***No equal access***. Those with mandatory and private health insurance have access to more services without a risk of impoverishment than people enrolled in Community Health Funds (CHF) or people with no insurance at all. A common basic health

services benefits package (BBP) is not implemented, although such package was proposed[52]

b. ***No equity in pa***yment into the health system. Voluntary private and community insurance schemes charge different flat fees, mandatory social health insurance charge wage-dependent, percentage-based contributions that vary among schemes. The latter are of different levels. Out of pocket (OOP) payments are an important component of health-care ***funding*** but they do not contribute to equity in financing the system.

No universal coverage. Despite tremendous efforts by the GOT and involved ministries, most people in the informal sector continue to be excluded from coverage owing to low enrolment to insurance schemes targeting such population

2. ***Fragmentation***. Like health finance in general and health insurance in particular, the legislation covering these areas is fragmented. There is no unified or even harmonized system of regulation covering the different forms of health insurance that uses similar governance regulations and the same body/organ for regulation and oversight.
    a. The National Social Security Fund and its Social Health Insurance Benefits (NSSF-SHIB) program report to the Ministry of Labour (MOL), but conform to the NSSF Act and its regulations and schedules.
    b. The National Health Insurance Fund[53] (NHIF) reports to the Ministry of Health and Social Welfare (MOHSW) and is regulated by the NHIF Act and subsidiary legislation.
    c. Both NSSF and NHIF are subject to oversight by the Social Security Regulatory Authority (SSRA) established under the SSRA Act[54], which in turn reports to MOL.
    d. Private health insurers are regulated/governed by the Tanzania Insurance Regulatory Authority[55] (TIRA), established by the Insurance Act and reporting to the Ministry of Finance (MOF). This Act does not, however, provide for any health insurance specific regulations.
    e. CHFs, through their respective Councils, report to the Prime Minister's Office Regional Administration and Local Government (PMO-RALG) and are regulated by the CHF Act[56]. MOHSW, PMO-RALG and NHIF attempt to improve efficiency in operations by charging NHIF with the administration of the CHF[57], keeping the option of further regulatory and practical steps open.
    f. Health maintenance organizations (HMOs) and medical benefits management organizations '(MBMO's) are not in the focus of any oversight body in the health sector.
    g. Vertical disease programs of MOHSW exist next to health insurance financed services of mainstream health care provided by the five tiers of the health services system. Furthermore, a devolved political system, which is not yet fully implemented, has

[52] Ministry of Health. National Package of Essential Health Interventions in Tanzania, January 2000
[53] Established under the National Health Insurance Fund Act, 1999 [Cap. 395 R.E. 2002].
[54] Established under the National Social Security Fund Act, 1997[Cap. 50 R.E. 2002].
[55] The Social Security (Regulatory Authority) Act, 2008, No. 8 of 2008
[56] Established under the Insurance Act, 1996 (repealed and replaced by Act No. 10 of 2009) [Cap. 394 R.E. 2002].
[57] Under a tripartite Memorandum of Understanding among these three institutions due to expire at the end of this year unless renewed. It is one of the documents reviewed for and appended to this report.

mandates in health financing next to the MOHSW vertical programs and insurance paid benefits. Although the benefits regulations of NHIF and NSSF-SHIB exclude MOHSW financed services (next to other explicitly mentioned medical interventions and diseases), yet, demarcation problems exist, imposing a burden on providers. This was noted during the focus group discussion with hospital representatives and arises when, for example, a hospital treats a patient for cancer (budget financed) and the patient has other diseases at the same time.

h. The regulatory framework in Tanzania has not been designed to regulate the common functions across organizations; rather they are designed to regulate the bodies/agencies themselves.

18. Explicit policies regarding ***competition in health insurance*** do not exist. At the moment, NHIF has a monopoly in the formal public sector, while in the formal private sector, private health insurers, NSSF, and (as of 2010) the NHIF compete for members. In the informal sector, some micro schemes compete with CHFs. The lack of a specific policy and regulatory framework on competition makes it difficult to deal with the possible adverse side-effects of competition and hence may not advance the GOT's SHP objectives. Topics to address in regulation are risk selection and risk rating by insurers. The absence of such regulations could possibly lead to reduced access to health insurance and thus to reduced health care. As a direct consequence there would be a reduction in access equality and an increase in inequity in financing.

    Competition in health finance also requires dedicated regulation and oversight. Should the Government decide to prevent risk selection, while using competition to advance efficiency and client orientation, it may want to establish a risk equalization schedule. To do this, considerable efforts are required to create a suitable HMIS infrastructure, to enforce the provision of reliable data and to have oversight mechanisms in place that enforce compliance. The regulations would obviously have to be amended to allow for such instruments.

    The SSRA Act is in line with the implicit policy of the GOT regarding the stimulation of competition among insurers as there are only formal criteria to register or deregister insurers. But the SSRA cannot prevent insurers from risk rating of individual contributions, from excluding certain services to insured based on pre-existing diseases and from refusing coverage. In other words this Act is not explicitly intended to promote equity in financing, equal access to insurance and to health services and to prevent impoverishment. However, it can "f*acilitate extension of social security coverage.* " (s. 5 (k)). So, SSRA may want to consider establishing rules governing competition in the health sector which would mitigate or prevent the negative aspects of competition.

B. Regulators

3. **SSRA** is a rather new but potentially very useful regulatory authority for social security related insurance schemes. However, it does not cover all health insurance schemes, among which the private ones, HMO's or MBMO's. The SSRA Act is not specifically oriented towards health insurance. But since it is a framework law, regulations based on this Act can provide

for health insurance specifics. SSRA lacks a mandate for cost containment and promoting quality assurance in health-care services delivery. Although SSRA does not directly deal with health-care providers, it could support the focus of NSSF-SHIB and NHIF in these areas and play a coordinating, regulatory and supervisory role, thus making sure that members get value for money.

4. ***TIRA*** is focused on insurance in general, and as such also covers private health insurance. However there are some grey areas between what is covered in this Act and in the SSRA Act and between the mandates of TIRA and SSRA, for example as regards HMOs. Furthermore, the TIRA Act does not allow for setting requirements for private health insurance as regards a benefits package etc. So, it is recommended that the TIRA Act explicitly refer to private health insurance as a second (voluntary) tier, supplementing the first tier of social health insurance which is regulated in the SSRA Act. The reverse should be done with the SSRA Act. Given the established expertise of TIRA in technical insurance matters and financial management, it would be advisable for there to be coordination and cooperation between TIRA and SSRA. Such coordination could be based on a memorandum of understanding (MOU) or on amendments of the two Acts.

C. Insurers

5. Although ***NSSF*** is mandatory for formal private sector workers[58], enrolment in its SHIB program is not. Funding for the SHIB program comes from the general NSSF contribution (which, however, is not disaggregated to indicate what portion, if any, counts towards the SHIB program).
6. The ***NHIF Act*** does not allow for flexible contribution rate setting to allow for adjustments to be made according to need. NSSF, on the other hand does not charge health insurance specific contributions.
7. The NHIF Act does not allow for the maximizing financial reserves.
8. Besides the fact that ***benefits***[59] are dissimilar in social health insurance (SHI), contracts with services providers and payment schedules also differ. A fee for services (FFS) contract is implemented by NHIF and a capitation fee is paid by NSSF to every registered provider for services. This burdens providers with having to run different administration systems. It may also create bias/double standard in the treatment of patients, because of the possibility of maximizing profit by "under providing" for those members who are under capitation scheme and "over provide" for those under FFS.
9. Criteria and a generally accepted method for ***determining fee amounts*** are lacking, raising questions among providers that have no negotiating power in the system as well as among health insurers that are requested to justify their payment levels. A dedicated forum with participation of all relevant stakeholders backed by supportive expertise might be worth considering. The ongoing service costing study may provide a good starting point.

[58] And, as an alternative choice among other social security schemes that have no SHIB programs, it could be said to be mandatory for public sector workers not covered under any other scheme

[59] Benefit package understood as the entitlement to health services of which the services can be described by either using a system of positive and/of negative lists, indicate the provider from whom the services need to be received, the location where the services will be offered and the conditions for access, such as existing medical need, referral, co-payment, pre-authorization etc.

10. NHIF and NSSF operate their own ***accreditation systems*** with different standards. The recent MOHSW Tanzania Quality improvement Framework in Health Care 2011-2016 (October 2011) makes no reference to the existence of SHI or to the possibility of using SHI legislation and SHI contracts as a tool for implementing the MOHSW quality assurance and quality improvement policies.
11. NSSF and NHIF have their own ***conflict resolution mechanisms.*** A generic health insurance ombudsman could serve both SHI and private health insurance in an advisory role, regardless of the differences in benefits packages. SSRA could also opt for such an ombudsman function provided that SSRA could also deal with private insurance, CHFs and other community-based schemes. There is a possibility that this would generate a considerable workload and capacity requirements, especially if the insured became aware of such a possibility. A dedicated patients' rights Act could serve as a legislative vehicle to support such a development.
12. Health insurance regulation can be a great tool for guaranteeing access to health services, which makes it a valuable health policy instrument. The NSSF and NHIF Acts provide for this via the benefits in kind system and the contracts with providers; the **Insurance Act** does not, its focus being mainly on general protection of consumers of insurance against fraud and insurer insolvency and on regulating the insurance market. Private health insurance is insurance to cover financial losses in case of financial damage. Health policy considerations do not play a role in this private sector.
13. None of the health insurance schemes includes the need to ***cross subsidize*** other schemes aiming at more equity in financing the health sector.
14. NHIF and NSSF make creative use of their reserve funds by ***providing loans*** to health-care providers (called advance payments, for which an administration fee is paid). The funds could actively use this facility to ensure the equitable distribution of health technologies. However, a national health facilities planning system, which could guide investments and loan policies, does not exist. MOHSW requirements for standard equipment, related to the type and level of facility, can provide guidance. NHIF and NSSF are not involved in any ***investment decisions*** of MOHSW even though those institutions have to pay (part of) the operating costs. Although this may not be perceived as an urgent problem, because of the obligation on the part of providers to comply with MOHSW standards, and because of the more than sufficient reserves of NHIF and NSSF, the situation may change and the current regulation does not provide for this. This is not just a matter of financial considerations, as quality of care is also important. Planning and concentrating *high tech and high risk interventions* enhances the chances for better health outcomes and for more efficiency. Legislation for this area should therefore probably be considered.

D. Governance

15. Generic regulation provides for conflict-of-interest avoidance rules as well as the declaration of assets/wealth for high level officials and public servants, both of which promote ***good governance***. However, other critical positions, where the risk of inappropriate use of funds exists, should also be identified in health insurance and regulatory bodies.
16. The system of financial ***auditing*** of public insurance is straightforward and guided and overseen by the National Audit Office (NAO). Although NAO has started "value for money" auditing in the health sector it has not yet done so with regard to SHI. There is no legal

obligation to do this. Coordination with SSRA would need to be developed and most of the activities could be left to SSRA, under the oversight of NAO.

2.2. Detailed Observations

Observations are based on an in-depth review of referenced Acts and Regulations. Other Acts and legal practice have also been taken into account.

2.2.1. National Health Insurance Fund (NHIF) Act

A. Principal Act

General

1. The ***intention*** of the Act is "to establish the National Health Insurance Fund and to provide for contributions to and payment of health-care benefits to certain government employees and to provide for related matters." This does not imply a specific health objective that is to be achieved by this Act, and it does not relate explicitly to a Government policy document or strategy.
2. ***Enrolment*** is mandatory and restricted to public servants[60], with a number of exceptions. Some of the members do, by law, also happen to belong to NSSF and thus qualify to register for NSSF-SHIBs (without the possibility of opting out of either of the two or of enjoying double benefits).
3. ***Funding*** comes from the Government budget via the Treasury, including the contributions deducted from the budget-funded salaries of public servants.
4. ***Collection*** of contributions thus goes through the general tax mechanism and is thus very efficient. How effective the tax collection system itself is, is not covered by the review. The Tanzania Revenue Authority and its procedures and business support systems have been modernized and strengthened, supporting effectiveness and good financial governance.[61]
    a. It is not clear whether NHIF is aware of the level of public servant salaries or receives an audited statement that the transferred monies do, indeed, reflect the amounts due or required.
5. The contribution rate is fixed at 6% and the ***NHIF Act does not allow for flexible contribution*** rate setting to allow for adjustments according to need. The actual revenue needs for a given year depend on the expected costs for the payment of NHIF benefits for that year, the actual reserves and the expected administration costs. The contribution level can be made dependent on the revenue needs, the actual salary levels of staff and the stratification of staff according to salary levels. The total revenues in a given year should be sufficient to cover the costs of the benefits to which members are entitled and not cause financial

[60] See the NSSF Act, s. 6 which enumerates compulsory members (as insured persons) to include: (a) every person who was a member of the National Provident Fund (NPF); (b) every employee in the private sector including private companies, Public Companies, self employed and non-governmental organizations; (c) every non-pensionable employee in the Government service and parastatal organization; (d) every employee or category of employees declared by the Minister by order in the Gazette to be registered as an insured person under the Act.

[61] GIZ. Reorganisation of tax administration: The Tanzania Revenue Authority (TRA), Fact sheet November 2008

resource shortages that become reasons for rationing of services. More flexible contribution rate-setting could prevent the unnecessary growth of reserves. It is suggested that the Government consider such a flexible approach and amend the Act. In the event that the contribution rate were lowered the Government could also consider using the surplus money to subsidize the CHF's or, for example, to reduce the level of public debt.

6. The ***Fund reports to the MOHSW***. MOF is represented in the Board of NHIF. However, the Minister responsible for social security is not represented, while this same Minister is also responsible for the medical benefits offered to the enrolees in the NSSF. MOHSW, in turn, is not represented on the Board of NSSF. Meanwhile, the coordination by the two agencies and their health insurance schemes is not regulated by law. This means that coordination is voluntary where it happens at all. In the event that the Government decides to align the mandatory health insurance schemes as regards (a) benefits packages, (b) contracting providers and other aspects to promote equal access to health services, and (c) efficiency in administration as well as effective provider performance and claims review, it may wish to consider regulating this kind of coordination and/or harmonization by amending the laws of NHIF and NSSF, respectively. The complete absence of the SSRA in the NHIF Act is striking (even though two amendments were passed after the SSRA Act came out). It is suggested that this be repaired in the next amendment to the NHIF Act.
7. ***Discretionary power***. Although the Act regulates many aspects, it leaves many other topics to be handled either by the Minister of Health and Social Welfare or by the Board of the NHIF, notably in areas such as accreditation standards and benefits amounts. Moreover, in virtually all such cases, there are no clear indications or guidelines regarding the criteria, principles and/or law-making procedures to be observed, thereby leaving much to the discretion of those accorded the power to draw up the detailed rules and regulations within the framework of the principal Acts.
8. The Act does not provide for ***cross-subsidization*** of other schemes, such as the CHF or TIKA. However, these are financed from the same source, i.e. the Government budget. So, formal cross-subsidization for this public-service-oriented health insurance system would only be a matter of appearances. Direct budget transfers can be made to CHF's. That aside, the ***benefits*** provided to public servants are broader and deeper than those offered to CHF-enrolled beneficiaries. In other words there is no equal access for those enrolled in these schemes. There is also ***no equity in financing*** since CHF's charge flat fees and NHIF an income-dependent contribution. The same can be said of the NSSF-insured.
9. The NHIF Act does apparently offer a framework for ***cost containment*** and for implementing a sustainable health insurance scheme, given the financial reserves of NHIF and the absence of defaults in its history. It also has the possibility of contracting health-care providers and using those contracts as a basis for provider performance review (section 27) and to safeguard against inappropriate use of resources. The question is whether this apparent framework will be sufficient if and when the justified demand for services increases. Such an increase may happen because of increased awareness of the health services covered among members, increased morbidity due to a greying population and because of the introduction of new health technologies in the sector which NHIF would have to cover.

   The ***sustainability*** of the scheme might be threatened because of the absence of explicit planning mechanisms for the expansion of the benefits package, and the lack of NHIF influence on the investment decisions of hospitals. New medical technologies and

interventions are gradually being introduced by hospitals, for which NHIF will have to pay part of the operating costs. It would be a good idea if NHIF were involved in investment decision making in order to assure future sustainability.

This would need an amendment of the NHIF Act and of the Private Hospitals Act, which would in turn oblige MOHSW, the hospitals (public and private) and external donors to request and review a ***license for investment in medical technologies*** (equipment, new medical procedures, etc.) to be granted by MOHSW after having formally consulted NHIF (and NSSF). The need for such licenses could be restricted to technologies explicitly indicated by MOHSW and listed as such and made known to hospitals. The choice for technologies on this list could be based on a number of explicit criteria, such as high tech, and high risks and investment costs above a certain threshold. Granting a license should, in turn, also be based on explicit criteria, such as: burden of disease reduction; medical need; cost-effectiveness; affordability when applied on a national scale (guaranteeing equality in access); human resources ascertained for application on a national scale; organizational and ethical considerations. Allowing NHIF to engage in technology assessment (section 26) would be supportive of such a process.

10. Although the Public Leadership Code of Ethics Act[62] calls for the declaration of wealth and avoidance of conflicts of interest, the NHIF Act itself does not include ***conflict-of-interest rules*** for members of the board and key staff members, unlike other Acts in the area of health insurance which thereby promote good governance. It is recommended that such rules be set either by law or by the NHIF board.
11. Nor does it provide for the ***declaration of*** assets of board, management and key staff *member**s.*** Establishing and implementing such rules would contribute to good governance.
12. Although the Act promotes ***portability*** within Tanzania, it does not allow for cross-border care.
13. The Act does not provide for any regulation as regards ***confidentiality*** vis-a-vis providers or members.

Specific

14. S. 4(3)(b) refers to ***sound administration***. Neither is it clear what is meant by "sound" in the context of the Fund, nor how this could be interpreted in an external audit or a court case.
15. S. 6 (2)(b) reflects a ***conflict-of-interest rule***: the Director General of the Fund should not be an interested party in any health-care institution. These are defined in s. 3 which lists primary health care, hospitals and medical clinics. Other conflict-of-interest areas are also possible, notably drugs companies, medical equipment and supplies companies, general or medical insurance institutions (companies, brokerage firms, agency firms), banks, etc. Such conflicts of interest could also be avoided by amending the NHIF Act and adding a general provision that the DG should avoid even the appearance of a potential conflict of interest, should **declare all his assets** and those of his immediate family members, the declaration to be yearly repeated, together with a declaration of all his other roles in the private or public sector. A similar set of rules could also be established for other high level staff members of the Fund and all staff, including those involved in inspection, financial management and in procurement decisions.

[62] Act No. 13 of 1995

16. It is not understood why the **Treasury** should deposit the monthly contributions to the Fund (s. 9(2)) instead of keeping it in a special account at the Treasury with a drawing right for the Fund when exercising its legal mandate. The regulation should possibly be amended allowing the Treasury such a ***special Treasury account*** and offering the possibility of carrying over funds from one budget year to the next as well as posting reserves. The Fund could then post its monies at commercial banks and make other investments which would always carry some risk. Such risks could be prevented by keeping the money in the Treasury. The same could be done with other social insurance schemes such as NSSF. Such posting at the Treasury could also allow for easy cross-subsidization between different schemes where the Government decides that is appropriate. It could also make cheap borrowing possible (s. 35), preventing borrowing from commercial banks, and preventing social schemes from taking temporary loans to overcome cash shortages due to, e.g., unforeseen increased consumption of medical and other insured services. Such an option would prevent social schemes having to pay interest and thereby reduce costs. It would also reduce administrative costs for the health insurance and other social schemes because there would be no need for internal Treasury departments and departments that engage in investment of reserves, etc.
17. S.11 (1) (c) allows **four children as dependants** to be enrolled. The reasons for this restriction are not provided[63], but it seems likely that it has been introduced for reasons of cost containment; to reduce fertility or to limit solidarity. However, subsequent children may also need care. This regulation can also create extra costs for society because of avoidable handicaps and complications of non-treated diseases owing to lack of access to timely treatment. Parents might also be confronted with impoverishment in the event that they have to sell assets or pay for health care themselves.
18. It is relatively easy for the Fund to achieve cost containment because the Fund can establish the ***reimbursement fee level*** irrespective of the fee being charged by a hospital (S. 16(1)(a)). However, this mandate does not encourage the Fund to embrace cost containment options or to critically review the effectiveness and efficiency of health services providers. It therefore may not feel the need for active strategic purchasing, or the urge to play the patient advocate role and because of that fails to protect the insured against high OOP payment at the point of service (s. 16 (2) and (3)).
19. ***Benefits.*** S. 17. The Minister, upon the recommendation of the Board, is empowered to prepare a list of health-care services that may not be granted under the Act. While this is more flexible than was the case under the former provision, there is still a lack of basic principles, values and procedure to be observed to ensure good governance, equity, and policy observance.
20. Part V, (Ss. 19 – 24) deals with ***accreditation.*** However, what it describes sounds more like a minimum standards checking programme for services delivery, taking into account mostly the structural and some process aspects of health services. That also seems to be the way it is applied. Such standards and the standards assessment programme could be part of a wider accreditation programme. This would also help develop standards for care delivery, including the use of clinical practice guidelines and medical protocols, and of standard operating procedures. This kind of wider accreditation programme should strive for continuous quality improvement and would serve to assess outcomes of the care process. MOHSW has taken

[63] See comment, *post,* in footnote No. 65.

initiatives to expand its health services quality initiative. MOHSW is also cooperating with the Safe Care Initiative[64] which, with international support from accreditation agencies, takes this broader approach to accreditation. These developments may need to be supported by a change in the NHIF Act as regards accreditation.

21. Section 41 does not explicitly list accreditation decisions by the Fund or offer a grading of decisions (s. 22) about the level of the services as a ***ground for appeal*** although such decisions can have important consequences for a health-care provider, including for his revenues.
22. The ***payment mechanism*** for providers is not based on negotiations between the Fund and the provider but is operated unilaterally by the board of the fund (s. 25). The same is true for the benefits amount. It is not clear how the fees set by the board can compensate for the costs of the providers and whether consequences for the members (e.g. additional OOP payments) are taken into account, although formally top-ups are not allowed.
23. Posting the Fund's (financial) ***Annual report*** (s. 30(c)) on the internet would facilitate transparency and therewith good governance. The obligation to do this could either be done by amending the Act or by a NHIF board decision.
24. Because the term ***"contract***" is not defined in the Definition section (s. 3), it is not clear what the differences are between contracts in s. 27 and s. 30 (h).

B. Regulations

General

1. This document provides ***implementation rules and guidelines*** about aspects of NHIF such as: enrolment; contribution payment; eligibility requirements (3 months waiting time); benefits package and conditions for receiving covered care; payment mechanisms; accreditation standards and processes; provider performance review; quality assurance, conflict resolution and sanctions. Attached to it are a number of schedules, containing forms.
2. The ***NHIF can act unilaterally*** in its relation with providers of health services as regards fee schedules, accreditation standards and recognition of bed numbers. Although this can contribute to cost containment, it can also lead to indifference as regards the needs of the providers. Although the Fund may recognize associations of providers, it unilaterally sets the requirements for such associations, including a number of quality assurance requirements. Such quality orientation is seen as positive.

   However, it takes two to tango. Creating a ***permanent forum for dialogue*** on issues such as fee schedules and amounts, on investments, on medical guidelines, on outcome measurement and on quality assurance programs seems useful and may be considered as an option for adoption. Given the current discourse, it is also possible to see the need for an independent forum or board under the Ministry of Health that would be a platform for stakeholders (insurers, providers and Government) to participate in setting the fees schedules and fee amounts. This would also be in line with the fact that the Minister of Health is mandated by law to announce such prices from time to time; hence what is missing

[64] Safe Care Initiative. Introducing standards to improve healthcare delivery in resource-restricted countries. https://www.safe-care.org

now is a representative advisory system for these matters and related pricing of medical services.

3. NHIF and NSSF, both mandatory schemes, have different ***accreditation*** programs and benefits packages. Having two different accreditation programs appears to be inefficient and may confuse health-care providers who have to cope with these different programs and requirements as well as with inspections by representatives of both programs.
4. It would be advisable to have *one national accreditation program* to which NSSF (and NHIF and other insurers) can refer in their contracts with providers. This is an inter-Ministerial and inter-sectoral issue in which MOL, MOF, MOHSW, and PMO -RALG as well as SSRA and TIRA would be interested and involved. MOHSW and SSRA could take the initiative in tackling this issue if that was judged to be appropriate. These Regulations, like with NSSF Regulations, refer to a "*National Quality Assurance Program*". This seems to be a good basis for referring to a national accreditation program also.

   It is striking that the MOHSW Quality Improvement Framework[65] makes no reference whatsoever to health insurance and to NHIF (and NSSF) and does not include an explicit option whereby insurers can refer to this Framework and to the concrete activities MOHSW intends to undertake and stimulate. Contracts between insurers and providers could be a useful vehicle for promoting quality assurance and insurers could work in tandem with assessors of a national accreditation program. Insurers are in almost daily contact with providers as part of their financial claims reviews process as well as in contact with their members, much more often than the incidental accreditation program assessor. Inter-Ministerial coordination/cooperation would be imperative here too and MOHSW and SSRA could, if such a step were desired, take the initiative.

Specific

5. Regulation 3 entitles a member of the Fund to ***enrol a spouse and up to four children***. It is not clear why this restriction exists and what this means for access to health care for children beyond that number. This Regulation does not contribute to equal access for the population. It may be conceded that NHIF (Act and related) regulations are not alone in having this type of provision in the country and that other enactments[66] have similar provisions. The consulting team is aware of the fact that the Teachers Service Commission (whose members constitute more than 50% of NHIF membership) has been pointing out that this provision is in conflict with their scheme of service which gives entitlement to spouse and children (with no restriction on the number of children or spouses). However, it would be good to establish whether or not there is any actuarial basis for these restrictions and any actuarial financial implications for not having them.
6. Reg. 5(1) states, similar to a relevant NSSF Regulation, and in furtherance of the provisions of s. 12 0f the Principal NHIF Act as amended in 2009, that membership becomes effective after

[65] MOHSW. The Tanzania Quality Improvement Framework in Health Care 2011-2016. October 2011

[66] Similar provisions existed in the former/early versions of the Income Tax Act when family allowances for income tax purposes were given to reduce tax liability on tax payers with children, as defined (repealed since the late 1970's for all practical intents and purposes). The number of children below the age of majority and of those still attending school if above the age was three. This feature was and has continued to appear in employment contracts for leave travel allowances/assistance and other family support purposes. That may be the historical basis and reason for its presence in the legislation under reference.

a ***waiting period*** of 3 months, stating specifically that the member "shall be entitled to the benefit package after payment of three months contribution." This implies that, only after 3 months, can members avail themselves of benefits. It is not clear why this waiting time exists for public servants, because NHIF is mandatory for them. A waiting time only make sense for voluntary insurance to prevent people waiting to get ill before enrolling. MOHSW/NHIF may want to re-consider this 3 months waiting period.

7. Regulation 7 states that the Fund may issue ***information materials*** on member's rights and obligations and on benefits. This should not be left to the discretion of the Fund but should instead be mandatory.
8. Reg. 41(a) mandates the Fund to analyse mortality and morbidity rates and to inform providers (Reg. 42). This is useful. However, it is not clear whether the Fund takes into account the case mix of a provider and the complexity of cases when it compares provider performance and whether the information is kept confidential or made public. Publishing such information without making ***corrections for case mix and complexity*** may not do justice to providers that take on the most complex cases and thus run the highest risks of mortality among their treatment cases.
9. Given that employers referred to in the Regulations are all Government (Reg. 2) how is it possible for the Fund to ***enforce the payment of contributions*** and the payment of fines ((Reg. 86(a))?

2.2.2. Review of Memorandum of Understanding for the Management and Administration of Community Health Funds between the Ministry of Health and Social Welfare, the Prime Minister's Office Regional Administration and Local Government, and the National Health Insurance Fund (4 June, 2009).

General

1. Although not an Act in itself it is an important piece of regulation (though, strictly, not legally enforceable) which relates to the CHF Act and is meant to further the implementation of this Act by delegating the mandate of MOHSW re the administration of the CHF to the NHIF. Freeing up a ministry's capacity for its core stewardship functions of policy making, regulation and monitoring and evaluation by such delegation is useful.
2. The MOU leaves many issues to be regulated by the partners without providing directions, deadlines and objectives for goal attainment. The transfer of funds via MOHSW to NHIF is limited to recurrent costs, i.e. it does not provide for a mandate to NHIF to provide investment loans to health facilities. However this mandate may be regulated elsewhere. It is not clear whether the matching grant from the MOHSW received by NHIF ought to be deposited into the CHF account together with the collected member contribution through local government.
3. The ***MOU expires on 30 June 2012***, although clause 11 provides for the revision of the MOU and clause 12 for termination. It is not clear what will happen thereafter and whether this depends on the evaluation of the effectiveness and efficiency of NHIF in the implementation of its mandate in accordance with this MOU or on a planned general

revision and amending of the CHF Act (or the MOU). The MOU does not provide for a transitional period and handing-over procedure.

4. The terms of reference (clause 4 c.) have not been taken into account in this review. The same is true of any directives of MOHSW to NHIF (clause 5.1.5)
5. Clause 9.0. requires that NHIF not disclose "Fund's affairs .... to any other third party persons including, but not limited to, ***business competitors*** and/or unauthorized employees of the Fund". This clause implies that the three parties in the MOU are apparently contemplating the possibility of competition in health financing and/or health insurance. Whatever the value of such competition re effectiveness and efficiency in health financing, it may undermine transparency and accountability in public finance at least to the public at large. It also begs the question about the existence of an ***explicit Government policy regarding such competition***, the existence of a level playing field for insurers and the implied competition influencing the possibility of Government transfers to one of the competitors, i.e., the NHIF to the disadvantage of other public and private insurers.
6. Clause 15.2 provides for a **waiving of liabilities** of partners for which not all reasons are made explicit, i.e. leaving the possibility of unforeseen external circumstances beyond the control of one of the parties in the MOU. This begs the question of compatibility or overlap with generic laws.

Specific

7. Clause 5.1.2. obliges MOHSW to "***rationalize NHIF and CHF policies and Laws***". This is rather vague because the objective of the rationalization has not been provided, criteria have not been included and, hence, goal attainment parameters are impossible to establish or specify. This will also make NHIF's task of proposing the rationalization of NHIF and CHF policies (clause 6.9) more difficult.
8. The **"matching funds**" mentioned in section 5.1.3. will provide an incentive for communities to enrol as many community members as possible, prevent the issuing of too many contribution waivers to insolvent members and to set the contribution level as high as possible. However, it may also harm the interest of members in case, e.g., the ward health committees, councils and boards underperform and do not manage to enrol and keep members as well as raise sufficient funds or when local authorities do not compensate for the lost revenues due to the provision of waivers.

2.2.3. Review of The National Social Security Fund Act, 1997

As published in the official Gazette on 30 January 1998

NB: Besides the general sections dealing with definitions, the Fund itself, the contributors, the eligibility to benefits, etc, only health Insurance specifics are reviewed and not the other aspects.

A. Principal Act

General

1. No specific ***objective*** or intention of this Act is explicitly mentioned.
2. Those subjected to this Act are clearly described.

3. The Act is a ***framework enactment*** leaving many topics to be detailed by the Minister. This is useful because of the flexibility such a framework act offers in dealing with the dynamics of the labour market and the formal private sector. Although the Minister needs to stay within the framework of the specific law, there is also a risk, inherent in this flexibility, of taking measures which are in favour of one of the stakeholders to the disadvantage of others, when deciding about temporary employment, for example, and the need or absence of need to pay contributions while in return receiving benefits. The Act does not provide for a procedure to transparently discuss and decide such issues and there is no possibility for Parliament to intervene except through an amendment of the Act.
4. The NSSF reports to the ***Minister in charge of labour matters***.
5. Health insurance, offered by the Fund to its members, covers the members themselves and their dependents (spouse and four children). It is not understood why a ***3 months waiting time*** is maintained for members to avail themselves of benefits. Although such a waiting time makes sense for voluntary schemes to avoid enrolment after falling ill and for mandatory universal health insurance for citizens, living abroad, who like to return to their home country to get what would otherwise be expensive treatment. However, that is not the case here unless people can take a job while ill, just for the purpose of obtaining benefits. But, this latter option is also blocked by the need to have a medical examination at job entry and exit. NSSF may want to re-consider this 3 months waiting period.
6. Stakeholder interviews have indicated that members may fear that by availing themselves of ***medical benefits they risk seeing a reduction in their pension payment, which is*** not the case. To increase SHIB enrolment it is advisable to clarify this issue and inform all members on access to medical benefits and the absence of any relation to the future pension amount. In case this kind of clarification is insufficient, automatic enrolment could solve the problem, especially in the event that the Government wants to align benefits packages across schemes and introduce a basic BP for the whole population, on top of which employer based and private health insurance schemes can be provided. This matter, among others of a similar nature, requires Government/inter-Ministerial level consideration in order to produce a streamlined policy framew*ork* ***within which proper coordination and rationalization*** of legal and related institutional build up could be based.

Specific

7. The Fund can enter into ***agreements*** with accredited hospitals (s. 43). There are no minimum requirements in this Act re the topics to be covered by an agreement. It would be useful to include such topics in this Act accompanied by an obligation for NSSF to have at least some of the topics to be regulated similar to NHIF and perhaps some private insurers (and vice versa), e.g. administrative requirements, HMIS compatibility, claims review and accreditation. This would prevent hospitals being confronted with multiple systems which would increase their admin costs and the likelihood of errors. Similar requirements in both insurance schemes may also improve the possibility for containment of costs, not only for admin but also for medical care because of the use of the same yardsticks for claims review, including their medical aspects. As suggested above, this is one such area that could be better coordinated both at Government policy level and institution-specific legislative level to avoid the problems pointed out here.

8. It is not clear whether s. 45 (b) also covers inpatient care in a maternity clinic or general hospital, although this may be covered by s. 42.
9. Section 47 seems to exclude the simultaneous payment for medical benefits and other benefits covered in the NSSF Act. In case this is not the intention of this section, it may be advisable to clarify this in the NSSF Act.
10. Since the monies of the Fund are not separated for the various benefits as such, but only in the general fund of NSSF, and despite registration of individual payments, it is not clear how medical benefits rates adjustment, for example, will result from the actuarial valuation of the Fund (s. 48).
11. Section 49 gives the Director General of the Fund the option to prescribe procedures for claiming benefits. This offers the possibility of requesting members to seek and obtain authorization prior to admission to a hospital or for a specific (expensive) benefit or a treatment abroad, in the event that the latter were to become part of the entitlements. Such provision would contribute to cost containment.
12. ***Cross border care*** is explicitly excluded, , i.e. there is no international portability which may become an issue as a consequence of the East African Community (EAC) and the internationalization of the labour force. However, s. 92 provides the option for the Government to conclude reciprocal agreements with other countries, but only for the collection of contributions and not for the delivery of medical benefits.
13. Also **portability across Districts** is limited for NSSF insured, i.e. only in case of emergencies and then only at NSSF accredited providers if available
14. Section 49(2)(c) gives the ***discretionary power*** to the General Director to adjust benefits in special circumstances. To the extent that this may give rise to higher expenses and depletion of the general Fund resources, such power may lead to inequity in access to the Fund's resources.
15. The Fund can post its monies in a commercial Bank (s. 61(1)), which brings the risk of bankruptcy, although it can only be posted in Bank of Tanzania (BOT) licensed banks perceived to be reliable[67] and viable. See also remarks about this topic and the possible use of the Government's Treasury system in the review of the NHIF Act.
16. The Fund may ***invest in any viable venture*** (s. 62). The Act does not provide for instructions of the Minister of Finance/SSRA in this regard, in contravention of the regulations of the NHIF SSRA Act. The SSRA Act provides for regulatory guidelines made by BOT in consultation with SSRA, which would like to have this amended so that SRRA has full mandate over them. These are to apply to NSSF as much as to NHIF, among other social security schemes, rendering ministerial intervention unnecessary.
17. Section 88 seems to be missing a conclusion at the end.

[67] Under the Banking and Financial Institutions A ct, 2006, Act No. 5 of 2006 [Cap. 342 R.E. 2002], Part VII (The Deposit Insurance Fund),ss.36-42 that perception finds a sound legal basis as the Deposit Insurance Fund established under the Part is to be managed and controlled by the Deposit Insurance Board to receive "all contributions and other payments required by this Part to be paid into the Fund and out of which shall be made the payments required to be made out of the Fund". The size of the Fund is to be fixed by the Minister as provided so as to be "sufficient to protect the interests of depositors …" Contributions are to be made by the licensed banks according to the relevant provisions (ss. 36 (2) and 38).

18. Section 69(2) mandates the Board to appoint the ***Auditors of the Fund*** from time to time, contrary to the provisions of the Public Audit Act, 2oo8[68], ss. 5(c) and 9(a). It thus calls for necessary amendment.

B. Regulations (Government Notice No.140 published on 20/5/2005)

General

1. This document provides ***implementation rules and guidelines*** about aspects of NSSF-SHIB such as: enrolment; eligibility requirements (3 months waiting time);registering with an accredited health services provider; emergency care when travelling (in country); benefits package and conditions for receiving covered care; payment mechanisms; accreditation standards and processes; quality assurance and sanctions. Attached to the Regulations are a number of schedules, containing forms and a list of covered health services and diseases, of medical interventions and of excluded services.
2. NSSF and NHIF, both mandatory schemes, have different ***accreditation programs*** and benefits packages. Having two different accreditation programs appears to be inefficient and may confuse health-care providers who have to cope with these different programs and requirements as well as with inspections by representatives of both programs. NSSF restricts its accreditation activities to those areas and providers where it has members and makes it further dependent on the availability of medical provider capacity in such areas (Reg. 38). This means that the NSSF program has a limited reach and only partially contributes to national quality improvement. It would be advisable to have one national accreditation program to which NSSF (and NHIF and other insurers) can refer in their contracts with providers. This is an inter-Ministerial and inter-sectoral issue in which MOL, MOF, MOHSW, and PMO-RALG as well as SSRA and TIRA would be interested and involved. MOHSW and SSRA could take the initiative in tackling this issue.
3. Reg. 45(a) refers to a ***"National Quality Assurance Program".*** This seems to be a good basis for referring to a national accreditation program also.
   It is striking that the MOHSW Quality Improvement Framework[69] makes no reference whatsoever to health insurance and to NSSF (and NHIF), and does not include an explicit option to have insurers refer to this Framework and to the concrete activities MOHSW intends to undertake and stimulate. Contracts between insurers and providers could be a useful vehicle to promote quality assurance and insurers can work in tandem with assessors of a national accreditation program. Insurers are in almost daily contact with providers as part of their financial claims reviews process as well as with their members, much more often than the incidental accreditation program assessor. Again inter-ministerial coordination / cooperation would be imperative here too, and MOHSW and SSRA can take the initiative.

Specific

4. ***Emergency care,*** when travelling outside the area where insured have registered with a provider, needs to be provided by an NSSF accredited provider. It is not clear what happens

[68] No. 11 of 2008, assented on 4th July, 2008.
[69] MOHSW. The Tanzania Quality Improvement Framework in Health Care 2011-2016. October 2011

when no such provider is available. It seems that in such cases one may seek service from any other available provider but at one's own cost, or from the nearest available accredited provider in the area, at one's own cost for travel and at the risk of not getting the needed help in time. This indicates a gap.

5. The provider with which the insured is registered is a kind of ***fund holder***: in case a patient is referred, all related costs need to be paid from the capitation fee (Reg. 20(2)(b)). This provision is excellent for NSSF in that it offers the possibility of cost-containment and predictability of expenditures. However, it may also prevent patients from being referred, since the referring provider may lose a part of its revenues from such patients and has no control of the costs in the referral hospital. Such behaviour may harm the patient, despite the fact that NSSF checks on appropriateness of care of providers (Reg. 46 (1) (e)).
6. In case insured are registered with a health centre or lower level facility these providers receive only a partial capitation fee. The remainder goes to higher level providers which have a ***partnership*** with the lower level providers (Reg. 20 (2) (d)). Such partnership is a good option because it can streamline referral procedures and provide feedback to lower levels.
7. Reg. 20 envisages ***referrals*** made from accredited medical providers of health centre level and below to higher hospitals with which the health centre etc is/are in partnership, and provides for sharing of the capitation. In the admittedly unlikely event that no partnership was to exist, it is not obvious which provider would be entitled to the capitation amount.
8. An accredited provider should have a ***quality assurance program.*** However, the regulations do not state the requirements for such program. A quality assurance program should be based on the results of an internal assessment, indicating a provider's weak areas. This approach is currently practised by the certification towards accreditation program of the Safe Care Initiative in Tanzania.
9. Regs. 29 (d), 43 and 45 (f) make favourable provisions in respect of membership in a national association of licensed hospitals, duly recognized by the Fund in accordance with its established standard criteria. This provides an opportunity to encourage ***self-regulation*** through such an association under its own or a statutorily introduced code of ethical conduct with some legal linkage to the general regulatory system.
10. Regs. 49 and 50 provide NSSF with the interesting and useful option of ***assessing service outcomes*** through indicators such as mortality and post-surgical infection rates and informing accredited providers and other stakeholders about these indicators. However, these regulations do not refer to the need to take into account the case mix of providers which influences outcomes. Leaving the case mix out of the equation may lead to the wrong perceptions among stakeholders and can make providers hesitant to take on complex and risky cases, as a consequence of which patients may suffer. Although Regs. 49 and 50 do not exclude the possibility of NSSF looking at case mix differences, it is nevertheless advisable to make this an explicit aspect of an outcomes review. Besides informing stakeholders, there is also a need for periodic mutual feedback at a ***participatory forum*** that specifically provides an opportunity for dialogue on contract and capitation/medicine costs-related issues among the Fund, the members and the providers (through representatives).
11. Reg. 49 encompasses the ***survey of patients' satisfaction***; health service provider satisfaction is also very important for the system, but a monitoring mechanism for it seems to be lacking.
12. Despite the detailed lists of services and types of interventions of which the insured can avail themselves set out in Schedule 2, and despite the listed diseases that can be treated as part

of the NSSF-SHIB program, the ***demarcation with the MOHSW-funded programs*** for TB, HIV and maternity care, for example, can still be problematic in instances of co-morbidity, such as in the case of an HIV patient getting pneumonia due to his compromised immune system. This demarcation problem may remain as long as insurance covers only part of the population. It could partly be solved by a flexible interpretation of the relevant provisions by the insurers to the advantage of the insured. A more ***structural solution*** could be achieved through the introduction of universal insurance with a ***basic benefits package*** for the whole population. Such a package would still need to be carefully demarcated from any supplementary voluntary health insurance.

2.2.4. Review of The Insurance Act, 2009

General

1. This Act has a clear ***objective***: "to establish the Tanzania Insurance Regulatory Authority, to provide for the functions and powers of the Tanzania Insurance Regulatory Authority in regulating and supervising insurance business and for related matters." It covers Mainland Tanzania and Tanzania Zanzibar. The SSRA Act, in contrast, covers only Mainland Tanzania.
2. The Act is rather detailed and has a limited number of items for which the Minister can provide more detailed regulations, such as on solvency requirements and investment options.
3. ***Private health Insurance is made subject*** to this law. Social health insurance is not explicitly mentioned in it. Nor is it included in the Second Schedule to the Act (Part A) which describes the categories of insurance business. The question then arises as to whether social health insurance should be explicitly mentioned, other than in the case of "permanent health" damage (number IV) and in the case of "sickness" as listed in Part B of the same Schedule (number 2). The latter seems to cover financial losses in case of sickness or infirmity. In any case, there should be ***no grey areas*** between what is covered in this Act and in the SSRA Act and between the mandates of TIRA and SSRA.

   So, with regard to TIRA, the TIRA Act could be made to explicitly refer to private health insurance as a ***second voluntary tier*** in supplement to the first tier of social health insurance which is regulated in the SSRA Act. The reverse could be done in the SSRA Act. Given the established expertise of TIRA in technical insurance matters and financial management it would be advisable to have ***coordination and cooperation between TIRA and SSRA***. Such coordination could be based on a MOU, for example, or on amendments of the two Acts.

   The ***separation between general insurance and health-specific insurance*** in the regulation is further cause for concern. In the current context it would be difficult to really regulate the private health insurance industry by, for example, imposing minimum benefits, setting accreditation criteria, or a maximum reserves requirement for health insurance. If the TIRA office were to get involved in this it would need to have medical professionals who might be able to assist in the regulation of health insurance.

The solvency requirements for general insurance should also be differentiated from those for health insurance. The latter bears only short term risks and a different risk profile.

4. HMOs, which combine the provision of health services with enrolment in a prepayment scheme, are not explicitly covered under this Act and they are not part of the definition section. Nor are they subject to the SSRA Act. This is apparently a *grey zone* in the health insurance regulations, which should, ideally, be clarified. In essence, HMO's can be seen as insurers because they have all the characteristics of insurers and, on top of common insurance practice, they directly provide services in kind by having health services providers under their jurisdiction and health staff as employees.
5. **MBMO's** are in the same ***grey zone,*** but they differ from HMO's by not individually charging, collecting and pooling contributions. However, for a fee, they take over the risks of companies to pay for medical services for their employees. MBMO's pay health services providers directly for services or reimburse patients, and also review the submitted claims, but have insufficient clout to negotiate fees with the public or private sector. So they either set themselves maximum reimbursement levels or accept the fees being charged to them. As with the HMO's, it would also be useful to subject the MBMO's to health insurance regulation to protect the people for whom they are responsible re their health services payment, and to maintain a level playing field for all legal persons that engage in health insurance under whatever name. It is therefore recommended that they be included in the definition section of the Insurance Act, and to the extent applicable, in compulsory health insurance, and also the definition section of the SSRA Act.
6. Public insurers, such as NHIF and NSSF, may also offer *supplementary voluntary* insurance. The NHIF is in fact already doing this with its brown/green card system. Such insurance is, actually, private insurance offered by public agencies. In this area, they compete with private insurers offering health insurance schemes which can also supplement public mandatory insurance. Public health insurance schemes have different requirements to private ones for operating on the private market and have a competitive advantage over the private sector, notably because they can build on their publicly funded infrastructure, existing capital investments and membership data base for marketing purposes. In order to create a level playing field, the supplementary insurance schemes of public schemes would also have to be brought under the Insurance Act and, hence, TIRA, as they would also remain regulated under the SSRA Act, and, hence, by SSRA. In practice and under clear correlated provisions in and under the two Acts, this would mean that the two regulatory authorities would enforce similar rules and regulations and share information and experiences on a systemic regular basis regarding these areas and related issues.
7. An alternative would be to bring all health insurance schemes and health insurers, irrespective of their ownership under ***one regulatory agency***. This would help create a level playing field, combine relatively scarce expertise, such as actuarial expertise, and reduce admin costs.
8. The Tanzania Insurance Regulatory Authority (TIRA) ***reports to the Minister of Finance*** also with regard to its health insurance aspects. This Minister is also responsible as stated in this Act for the formulation, development and implementation of the national policy

on insurance. The SSRA reports to the Minister in charge of social security and according to SSRA Act section 5(1)(f) is required, to "advise the Minister on all policy and operational matters relating to [the] social security sector". By implication, it is this Minister who is responsible for the formulation, development and implementation of the national policy on social security/insurance. So, coordination and cooperation between TIRA and SSRA is also warranted, and may be considered for this area.

Specific

9. TIRA has the responsibility to specify a ***code of conduct*** for members of the insurance industry (s. 6 (c)). Designing and accepting such a code of conduct could also have been left to an association of insurers, such as the Tanzania Insurers Association (TIA)]. However, because the insurance sector in Tanzania is still in early stages, it is understandable that the Government has taken the initiative.
10. There is no ***conflict-of-interest*** regulation in this Act and no need to declare assets before the start of an assignment and yearly thereafter for the Commissioner or the Deputy Commissioner and staff of the Authority. However, The Commissioner and Deputy Commissioner may be governed by the Public Leadership Code and Ethics Act[70] as "leaders" but this is probably not true for the staff. It is advisable to have such regulation included in the Act or in a bylaw/schedule of the Act or a guideline established by the National Insurance Board.
11. Such conflict-of-interest regulation however does exist for insurance companies and insurance brokers (corporate institutions and their managerial personnel) (s. 18).
12. The Act instructs TIRA to establish an Ombudsman Service to help solve disputes between insurers and insured (S. 122) and eventually grant the complainant a compensation for losses. It also provides the option of establishing an Insurance Appeals Tribunal which will be an ad hoc forum (S.126). Appealing a decision of the Tribunal (but only on questions of law(s) can be done through the High Court of Tanzania (s. 126 (7)).

2.2.5. Review of The Social Security (Regulatory Authority) SSRA Act, 2008

General

1. The SSRA Act is a **framework** piece of legislation which leaves a lot to be filled in by the Minister and SSRA Board. This allows for some flexibility in the implementation of the Act and makes it possible to respond quickly to changing circumstances. The SSRA has existed since 2011, a relatively short time. Because SSRA needs time to build its organization from scratch, it has not yet used its mandate to issue guidelines and initiate activities that are not detailed in the text of the Act itself. These factors make it difficult at this stage to evaluate the possible workings of the Act. The establishment of a ***business plan*** by the SSRA Management, which is scheduled for January 2012, would offer an additional opportunity to review this Act.
2. This Act does not indicate what its ***objective*** is, nor is it accompanied by a memo that indicates the objective and/or explains its content. However, the functions and duties of

[70] Act No. 13 of 1995, Cap. 398 R.E. 2002.

the Authority are listed in s. 5 of this Act. These can be characterized as covering ***governance and oversight*** *elements of, among other things, health insurance*.

3. The Act is in conformity with the policy of the Government to ***stimulate competition*** among insurers as there are only formal criteria to register or deregister insurers. However, SSRA cannot prevent insurers from risk rating individual contributions; from excluding coverage for certain services to the insured based on pre-existing diseases and from refusing coverage. ***This Act is therefore not explicitly intended to promote equity in financing, equal access to insurance and to health services and to prevent impoverishment.*** However, it can "facilitate extension of social security coverage... " (s. 5 (k)).
4. GOT has not developed a more detailed policy and strategy regarding ***competition in health insurance***. Such a policy would probably need to weigh the potential gains in, for example, efficiency, client orientation and patient choice against the potential losses in, say, solidarity, equity of access, costs control and increased admin costs. The GOT could also embark on ***mitigating the potential negative implications of insurer competition and subsequently establish the necessary regulations.***
5. The Act is ***not designed to contain costs*** of health insurance or of health services and to promote the quality of health services. However, using its mandate to issue guidelines, SSRA may be able to address these aspects. SSRA has a responsibility as regards actuarial studies. With the results of these studies, SSRA can review the adequacy of the revenue collection and contribution level of the social/mandatory insurance schemes and/or indicate the need for additional funding from the Government budget or from OOP, for example. However, SSRA is not involved in decisions about changes in the benefits packages or the expansion of health facilities. This, together with the inbuilt automatism of benefits package extensions via the currently unregulated expansion of medical services by public health institutions, especially as regards high-end medical technology, makes it impossible for SSRA to predict the operating costs consequences of such decisions. This could lead to a shortfall in revenues at NHIF and NSSF-SHIB. Although these shortfalls can, on a temporary basis, be covered from the reserves of these insurance agencies, this is not what reserves are for and it should not be seen as a permanent solution.
6. It is worth considering having SSRA involved in, or at least being notified in a timely manner of, any ***benefits package extensions*** or service expansions to enable it to implement its mandate in accordance with s. 5 (d): "protect and safeguard the interests of members ".

   SSRA could issue a guideline as regards this issue in accordance with s. 5 (c) and/or (g) of the SSRA Act. This may cover NHIF and NSSF, but it is not clear to what extent it can also use these guidelines to instruct MOHSW, PMO-RALG and LGA, which also are in charge of health facilities and make decisions about investments as well as to health facilities which can also independently find resources for investments. Due to the fact that, among other things, the latter two institutions are in different ministries, calls for **an inter-ministerial approach to consideration and proper handling of the Act, as is suggested elsewhere in this report with regard to other reviews of individual Acts**.

7. In fact *investment decision-making* and actual investments and their consequences for operating costs are crosscutting issues which also deserve attention from the legal perspective of facility planning by NSSF and NHIF, as governed by their respective Acts.
8. The Act does not indicate how SSRA's **yearly budget is set to initiate studies** (s 5. (i)) and to conduct programmes for public awareness (s. 5.) .
9. A Board decision which affects NSSF, NHIF and its health insurance schemes should, ideally, be preceded by a formal hearing of these public agencies. This could perhaps be regulated in a decision by the Board or a guideline.
10. There is no ***confidentiality regulation*** in the Act, contrary, for example, to the "Memorandum of Understanding for the Management and Administration of the Community Health Fund between MOHSW. PMO-RALG and NHIF" presented earlier in this report (see 2.2.2). This gap could be closed by either an amendment to the SSRA Act or by the adoption by the SSRA Board of a confidentiality regulation.

Specific

11. The terms "benefits" and "long term benefits" are not defined in Part I, s. 3.
12. HMOs and/or MBMOs are not covered by this Act, and are also not covered by the Insurance Act, 2009. This could be remedied in s. 3 to the extent that these deal in benefits and matters covered by the SSRA Act.
13. S. 5 (e) "create a conducive environment for the promotion and development of the social security sector". This is a rather vaguely formulated paragraph or, to put it in a more positive way, it leaves a lot of discretion to SSRA which would be difficult to evaluate. It would be good to have either a legal provision in the SSRA Act that stipulates the options for SSRA or to have SSRA develop a business plan that would incorporate the feedback from organizations and legal persons with an interest in social security.
14. The previous item can be seen in relation to the existence of and possible ***promotion of competition*** among insurers and between NSSF and NHIF with regard to the informal sector, and limited to the first tier of health insurance, covering the basic (compulsory) benefits package. If the GOT chose to promote such competition, it would be useful to create a level playing field for the insurers and ascertain the position of the insured as regards access to health insurance regardless of individual health risks and also regardless of other insurance products of the insurer that the individual may be covered by. It would also be useful to ***prohibit risk rating*** by insurers and to establish a ***mandatory minimum benefits package.*** Risk rating could still be allowed for the second tier of voluntary and supplementary insurance.
15. It may be a good idea to include a definition of "studies" (s. 5(i)), i.e. what topics this could entail. For example, mainly in support of the implementation of social security schemes and not in, say, basic scientific medical research.
16. It might also be useful to set a maximum budget to conduct "studies" (s. 5(i) or to have such a budget included in SSRA's yearly budget proposal, and have this subjected to approval by the Minister.
17. Although SSRA also has the mandate to deal with health insurance, it has no representative of MOHSW on its Board (s. 7) and has more generally ***no specifics on health insurance in its regulations and in the SSRA Act itself.***

18. The SSRA Board can delegate (s. 10) the exercise of its powers to a committee and a Director. It can also delegate to an employee or agent of the Authority. This may lead to the bypassing of the management of the Authority, undermining its authority and causing internal conflicts. It would be advisable to leave engaging employees to the Director General of the Authority except as regards internal financial control.
19. Section 15 (a) (ii): just presenting an "***actuarial valuation report***" should not be sufficient, and it might be worth adding: acceptable to SSRA and in accordance with SSRA's guidelines. Such guidelines would need to be adopted by SSRA.
20. It is not clear whether an appeal against the Rulings of the Tribunal is possible.
21. There are ***no conflict-of-interest rules*** for managers of schemes. It is worth considering the introduction of this, for example in s. 16, or issuing a guideline.
22. There is no need to make a ***minimum deposit*** to start a private health insurance scheme or to maintain a financial reserve as a percentage of the potential risks of the insurance, i.e. there are no liquidity or solvency requirements. This could either be solved through the issuance of a guideline by SSRA or an amendment of the Act. See also point 36 hereafter.
23. The regulation of "administration expense" could also include the possibility of paying for health services through ***provider's performance review***, which is essential for the purchasing function of an insurer, and notably for cost containment and combating fraud.
24. An addition to s. 15 (a)(ii) of the clause '... acceptable to SSRA' could render what is intended clearer.
25. It is not clear how s. 25 (2) and (3) relate to the mandates of MOHSW and NHIF as regards contribution rates and minimum health-care benefits. It would be useful to have this clarified.
26. S.27 (5) (b): it might be useful to distinguish between the initial investment costs of a scheme and the operating costs to ensure that reasonable/adequate ***investments*** in, for example, health management information systems will be possible to allow for adequate health-care provider performance review. Alternatively, the amortization and interest payment consequences of investments could be reviewed and found to be acceptable for SSRA.
27. It might be worth making it possible to interpret s. 28 (5) "publish" as including ***internet publication***, accessible to the general public.
28. Section 29 (3)(a) seems to forbid the apparent current practice of having to be enrolled in NSSF/SHIB and NHIF. It is not clear if this is explicitly meant, and if so how the existing ***double enrolment*** would be solved and can be left to the insurer/s.
29. Section 30: seems to offer the possibility of ***competition between NSSF and NHIF*** with regard to enrolling members, whether public servants and private sector employees or persons in the informal sector. It is not clear if this is intended.
30. Does s. 33 include the ***possibility to tax public schemes***? If so, that would seem to be unhelpful where a scheme is paid from the Government budget, i.e. for the public servants insured at NHIF.
31. S. 36 (2) could include a reference to the need to ***coordinate with MOHSW*** in respect of (or , indeed, to have the MOHSW be in charge of) all health benefits-related matters of NSSF to avoid overlapping mandates and lack of clarity.

32. S. 38 (1) on "benefit entitlements" as ***collateral for mortgages*** does not seem tenable with respect to health services benefits since these are different from, for example, pension benefits, and are not based on individual savings accounts or entitlements, unless a system of individual medical savings accounts were to be used.
33. It might be advisable to make S. 41 (2)(a) bear an additional requirement re guaranteeing the rights of the insured.
34. S. 42 (3) does not include the option to sell a scheme to another insurer, while guaranteeing the rights of the members of the scheme to be sold, which might be useful for schemes found fit for de-registration (s. 42 (3) (c)).
35. Does s. 54 (2)(a) allow for regulation across borders, especially as regards health benefits?
36. S. 54 (2)(j) should also include a possibility to maximize the benefit, especially as regards health services benefits and medical liability benefits - the latter in case medical liability insurance exists or just to anticipate its establishment in case this is not the mandate of TIRA.

2.2.6. Review of the Private Hospitals (Regulation) Act (1st March, 1977) Cap. 151 R.E. 2002,

A. Principal Act

General

1. This Act aims "*to make provision to restrict the management of private hospitals to approved persons and organizations, to control fees and other charges payable in respect of medical treatment and other services rendered by private hospitals, to regulate scales of emoluments payable to medical practitioners employed at private hospitals, and to make other provisions for related matters.*"

   This Act does not aim to contribute to the distribution, or regulation of the capacity and type of medical interventions at private health facilities. It cannot be used by national or district health authorities to prevent oversupply of private health facilities in general, and of high risk/high tech medical equipment and medical interventions in particular. Oversupply in the health sector may lead to unnecessary and potentially harmful medical interventions making financial returns on investments. It may also lead to a lowering of quality because of low volumes of high risk interventions. A market-based approach will not work in the health sector, which does not work as a regular market because of information asymmetry between doctor and patient and the absence in most cases of time to shop around. So, some form of capacity regulation would be useful to prevent future oversupply.

   The review team has not received information about the existence of oversupply. However, what matters is the preparedness of the system for future developments. Oversupply seems indefensible in a financially and human resources-constrained country such as Tanzania. The unregulated distribution and concentration of for-profit health facilities in urban areas may further widen the human resources gap between rural and urban areas.

The ***likelihood of oversupply*** is increased where public doctors are able to work in private facilities. Such dual practicing, which has many negative side effect[71], is allowed in Tanzania. Since public doctors may only do this after their regular duty hours in public facilities and do it to supplement their perceived low public remuneration, they face an obvious temptation to get the most out of their private activities, thus further increasing the likelihood of unnecessary medical interventions.

The review team suggests an alternative in terms of the more direct regulation of the distribution and capacity of private hospitals via a system of licensing. In the implementation of such a system, the capacity of the public sector would need to be taken into account. The GOT may also want to consider whether it wants to use competition between the public sector private health services facilities as a tool to promote efficiency and quality improvement. If so, this would generate further questions such as how to create a level playing field. Elaborating on this is not part of the current review.

While this Act does not provide for cost-containment via a planning and licensing system (nor for that matter does any other regulation), it does offer a powerful tool to contribute to cost-containment in the health sector as regards the ***setting of prices and salary levels***. The Act aims, among other things, "to control fees and other charges payable in respect of medical treatment and other services rendered by private hospitals, to regulate scales of emoluments payable to medical practitioners employed at private hospitals ..." (Preamble to the Act). The idea behind this was to prevent price under-cutting and over-charging in some cases, and excessive payment for medical and dentist expertise. It was also designed to check the flow of skilled personnel from public to private hospitals and hence, to restrict/prevent competition between public and private sector services and related technology and manpower supply. However, since the late 1980's early 1990's, there has been a policy change towards liberalization and public-private partnership or competition. However, the legal provisions do not reflect this policy change in clear terms and the Government could consider the updating of the regulations and furthering amendments[72] to the Act.

Such amendments could include the ***setting of criteria and price limits or*** provisions allowing for the Minister to intervene if and when the liberalized system does not work and high prices impede access to care or lead to prohibitive health insurance contributions and hence to increased labour costs and subsequent loss of competitiveness.

The establishment of a ***forum for negotiating prices and fee levels*** could also be considered. Such a forum could play an ***advisory role*** for stakeholders and advise the Minister about possible measures to be taken. The forum could have a tripartite composition: representatives of insurers, health-care providers and the Government (MOSHSW, MOL and MOF). It would need independent supportive expertise to produce analyses and proposals for the forum.

The existence and more so the implementation of this Act could be taken into account when considering the adequacy of cost-containment options for health insurers (public and private ones). Everything that is regulated elsewhere and covers the whole

[71] World Health Organization. The World Health Report 2005: Making Every Mother and Child Count. Geneva: World Health Organization, 2005.

[72] The latest amendments were made in 1991 under Act No. 26 of 1991 and have been incorporated in the revised edition of the Laws, Cap. 151 R.E. 2002, on which the consultant team's present review is based.

health-care sector or significant sub-sectors, such as the private providers, does not have to be regulated by a health insurance Act or via contracts between insurers and health-care providers. Health insurers can simply make use of the results of measures taken by other institutions.

2. The Minister in charge of the implementation of the Act is the Minister "responsible for matters relating to medical and health services".
3. The Act does not contain a ***conflict resolution*** mechanism or an appeals procedure. On the contrary, on some sensitive ministerial decisions, courts of law are disallowed from entertaining challenges, applications for review or indeed any questions on any ground. Given the possibly sensitive topics regulated in this Act, it would be advisable to include a conflict resolution mechanism and amend the Act.
4. The Minister is required to ask the advice of and delegate mandates to the ***Private Hospitals Advisory Board*** as regards applications for registrations and the renewal thereof, suitability of premises, carrying out ministerial instructions on such and other matters covered by the Act and to keep and maintain a register of approved organizations and individuals.
5. The Minister also appoints the members of this Board, except for the Chief Medical Officer who comes ex officio and a representative of the Attorney General. The members to be appointed are not necessarily representatives of the interests of the private hospital sector (s 5(7)). This makes the Board independent. However, because the Minister is also the owner of public hospitals and employer of health personnel, the risk of bias in favour of public hospitals in his choice and appointments of the other members of the Board does exist.

   Although appeals to an applicable Court in case of negative decisions on a request of a private person or organization in charge of or planning to establish a hospital facility could perhaps be upheld by a ruling of such Court, the ***appeal procedure*** may take a long time and is thus not really an effective method for the person or organization to get a timely decision on his/its request and hence cannot start establish and run a health facility in the meantime.

   In the event that the Government decides to encourage competition between health-services providers, including between public and private ones, as a tool for enhancing efficiency, service availability and access for patients, it may want to consider amending the composition of the Board and to include representatives of private health-service providers such as the Association of Private Hospitals in Tanzania (APHFTA). This widening of representation would counter possible bias while enriching the deliberations of the Board with insights from the private sector.

Sp*ecific*

6. The Minister may refuse to approve or renew the approval of any organization in charge of a private hospital without providing any reason (s 6(2)). This does not improve ***transparency*** in policy making and implementation of hospital regulation. It may also make it difficult to apply for review orders[73] against a decision of the Minister in Court of competent jurisdiction. For, under this section, the Act is silent regarding the inviolability of the exercise of power by the Minister in this regard. Should the Government choose to improve overall

[73] Under the Judicature and Application of Laws Act, 1961, Act No. 57 of 1961 [Cap. 385 R.E. 2002], the High Court of Tanzania has inherent powers of review over decisions of administrative and quasi-judicial bodies and to quash, set aside and issue corrective and restraint (i.e., prerogative) orders of mandamus, ceciorari, and prohibition/injunction.

governance of the health sector, this section should certainly be amended. The eventual encouragement of competition between public and private hospitals by the Government would be another reason for amending this section.

7. The functions of the Board are wider than the ones indicated in comment 1. above, i.e. the Board should also advise about the suitability of premises of any private hospital (s. 7(5)(b))
8. One of the reasons given for refusing the registration of the hospital by the Board relates to a "situation" where it is not "in the public interest to register the hospital" (s 1 3 (7)(c)). It is not clear how "situation" can be interpreted, but it may refer to the needs of the population, thus providing a planning tool for the Minister.

   If it can be used as a planning tool, then the term "situation" should be defined and clear criteria should be developed to avoid ad hoc and subjective decision making.
9. The Act mandates that the Minister set "***price structures of medical treatment*** rendered by private hospitals either on a national basis or in relation to any particular area or areas" (s. 17) and to set maximum prices (s. 17 (2)). The application of this mandate would contribute to overall containment of health-care costs and facilitate the contracting and payment of insurers and especially the private insurers. Private insurers complain that this mandate is not exercised by the Minister. For the public insurance schemes, price setting is apparently left to NHIF and NSSF. The Act does not oblige the Minister to set prices, but offers a ***discretionary power.***

   The lack of uniform price setting and the absence of adequate information, which could justify the fees charged by health facilities, tend to increase admin costs. In order to address this issue it is recommended that private and public insurers create a more transparent and uniform mechanism for price in the public and private sectors via a participatory approach, for example by establishing a pricing forum or board in which representatives of Government, insurers and providers participate. Such a health-care prices board could act in an advisory role for the Minister. If GOT decided to adopt this approach, it would need an amendment of this Act.
10. The pricing levels for private providers have apparently to be seen in relation to the public sector and the services they provide as supplementary to the services offered by public hospitals (s. 17 (3)(d)). However, it is not clear whether this relates to the quantitative capacity of public hospital or to the private hospitals having more technical capacity and more sophisticated medical technologies than the public hospitals or to both. It is recommended that this be clarified.
11. Section 17 (4) allows the Minister to take into account several factors in setting maximum prices. However, **investment costs** are not included as a factor. If the Government decides to stimulate the private sector and to encourage competition between public and private hospitals, these costs should be taken into account, possibly leading to higher reimbursement rates for the private sector, but at the same time creating a level playing field. A well-equipped, price-setting advisory forum could advise MOHSW about these issues. However, the adequate distribution of health service providers could also be taken into account.
12. The Minister cannot only set maximum prices for a health facility, he can also ***set the scales of emoluments of medical practitioners*** working in private hospitals if he thinks that such a measure would be in the public interest (s. 23 (1)). When determining fee scales and setting maximum salaries, the Minister has to take into account several aspects such as: (a) medical

competence; (b) maintaining efficiency standards of the profession; (c) employment levels of medical practitioners and (d) maintaining a fair relation between incomes for different sectors in the community (s. 23 (3)).

These mandates offer instruments for overall cost-containment and for the stimulation of efficiency in medical practice, two essential elements in health financing policy and practice. However, the Minister has not used this mandate until now as far as is known. It is not clear whether there was no need to, or whether there was either a lack of capacity at the Ministry or a lack of data regarding the fixing of salary levels. In the meantime the policies have changed and more liberal pricing policies now exist.

Apparently, the setting of salary scales and salary levels is left to the market and to the management of private hospitals. Health insurers can have some indirect influence on salaries through negotiations with health services providers, but they will be more interested in cost containment, stability in fee levels and setting the incentive structure in support of efficiency and appropriateness of care. This would provide certainty about overall costs and ease the setting of adequate contribution rates.

NHIF and NSSF-SHIB do not really negotiate fees, but set a reimbursement level for which they hope to get some support and justification from costing studies. Private insurers in Tanzania generally have little financial clout and will not be able to strongly influence fee levels. Neither category of insurers seems to have any incentive to get involved in setting the salaries of staff of private hospitals as long as they can set general fees for diagnostic interventions and treatment. In general, setting fees will be left to the management of a facility or to a national forum of associations of hospitals and health-care professionals.

So, the motive behind having the mandate for setting salaries would most likely be to have an instrument for human resources policy, by making the health professions sufficiently attractive to get vacancies filled, while at the same time maintaining good occupational/industrial relations and social peace as well as a measure of income equality.

The question also arises regarding why a Government would want to determine salary levels at all if costs can be contained and access to and quality of care can be influenced by other measures such as overall health service fees. If a health prices board [or ministerial advisory committee and stakeholder forum for regular price reviews] can be established to set overall health-service fees, the setting of salaries can mostly be left to the management of contracted health facilities.

The parallel question is what are the possibilities for managers of public health facilities to incentivize their staff to improve motivation, reduce absenteeism and improve quality and efficiency of care? Answering this question is beyond the scope of this health insurance regulatory review.

13. It is striking that the Act does not provide a structured role for associations of private hospitals and of health professionals and other workers in the health sector in decision making about price levels, salary scales and salary levels. The existence of such a structure could channel unrest and provide a forum to promote dialogue, fairness and acceptance of negotiation results. The already cited health services prices board could also have a sub-forum to organize this kind of dialogue and facilitate negotiations. The Minister could always be left the mandate to intervene in the public interest. However, the term “public interest” and its aspects should be defined to prevent abuse for political gain.
14. The Act does not contain nor refer to:

a. Regulations concerning the prevention of conflicts of interests for members of the Private Hospitals Advisory Board;
b. Regulations for keeping sensitive information confidential, such as information related to private hospitals as business entities.

15. The Minister can prescribe *minimum standards of diet* to be provided to a person admitted to a hospital as inpatient in private hospitals (s. 15 (c)). Diets of adequate composition and caloric value are important for patients and setting minimum standards is useful. However, it is not clear why diet is the only element referred to in this law, as it is only one of the many factors that co-determine the outcome of the care process in a hospital. The reference to diet standards could be included in the accreditation system and gain in significance if such standards were two be complemented by the need to weigh every patient at entry and exit, examine his nutritional status, possible metabolism issues, give specific diet prescriptions and advice according to nutritional status as well as have all these items properly included in the medical record of the patient and used for the evaluation of the hospital's nutritional policy.

B. Regulations

The Private Hospitals (Standard Guidelines for Health Facilities) Regulations, (1st July, 1997)

16. This document is based on the above-mentioned Act and provides a set of definitions and guidelines for all health facilities. It seems that: (a) it is intended to prevent conflicts of interest between the duty of doctors working in public health facilities and their ownership of a private facility; (b) it provides a minimum set of quality-oriented standards for different (defined) types of health facilities.
17. Section 30, 1st July 1997 (G.N.) No. 233 of 1997)
    a. Provides the definitions of the different health facilities to which the guidelines in the same document refer.
    b. Sub-reg. 4.2. prohibits the ownership of a health centre or hospital by a doctor or a clinic or dispensary by a dentist, except if the doctor is only working part-time in a public facility. However, it does not prohibit the ownership of pharmacies and laboratories or diagnostic facilities by doctors and dentists or prohibit them from being shareholders or otherwise having a financial interest in such facilities. Such financial interests may lead to collusion and to over-referral and over-prescription. These can both be harmful and costly for the patient, as well as for the third party payers, such as social and private health insurance schemes. The financial interests of doctors and dentists may also act as a disincentive for doctors to retain and maintain adequate lab facilities and stocks of drugs and supplies in the public facilities, thus leading to limited availability for patients and possible higher OOP payments and/or higher expenses for insurers. It is therefore recommended that the Regulations the amended and that the list of institutions and facilities in which publicly or privately working doctors and dentists cannot have an interest the expanded, and that they be ***prohibited from owning or having shares in pharmacies and laboratories, and that the same restrictions apply to health professionals working part time.***

2. The guidelines focus on the structural aspects of quality of care, such as minimum staffing, premises and equipment availability as well as on process-oriented aspects such as medical record keeping, disease reporting, recommendable lab tests options related to the type of institution, and training possibilities. Its annexes state essential requirements for "assorted places" of health facilities.
3. Although the "Schedule standard guidelines for all health facilities" includes the requirement that a registered professional should always be available during its opening hours (Reg. 1.18) and that there should be effective communications and referral systems, including transport systems in case of emergencies, there is no obligation to have a ***written agreement with a health facility that can deal with occurring emergencies***, guaranteeing continuity of care and adequate takeover of referred cases. It is recommended that such an obligation should be included in either this regulation or by health insurers when concluding a contract or services agreement with such a health facility.
4. The document includes references to ***enforcement options*** in other legal documents such as those for the Medical Council of Tanganyika, the Private Hospitals Advisory Board and the Registrar of Private Hospitals, based on the inspection report of the District Medical Officer. It is not clear to the review team whether the health facilities are subject to regular follow-up inspections or other external assessments except where contracted by NHIF and NSSF, or where the requirement that the registration of a health facility shall be renewed annually (Reg.1.15) is predicated on proof and third party verification of compliance with the minimum standard conditions set for the type and level of the facility. But in the apparent absence of follow-up procedure and machinery, it is not clear how this can be done systematically and for every facility at annual registration renewals.
5. Because of the seeming inability for the national and district governments to control the capacity and distribution of private facilities,) only the ***mandate of NHIF*** to selectively contract private health facilities can help to some extent to mitigate oversupply and misdistribution of private health services providers. Districts only have the possibility to advice about the planned establishment of a health facility by an NGO, if and when invited to.
6. Should the Government want to ***reduce the administrative burden of NHIF, NSSF and private insurers*** and prevent the application of different sets of requirements for health facilities, it may consider the development and establishment of capacity and regulations for **licensing and quality assurance independent of health insurance**. If such regulation and independent institutions were created and functioned appropriately, health insurance regulation could leave out the current requirements for quality control. It would be sufficient for the insurance bodies to refer in their contracting activities to such regulations and assessments and only require the existence of permits/licenses, accreditation status and subsequent adherence to recommended quality improvement based on elsewhere-regulated external assessment systems and their advices. Health insurance schemes could then concentrate on the review of claims of providers and the appropriateness of the care provided. They could hence limit themselves to referring in their contracts with providers to the need for such licences and accreditation and subject themselves to regular external assessment by the responsible institutions. Such external regulation would prevent every health insurance body having to develop and implement its own quality assurance capacity and standards, which may be confusing to the health-care providers, unnecessarily drawing

upon the already limited human resources capacity of health facilities. It would also prevent inefficient use of scarce financial resources.

7. Established relevant general regulations for ***capacity control and quality assurance of*** health facilities could act as the starting point for selective contracting by health insurance institutions.

2.2.7 Agreement for the provision of health services between the Government and the service providers.[74]

1. "*This document is intended mainly for use when the Government and the private providers of health services agree for the latter to provide health services on behalf of the Government. It does not in any way replace the Council Designated Hospital Agreement currently in use.*"
2. This is a very good generic agreement, a model agreement. The schedule of quality and standards is excellent and up to international best practice. One would hope that not only private but also public providers could live up to the requirements as stated in this contract
3. The only aspect missing in the quality section are references to waiting list management, criteria and procedures.
4. The agreement refers to the need to agree on prices between Government and services providers. The process for this could be supported by the proposed stakeholders' forum for price/fee setting.
5. This agreement could very well be the starting point for a more elaborate services agreement or contract between the designated purchaser(s) in the developing system of health financing, dependent on the decisions being made in the framework of the planned health financing strategy.

[74] Tanzania MOHSW. Agreement for the provision of health services between the Government and the service providers. Dar es Salaam, August 2007

V. Towards an adjusted framework for the health insurance sector.

Using the already discussed frame of reference for legal review, and taking into account the review findings, it is possible to draw up a more specific framework for health insurance. This framework would most likely also have to be based on Government decisions regarding broad objectives, which would in turn be part of an overall Government health financing strategy.

The following choices arise:

A. Competition in social health insurance: a single payer or multiple competing payers (the latter is supposed to advance efficiency and client orientation).

Does the Government want competition only between NHIF and NSSF (the simple variant) or between these and private insurers willing to accept the Government conditions (the more complex variant)?

Depending on the decision taken regarding outing competition and reflecting the Government's broad SHP objectives, regulation can be considered to:

1. Guarantee access to insurance;
2. Avoid risk selection;
3. Avoid risk rating;
4. Create a level playing field for insurers
    i. To ensure that insurers accept all people as members, irrespective of their health status and health risks
    ii. Establish a basic benefits package that would need to be implemented by all insurers
    iii. Establish a financial equalization mechanism
    iv. Supported by an adjusted health management information system (HMIS)
5. Allow insurers to compete on efficiency in service delivery and client orientation. This presupposes the regulation of:
    i. Autonomous health-care providers (public and private);
    ii. A level playing field for private and public providers, requiring a solution for the funding of investment to prevent public providers having an advantage over private ones in the event that their investments are paid from the Government budget;
    iii. Selective contracting of providers (public and/or private) ;
    iv. Bankruptcy of hospitals;
6. Have unified regulation, supervision and auditing;
7. Have an independent accreditation system for providers of health services;
8. Adjust institutional mandates and capacity of insurers and regulatory/supervisory/auditing bodies;
9. Institutionalize value-for-money auditing.

B. If ***no competition*** is the objective, and a single payer system is adopted, at least for the time being, while keeping in sight SHP objectives, cost containment, quality assurance and client orientation, then regulation could be considered to:

9. Formulate a BBP or different packages that is/are exclusively covered by the public insurer. Different packages could be based on the availability of services in different areas. As a consequence, different levels of contributions could also be considered. However, different BPs and contributions should only be considered temporary in the transition to the universal BP;
10. Have a mechanism for sufficient funding through mandatory paid income-dependent contributions, Government budget transfers (to cover the poorer segments of the population) and income dependent copayments;
11. Restrict private insurers to voluntary supplementary insurance and prevent opting out of the public system;
12. Unwind and integrate the current systems of NSSF, NHIF and CHF into the indicated public insurer and have a transition period and transitional arrangements;
13. Adjust the regulatory/supervisory/auditing body and its capacity to assure compliance of the single payer with the changed regulatory environment, to ensure the efficiency and the client orientation of the public insurer;
14. Have an independent accreditation system that would work for all providers, irrespective of their health services and legal status;
15. Increase the autonomy of providers;
16. Allow for competition between public and private providers.

It should be noted that the above are just the headlines.

C. Accreditation

When rethinking the regulatory framework for health insurance in the wider context of a health financing strategy, the Government may also want to reposition the responsibility for accreditation. It is currently done separately by NHIF and NSSF-SHIB programs. This looks like duplication and is the cause of strain on providers. Moreover, MOHSW is also engaged in the implementation of its quality improvement strategy and cooperating in the “certification towards accreditation” program. It is therefore advisable to consider the mandating of accreditation of all health services providers to an independent body (state agency or NGO) and adjusting the NSSF and NHIF Acts and related subsidiary regulations accordingly. The modalities would need to be worked out, but MOHSW, NSSF and NHIF could still opt for a position on the Board of such an accreditation body in which other stakeholders could also participate, such as representatives of LGA’s, private insurers and associations of health facilities and health professionals. In this way, a new body could cater for all health facilities irrespective of their funding sources. It would also be more efficient. The participatory approach could lead to better uptake of quality assurance by all stakeholders and especially the providers. Insurers can still refer in their contracts with providers to the need for accreditation and continue with their provider performance review.

D. Adjustments

The findings point to several areas that could either profit from adjustment of regulations to create clear responsibilities and lines of management, instruction and reporting, or from better, institutionalized coordination between stakeholders. The use of memoranda of understanding is an 'in-between' solution.

Recommendations

The foregoing in-depth review of the different legislation documents contains many detailed questions, remarks and recommendations pertaining to the specific Acts and subsidiary legislation. These do not affect the grand design of the health insurance sector as much as the following recommendations, which may have to be considered in the preparation of a health financing strategy, dependent on the preferred modalities of that strategy. Once choices have been made, codification will need to follow. However, it is also recommended that the comments which could improve the workings of single principal enactments and subsidiary legislation be considered.

Table 4 on the following pages provides the recommendations based on the in-depth legal review and provide explanation.

Having set out the results of the legislation review, the question arises as to how to move forward in developing of a health financing strategy.

Table 4: Recommendations

Area	Recommendation to	Recommendation: Decide	Amend
Governance	Government/ Parliament. MOHSW can take initiative	Ministry in charge of HI (public and/or private)	Insurance Act/ TIRA Act; NHIF Act; SSRA Act; CHF Act
	Government/ Parliament. MOHSW can take initiative. SSRA can set rules for SHI	Competition in HI (BBP and/or SP), modalities and safeguards	NHIF Act; NSSF Act; Insurance Act/ TIRA Act; SSRA Act
	Government/ Parliament. MOHSW can take initiative.	Regulatory body in charge of health insurance (public and private)	Idem
	Government/ Parliament. MOHSW can take initiative.	Make HMO's and MBMO's subject to either TIRA or SSRA	Insurance Act/ TIRA Act; SSRA Act
	MOL & SSRA	Mandatory character of NSSF-SHIB	NSSF Act, SSRA Act
	MOHSW, PMO-RALG & NHIF	Future of CHF and CHF administration	CHF Act and MOU between PMO-RALG, MOHSW & NHIF
	MOHSW, MOL, SSRA, NHIF and NSSF	Regulations on avoidance of conflict of interest and declarations of assets for all critical functions	Idem; NHIF Act; NSSF Act; plus respective Subsidiary legislation
	MOL. MOHSW can take initiative and consult with MOL and TIRA	Specify mandate & activities of SSRA re health insurance and allow for coordination & cooperation with TIRA on general insurance issues, extent of which is dependent on decisions on competition between health insurers	Insurance Act/TIRA Act; NHIF Act; SSRA Act, plus respective subsidiary regulation. Possibly develop new legislation on health insurance, in case of competition policy.
	NAO	Doing routine value-for- money auditing of SHI	Public Audit Act; Public Finance Act (?); SSRA Act; NHIF Act; CHF Act
	Government/ Parliament. MOHSW can take initiative.	Public (internet) reporting of accounts, yearly reports and audit results	Idem
	Government/ Parliament. MOHSW can take initiative. SSRA and TIRA; NSSF and NHIF	Enacting confidentiality regulations vis a vis insured and providers	NHIF Act; NSSF Act; SSRA Act; Insurance Act/TIRA Act; possibly new Act on patient rights
Coverage	Government/ Parliament. MOHSW can take initiative.	Which HI is mandatorily covering which categories of the population	NHIF Act; NSSF Act; Insurance Act/TIRA Act; SSRA Act; CHF Act ;
	Government/ Parliament. MOHSW can take initiative.	Cross border utilization of benefits according to TZ BP, including conditions	NHIF Act; NSSF Act; SSRA Act
	Government/ Parliament.	Abolishing waiting periods in mandatory HI	NHIF Act; NSSF Act; SSRA Act

Area	Recommendation to	Recommendation: Decide	Amend
	MOHSW can take initiative.		
Funding	Government/ Parliament. MOHSW can take initiative.	Cross-subsidization between schemes	Insurance Act; TIRA Act; NHIF Act; SSRA Act; CHF Act
	Government/ Parliament. MOHSW can take initiative in consultation with MOF.	Transfers from GOT budget to subsidize the agreed BBP for the defined categories of poor residents	Public Finance Act, and related subsidiary legislation
	Government/ Parliament. MOHSW can take initiative in consultation with MOL and SSRA	Separation of SHIB contribution and funds pool from other NSSF benefits	NSSF Act
	Government/ Parliament. MOHSW can take initiative.	Flexible income-dependent contribution rate setting for mandatory HI in formal sector	NHIF Act; SSRA Act;
	Government/ Parliament. MOHSW can take initiative in consultation with PMO-RALG.	Mandatory character of CHF and flat rate contribution, related to wealth categories	CHF Act and MOU between PMO-RALG, MOHSW & NHIF and/or NSSF
Collection & Pooling	Government/ Parliament. MOHSW can take initiative in consultation with MOF	Mandating the MOF Treasury to pool all mandatory health insurance funds in a dedicated account	Public finance Act, NSSF Act, NHIF Act, SSRA Act, Public Audit Act
	SSRA, NSSF & NHIF	Operationalization of the regulation of maximum reserve funds of NHIF and possibly of the HI dedicated fund of NSSF	NHIF Act; NSSF Act; SSRA Act
	Government/ Parliament. MOHSW can take initiative in consultation with TIRA.	Differentiation of solvency requirements for private health insurance schemes from other (long term) insurance schemes	Insurance Act/TIRA Act
Benefits	MOHSW	Criteria for BP design and adjustments	NHIF Act; NSSF Act; SSRA Act
	Government/ Parliament. MOHSW can take initiative.	Composition of BP of essential health services, uniform across schemes; including conditions for access (enjoying benefits)	NHIF Act; NSSF Act; possibly also of Insurance Act/TIRA Act in case private insurers will implement mandatory package
	MOHSW and MOL, in consultation with NHIF and NSSF	Demarcation between HI BP and budget-funded vertical programs	NSSF-SHIB Regulation; NHIF Regulation; MOHSW regulation on vertical programs
Purchasing	Government/ Parliament. MOHSW can take initiative in	Purchasing mandate of NHIF and NSSF as regards provider selection and specific services in specific	NHIF Act; NSSF Act; SSRA Act

Area	Recommendation to	Recommendation: Decide	Amend
	consultation with MOL	volumes	
	Government/ Parliament. MOHSW can take initiative, in consultation with MOL, SSRA and after hearing insurers	Minimum requirements of contracts between insurer and provider	NHIF Act; NSSF Act; SSRA Act
	MOHSW in consultation with MOL and SSRA and after hearing public and private insurers	Establishment of forum to discuss or negotiate fee schedules and fee levels	NHIF Act; NSSF Act; Private Hospitals Act; Insurance Act/TIRA Act; SSRA Act
	SSRA and TIRA	Mandatory and extensive publishing of rights, benefits, complaint procedures and obligations of insured by insurers	NHIF Act; NSSF Act
Delivery of services	Government/ Parliament. MOHSW can take initiative.	Planning mechanism and criteria for establishment , distribution, functions and capacity of health facilities (public and private). Sub-mechanism for planning of high tech-high risk medical interventions.	Private Hospitals Act; Public health facilities legislation; NHIF Act; NSSF Act; CHF Act;
	Government/ Parliament. MOHSW can take initiative.	Funding of investments of health facilities with an eye on competition between public and private providers	NHIF Act; NSSF Act; Private Hospitals Act; SSRA Act
	Government/ Parliament. MOHSW can take initiative.	Abolishing dual-practice option of doctors and other health staff. If continued: prevent auto- referral.	Public Service Act; NHIF Act; NSSF Act; SSRA ACT
	Government/ Parliament. MOHSW can take initiative.	Forbidding ownership of pharmacies and labs by public doctors (including part time ones), to prevent over-prescription and test-ordering	Private Hospitals Act and Regulations; CHF Act
	Government/ Parliament. MOHSW can take initiative.	Quality assurance and accreditation system (separate from NHIF and NSSF)	NHIF Act; NSSF Act; possibly new Act on health care quality
Conflict Resolution	Government/ Parliament. MOHSW can take initiative in consultation with SSRA and TIRA	Establishment of single ombudsman function for all HI; accessible to insured/residents and providers	SSRA Act; NHIF Act; NSSF Act; possibly also of Insurance Act /TIRA Act

VI. Towards a health financing strategy

The GOT may further consider defining its vision and policy regarding actors in the operation of the health insurance system in Tanzania, including MOHSW, MOL and PMO-RALG, and depending on the choices it makes, enhancing the effectiveness and efficiency of the actors, and aligning the current legislation with the objectives of this Government and policy. As a part of this process the GOT could take into account the findings of this review, and the options for clarification and strengthening of the legislation provided.

Key considerations would include:

- A competitive or non-competitive insurance model?
- The implementation of a national BBP by SHI only or by SHI and PHI on equal terms?
    - In case SHI only, PHI will be left with offering a voluntary supplementary package?
- Contribution system
    - Income based?
    - Flat rate?
    - Combined?
    - Both?
- One or more funding pools?
    - If more pools: cross-subsidization between pools to increase equity in funding?
    - Government budget transfers?
- One Minister in charge of health insurance (albeit in consultation with other relevant ministries) or more ministers?
    - If the latter, who has the lead and/or how to coordinate?
- One or two regulatory bodies?
- One National accreditation system or several (per insurance scheme)?
- Establishment of a forum to discuss and advise about fee schedules and levels?
- Complementary regulation:
    - Establishing a national health services provider planning and licensing system?
    - Special attention to high-risk/high-tech interventions?

Legislation enacted in a timely manner would support the implementation of the Government's strategy by creating universal access to services, and the financial and institutional capacity to fund the services more equitably by improving administrative efficiency and oversight capacity to prevent the derailing of the health insurance system.

A failure to implement legal reform, even without any other changes, could lead to unregulated competition between insurers, leaving the poor behind, and to inadequate governance of health financing.

VII. Institutional consequences

Depending on the approach the Government takes, the mandates of institutions will need to be adjusted and capacities tuned to reflect changed mandates and tasks. This concerns the public and possibly the private insurers, the regulators and most likely also the health sector providers which may have to adjust their management and administration to the new situation. The providers would especially have to adjust were they to be granted more autonomy and were they obliged to compete for contracts with the public and private insurers.

A parallel development might involve making accreditation the mandate of a separate accreditation body which could cater for all health providers irrespective of the way they are financed.

VIII. Conditions

In order to achieve the preferred options for organizing health insurance, and especially if the preferred option is a competition-based model, certain conditions for achieving the Government's policy objectives will need to be set, notably: (a) the establishment of a risk equalization system between different insurers and: (b) the strengthening of capacity for supervision and auditing of insurers and the establishment of an up-to-date health management information system, backed by good internet connectivity

International experience shows that it takes considerable effort, detailed health services consumption data per social stratum and adequate institutional capacity to establish a workable system of risk equalization between health insurance schemes. If this cannot be achieved, there is a great risk of the competition model unravelling, with the poorest and the sick suffering most.

IX. Next steps

The findings and outlined options with regard to the preferred direction can feed into the development of a Tanzania health financing strategy. Such a strategy would lead to concrete choices which can subsequently be codified in legislation. Not all of the identified gaps in legislation are interconnected. Several gaps and topics can be dealt with without making far-reaching decisions on the health insurance model. This is true of the accreditation system, autonomy for public health-care providers, the establishment of a platform to discuss fee schedules and levels. Also a number of suggestions are included, aimed at clarification and/or strengthening existing Acts and Regulations.

X. Annexes

Annex 1 Terms of Reference

Consultancy on Health Insurance Regulatory Framework for Tanzania, with a focus on Social Health Insurance

1. Background

The Tanzanian health system is financed through a mix of health financing sources from Government (GOT), Local Government Authorities (LGAs), Development Partners (Basket Fund and Project Funds), Social Health Insurance (SHI), Community Health Funds (CHF) / Tiba kwa kadi (TIKA), and community/micro- and private health insurance (PHI). There are different rules and regulation for the different pre-payment schemes and other funding agents, resulting in different levels of access to services at different prices for different population groups.

The two **formal public SHI** providers are the National Health Insurance Fund (NHIF) and National Social Security Fund (NSSF). They offer members relatively broad service packages with access to all levels of care for income-based premiums, reimbursing providers for their services. The voluntary CHF/TIKA is usually referred to as the third public SHI scheme. It is a flat user-fee prepayment that allows access to primary level and in some Councils to District Hospital services.. The CHF does not reimburse claims for services provided but supplements the district budget, through which health facilities can benefit from the CHF premiums.

Besides those public approaches there are also several **private health insurance** companies operating on the Tanzanian market as well as a large number of smaller micro-health insurance schemes that partner with private providers. There is also a multiplicity of stakeholders involved in the SHI sector, ranging from various Ministries and donor organisations to local and international NGOs and even private companies, working on different programmes and projects under the SHI umbrella for over 10 years now.

While insurances currently only finance a minor share of the health sector with the major share being provided through input-based Government budgets, their contribution is growing and the Health Sector Strategic Plan III aims to “enhance complementary financing” to provide 10% of the sector budget by 2015. Alignment of funding streams is thus an important issue.

The need for a revision of the health insurance regulation was first raised during the **National CHF Best Practices Workshop** of 2007, held in Dar Es Salaam. As a result, a first consultancy on this topic was carried out in 2008, financed by GTZ and SDC. This consultancy provided an overview of fields of regulation for health insurance and focused on proposals for a future structure of the health insurance sector in Tanzania. With this focus, it provided an important impetus for a discussion of further reforms in health financing.

Now the MoHSW, together with other Ministries, Departments and Agencies and non-Government stakeholders, is in the process of preparing a mid- to long-term **Health Financing Strategy**, which is part of the Health Sector Strategic Plan III work plan. It is expected that the Strategy will provide guidance on the future structure of the health insurance sector (social and private) in Tanzania and on regulatory issues that need to be addressed and institutions that may need to be reformed or built.

The regulatory framework currently in place has some well-known weaknesses. It is highly fragmented with separate regulation guiding different insurance operations, often without regard to the specific requirements of health insurance. Similarly, there is still considerable uncertainty over the role of the different oversight institutions and their remit. In order to inform the Health Financing Strategy process, a deeper analysis is now needed.

The international Providing for Health (P4H) Initiative is supporting this endeavour as part of its support to the development of a Health Financing Strategy for Tanzania. P4H is a global health initiative aimed at improving social health protection (SHP) in low and middle-income countries, particularly for the poor. Launched in 2007 during the G8 summit in Germany, P4H operates through a network of partners viz., Germany, France, Switzerland, ILO, WHO and the World Bank. It works with a lean management structure and draws on the global, regional and country structures of its members.

2. Purpose

The consultancy aims at informing the further development of a comprehensive and coherent regulatory framework for health insurance in Tanzania. As an input to the Health Financing Strategy, the purpose is to identify issues and principles for regulation and regulatory institutions, comparing them to the regulatory status quo, and providing options for reform. Due to its importance to the Tanzanian Health Financing, the focus will be on Social Health Insurance (i.e. NHIF, NSSF, and CHF), although private health insurance will also be integrated in the analysis. The study will also describe possible regulatory options for an effective alignment of funding streams.

Once the Health Financing Strategy is developed and accepted, and a sector reform course is agreed on, this consultancy may be followed by one focusing on formulating a specific framework for the Health Financing option selected.

3. Objectives

Building on the 2008 “Consultancy for Situational and Needs Assessment on setting up a Social Health Insurance (SHI) Regulatory Framework for Tanzania”, the Consultant is expected to

1. Provide a comprehensive and updated overview of all health financing regulation; this shall include a brief discussion and review of the relevance and significance of health insurance regulation in Tanzania; and a discussion of the different types of regulation, including the possible role of self-regulation;

2. Identify areas in which regulation is needed to govern health insurance (social and private) in line with the health sector objectives as stated in the HSSPIII in the context of a mixed health-financing system (i.e. tax and contribution funded) and to facilitate the move towards the goal of universal coverage of social health protection, i.e. universal access to necessary health care without running the risk of catastrophic health expenditure. This should include an analysis of the goals and principles guiding such regulation. The consultants shall prepare a comprehensive list which should include but not limited to the role of regulation in terms of:

- Alignment of health insurance financing with other health financing mechanisms (input- and output-based) for reduced complexity and equitable and efficient resource generation
- Minimum benefit package
- Premiums (incl. equity of contributions and efficiency of collection)
- Pro-poor and informal sector enrolment
- Mandatory enrolment
- Provider payments
- Administration expenditure, reserves and profits
- Accreditation and quality grading of health facilities
- Governance (incl. participation of and information to members)
- Risk-pooling, cross-subsidization and equalization in and between insurers
- Framework for task-sharing between SHI schemes at different levels (e.g. NHIF and CHF)
- Requirements for subsidies from public sources
- Competition in service provision and insurance markets
- Registration of insurance schemes

3. Conduct an analysis of regulatory, oversight and enforcement bodies (including but not limited to: MOHSW, SSRA, TIRA, BOT) to determine current regulatory and oversight responsibilities, their functioning (e.g strategic decision making and oversight of implementation) and the links and relation between these bodies, gaps, unclear areas and potential conflicts in the areas identified under point 2;

4. Based on the above analysis provide options:
   - For establishing a regulatory framework, which will reflect the principles established under point 2, and which will be conducive for accelerating the transition towards universal health protection, i.e. addressing critical issues for equitable, effective and efficient resource generation, pooling, use of resources, entitlements/benefits, purchasing arrangements and service provision;
   - Exemplify the previous point by describing how regulation would need to differ necessary for a competitive insurance market and a single-payer model in order to reflect the principles established under point 2, taking into account the level of administrative capacities for each model;
   - For a clear, comprehensive and efficient allocation of regulatory and oversight responsibilities to existing or newly established bodies;
   - For addressing issues of gaming and avoidance behaviour of regulation;
   - For strengthening alignment of health insurances with other health financing mechanisms (especially input financing) and reducing complexity of the health financing system.
   - On how to integrate regulatory reform options effectively into the Health Financing Strategy.

4. Tasks

For the lead consultant(s), it is expected that in order to achieve the above results, the following activities will be necessary:

- Review and reassessment of documents (acts, decrees, guidelines, reports, etc.) and other data used in or produced for the 2008 consultancy;
- Search for and review of documents and other data published between the data collection for the 2008 report and the current consultancy;
- Take into account the results of the Health Financing for Equity national workshop conducted on 06/09/10;
- Coordinate and cooperate with the ongoing efforts for the development of a Health Financing Strategy;
- Conduct key stakeholder interviews with representatives from all sectors involved in drafting and enforcing regulation, and those affected by different pieces of regulation (e.g. Government ministries and agencies, public and private providers and insurers, organised patient and consumer protection groups, key Development Partners);
- Close coordination with the MoHSW and the local P4H partners during the assignment;
- Dissemination of findings on a local stakeholder workshop;
- Produce a final report that reflects all objectives set out.

The consultant will be assisted in these tasks by up to two local consultants and local offices of P4H partners as necessary.

The local consultants will assist the lead consultant with the following activities:

- An update on the collection of relevant literature prior to his mission in Tanzania
- Identification of relevant stakeholders and building an updated contact database
- In cooperation with GTZ and SDC, establish a timetable for activities in Tanzania
- Provide an update on the 2008 consultancy mapping of the existing social security bodies, legal frameworks and regulations
- Assist the lead consultant in all activities carried out for achieving the above results
- Provide feedback and suggestions on the draft report and presentation
- Organise the dissemination workshop
- Be available for necessary follow-up work and presentations after the stakeholder dissemination (in line with the number of days contracted here)

5. Time frame

It is expected that, taking into account the existing work for the 2008 consultancy, the task will not exceed 32 consultancy days for the main consultant(s), and 50 consultancy days for two local consultants.

For the lead consultant(s), it is expected that between 20 and 24 consultancy days will be spent in Tanzania for collection of updated data, key stakeholder interviews, and a presentation of preliminary results. Review of existing documentation and report writing will be done in the consultant's home location.

For the two local consultants, it is expected that each consultant will spend up to 5 days in preparation of the lead consultant's visit (including collection of materials), up to 20 with the consultant and the remaining days in follow-up.

6. Oversight and Steering

Oversight over the study will be done by the Health Care Financing Committee (HCFC). The consultants will present a work-plan at the beginning of the assignment to the HCFC, as well as a debriefing at the end of it. In-between, they will provide will provide information to the HCFC and the funding agencies upon request.

7. Deliverables

The consultant is expected to provide the following documentation to the MOHSW and the HCFC:

- Electronic copies of all reviewed documents (hard copies if electronic not available);
- A draft presentation in the HCFC before the stakeholder workshop;
- A presentation on a wider stakeholder workshop;
- A final report of not more than 60 pages (softcopy and two hardcopies) that reflects all objectives set out.

All documents are to be made available not later than 14 calendar days after the end of the consultancy.

Annex 2 Literature (referenced in the report and used as background material)

Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. African Summit on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases. 24-27, April 2005 2001. OAU/SPS/ABUJA/3

The Auditors and Accountants (Registration) Act, 1972, (Cap. 286 R.E. 2002)

Agreement for provision of medical services between National Health Insurance Fund and Muhimbili Hospital

Agreement for provision of medical care between NSSF and a medical care provider. 2011

Bartolo, Sergio. Good law making principles. Report for a Meeting of the European Commission for democracy through law (Venice Commission).Strassbourg. 1 July 2010 http://www.venice.coe.int/docs/2010/CDL-UDT(2010)016-e.pdf

Community Health Fund Act, 2001, No. 1/2001 [Cap. 409 R. E. 2002] with subsidiary legislation in G.N. Nos 350/2004,b38/2007 and 313/2009.

Constitution of the United Republic Tanzania of 1977, as amended from time to time

Economist Intelligence Unit. Country Report Tanzania, September 2011

Employment and Labour Relations Act, 2004No.6 of 2004 [Cap. 366 R.E 2002]as amended by Act No.2 of 2010

GIZ. Reorganisation of tax administration: The Tanzania Revenue Authority (TRA), Fact sheet November 2008

Humba, Emmanuel. "Pioneering Social Health Insurance in Tanzania: The Case of the National Health Insurance Fund (Nhif)." Improving access through effective health financing. Swiss TPH, 2011

Humba, Emmanuel. Social Health Insurance. Implementing social security health care, the experience of the National Health Insurance Fund. Paper presented at the ISSA Regional Conference for Africa, Lusaka, 9-12 August 2005

Income Tax Act, No.33 of 1950 [Cap. 332 R.E. 2002], as amended by Act. No. … of 2006

Insurance Act, No.10 of 2009 which came into force on 15/05/2009 [Cap. 394 R.E. 2002]

Judicature and Application of Laws Act, No.7 of 1920 [Cap.358 R.E. 2002] amended by Act No.10 of 1971

Kamuzora, Peter, and Lucy Gilson. "Factors Influencing Implementation of the Community Health Fund in Tanzania." Health Policy and Planning 22.2 (2007): 95-102

Labour Institutions Act, No.7 of 2004

Lankers, Mtei et al. “Suggestions towards a Framework for the Future Development of Health Insurance in Tanzania. Dar es salaam, 2008

Law of Contract Act, No.55 of 1963 [Cap. 345 R.E. 2002]

Law of Limitation Act, No.10 of 1971 [Cap.89 R.E. 2002]

Local Government (District Authorities) Act, 1982, No. 7/1982 [Cap. 287 R.E. 2002]

Local Government Finance Act, No.9 of 1982, [Cap.290 R.E. 2002]

Local Government Service Act, 1982, No. 10 of 1982

Luce Robert. Legislative principles. The history and practice of law making by representative government. The Riverside Press Cambridge. Boston 1930

Maarifa, H, Medical Scheme Training for HMO's. Dar es salaam, 2005

Magistrates' Courts Act, No.2 of 1984 [Cap.11 R.E. 2002] an Act to provide for jurisdiction, powers and functions of magistrates' courts and for the related matters

McIntyre, Diane, et al. "Beyond Fragmentation and Towards Universal Coverage: Insights from Ghana, South Africa and the United Republic of Tanzania." Bulletin of the World Health Organization 86.11 (2008): 871-76

McIntyre, Diane, et al. What Are the Economic Consequences for Households of Illness and of Paying for Health Care in Low- and Middle-Income Country Contexts? Social Science & Medicine 62.4 (2006): 858-65.

Mdee, Hamis I.Z. Challenges and opportunities of communit based health funds (CBHF) in the emerging social health policy environment in East Africa. Paper presented at CHeFA-EA Regional Conference, 18-22 May, 2009, Entebbe

Medical Practitioners and Dentists Act, 1968

Medical Practitioners and Dentists Act; Rules: The Medical Practitioners rules, 1968

The Medical Practitioners (Fees and General) Rules, 2001

Medical Practitioners and Dentists (Appeals) Rules of Court, 1960

Ministry of Finance and Economic Affairs. National Strategy for Growth and Reduction of Poverty II (NGRP II), July 2010

Ministry of Health and Social Welfare. Health Sector Strategic Plan III. Dar es Salaam: MOHSW, 2008

Ministry of Health and Social Welfare. Tanzania National Health Account 2002/03 - 2005/06. Dar es Salaam, 2008

Ministry of Health. National Health Policy. October 2003

Ministry of Health. National Package of Essential Health Interventions in Tanzania, January 2000

Ministry of Health and Social Welfare National Health Policy, Oct. 2007

Ministry of Health Community Health Fund (CHF) Operations Guidelines

Ministry of Health and Social Welfare . Health Sector Performance Profile report 2009 update. Mainland Tanzania July 2008-June 2009. October 6, 2009

Ministry of Health and Social Welfare Health Sector Public Expenditure Review 2009/2010. Dar es Salaam, Tanzania 2011

Ministry of Health and Social Welfare. The Tanzania Quality Improvement Framework in Health Care 2011-2016. October 2011

Ministry of Health and Social Welfare. Implementation guidelines 0n %s-CQI (Kaizen)-TQM Approaches in Tanzania. 2nd Edition, November 2011

Ministry of Health and Social Welfare. Agreement for the provision of health services between the Government and the service providers. Dar es Salaam, August 2007

Ministry of Health and Social Welfare, Prime Minister's Office Regional Administration and local government and National Health Insurance Fund: Memorandum for the managemet and administration of Community Health Fund. June 2009

Ministry of Labour, The National Social Security Policy, Dar es Salaam, January 2003

Mtei, Gemini , and Jo-Ann Mulligan. Community Health Funds in Tanzania: A Literature Review. Dar es Salaam: Ifakara Health Research and Development Centre (IHRDC), 2007

Mtei, Gemini, and Josephine Borghi. An Assessment of Health Care Financing Progressivity in Tanzania. Dar es Salaam: Ifakara Health Institute, 2010

Mtei, Gemini, et al. An Assessment of the Health Financing System in Tanzania: Report on Shield Work Package 1. Dar es Salaam2007

Musau, Stephen et al. Tanzania Health system assessment 2010-Draft Report. Abt Asociates, USAID. July 2011

National Audit Office. A Performance Audit Report on Management of Primary Health Care: A Case Study of Health Centres. Dar es Salaam: National Audit Office (NAO), 2008

National Audit Office. Annual general report of the Controller and Auditor General On the audit of the Financial statements of the central Government for the year ended 30th June, 2009

National Audit Office. Annual general report of the Controller and Auditor General On the audit of the Financial statements of the central Government for the year ended 30th June, 2010

National Audit Office. Annual general report of the Controller and Auditor General On the Audit of Public Authorities and Other Bodies for the financial year 2009/2010

National Health Insurance Fund Act, 1999, No. 8/1999 [Cap. 395 R. E. 2002], (including updates up to 2010 as availed by NHIF and incorporated into the Act by KMM Advocates)

National Health Insurance Fund Quality Assurance Guidelines

National Health Insurance Fund , NHIF Accreditation Guidelines

National Health Insurance Fund, Inspection/supervision check lists (various types of health facilities)

National Health Insurance Fund. Action Plan for CHF Operations 2009-2012. October 2009

National Social Security Fund Act, 1997, No. 8/1997 [Cap. 50 R. E. 2002]

National Health Insurance Fund. Action Plan for Chf Operations 2009-2012. Ed. NHIF2009.

Non Governmental Organisations Act, 2002 Act No.2 of 2002

Prevention and Combating of Corruption Act, 2007-No.11 of 2007 [Cap.329 R.E. 2002]

Private Hospitals (Regulation) Act, Act No.6 of 1977 [Cap.151 R.E. 2002], amended by Act No.26 of 1991

Private Hospitals (Regulation) Act. Regulations 1997

Public Audit Act 2008, Act No.11 of 2008

Public Finance Act, 2001, , Act No. 6 of 2001 [Cap. 348 R.E. 2002]

Public Leadership Code of Ethics Act (Acts Nos. 13 of 1995, 5 of 2001) [Cap. 398 R.E. 2002]

Public Private Partnership Act. 2010, Act No. 18 of 2010

Public Private Partnership Act. 2010, Regulations, GN No. 165 of 3/6/2011

Report of the Tanzania Labour Law Reform Task Force, circa May/June, 2005

SafeCare Initiative. Introducing standards to improve healthcare delivery in resource-restricted countries. https://www.safe-care.org

Sikika: The Ineffectiveness of the Tanzanian AccountabilityFramework. July 2011

Social Security (Regulatory Authority) Act, 2008, No. 8/2008 (Cap. 135 R. E. 2002)

State Council of The Netherlands. Law assessment framework

Tanganyika Medical Council Inquiries Rules

Tanzania Insurance (Regulatory Authority) Act, 2009, No. 10/2009 (Cap. 394 R. E. 2002).

Tanzania Insurance Regulatory Authority. Annual insurance market performance report for the year ended 31st December 2010

Tanzania National Five Year Plan 2011/12 – 2015/16.

Tanzania National Bureau of Statistics. 2010 Tanzania Demographic and Health Survey. Preliminary Report. August 2010.

World bank. Making Health Financing Work for Poor People in Tanzania: A Health Financing Policy Note. Dar es Salaam: The World Bank, 2011

World Health Organization, and Health System Financing: The Path to Universal Coverage. Genera: World Health organization, 2010

World Health Organization. The World Health Report 2005: Making Every Mother and Child Count. Geneva: World Health Organization, 2005

Annex 3 Notes of the inception meeting

12 December 2011

Attendants

No.	Name	Institution	Position
1.	Kai Straehler-Pohl	GIZ/P4H	HFIN Adviser
2.	Tawa Meramba	TNCHF	S/Health Ins. Coordinator
3.	Margret Mngumi	TIRA	P. Legal Officer
4.	Michael Semiono	SSRA	Research Officer
5	Joseph Mutashubilwa	SSRA	Principal Financial Analyst
6.	Josaphat Kanywanyi	UDSM/KMMN Advocates	Professor /Firm's Chair
7.	Gemini Mtei	IHI	Researcher
8.	Flora Minja	Strategis	Manager Medical Senior
9.	Janeth Kibambo	MOHSW	Economist
10.	Mariam Ally	MOHSW	Economist
11.	R.L.Kikuli	MOHSW	DPP
12.	Kuki J. Tarimo	MOHSW	Economist
13.	Regina Ndakidemi	MOHSW	Economist
14.	Dr. Njuma Mwinyi	NSSF	Ag. SHIB AM
15.	Haroun Maarifa	Health Focus	MD
16.	Dr. Mathias Sweya	NHIF	DFPM
17	Dr. Charles K. Otito	Muhimbili Hospital	Doctor
18.	Maximilian Mapunda	WHO	NPO-HEL
19.	Kambetta Mwinuka	MOLE	PLO
20.	Neema Lutula	TIRA	Actuarial Officer
21	Jan Bultman	GIZ Consultant	MD, Consultant Health systems

Introduction:

The consultant team presented its approach and the expected outcome of the planned review. It invited comments and advice.

Salient issues discussed and remarks made during the meetings:

1. The need for in-depth analysis of the regulatory framework study of health insurance was supported and its expected contribution to the ongoing health financing strategy formulation/review MOHSW perspectives would be welcomed.
2. Need for a review of social health insurance competition. Does it give room for the social health insurance principles?
3. Portability of social health insurance benefits among schemes and within the economic integration such as in the east African community.
4. Coordination of the many authorities involved in supervision and auditing such as TIRA, SSRA, auditor general, MOHSW, MOL, PMOLAG etc.
5. Need for clarity and simplicity, notably regarding key issues addressed by the study on enrolment of members to each scheme, exit, benefits and premium. The focus being to identify the *what, who, how and why* .
6. Concern expressed by the participants regarding the long list of institutions and people to be met, as it is so ambitious, although also additional meetings were suggested i.e. .with the Ministry of Constitutional Affairs and the legal unit of MOHSW.
7. Need for harmonization of community health funds through setting standard criteria for all council boards in terms of membership enrolment, benefits and portability of services.
8. Remarks on the issue of relatively high NHIF reserves which may soon decrease due to better dissemination of information and the increasing utilization of services by members.
9. Remarks on the difference between health insurance and health-care services.
10. A proposal to create a forum to regulate tariffs and pricing of health services.
11. A proposal to use the dissemination meeting as a means of feedback to the interviewed people who took part in the study.

Annex 4 Notes of Focus Group Discussion with Health Services Providers

Experiences with health insurance schemes and issues with the respective laws that govern the health insurance system –

21 January 2012

Participants

#	Name	Institution
1	Merina Nkuhua	Mwananyamala Hospital
2	Njela Nsubili	Amana Hospital
3	Mehul Sheth	Regency Hospital
4	Mjema Victor	Madong Hospital
5	Dr. S Mwaruka	Amana Hospital
6	Emanuel Masanga	Mikocheni
7	Dr Husna T Msangi	Tekmeke Hospital
8	Dr Petronilla Ngilai	Tumaini Hospital
9	Gifi Kumbakumba	Temeke Hospital
10	Johnbosco Baso	Marie Stopes

Salient features of the discussed topics

1. One issue limiting the benefits of patients from some insurance schemes mentioned was the access to different service providers at primary and referral level. NHIF members can access any primary care facility in the country, while NSSF SHIB members can only access their pre-selected facility at which they are registered. Both schemes allow for referrals to accredited higher level facilities. Due to the limited accreditation of facilities with NSSF, lower level facilities do not always know where to refer patients. This is not an issue for NHIF which has a very extensive network (incl. all public facilities).

2. An issue for the service providers is the level of reimbursements, which they perceive to be inadequate. The capitation fee, though based on average costs, was perceived as too low and not covering the real costs of the hospital.

3. Another issue is the lack of an established forum for the discussion of the expansion of the benefit package of insurance schemes. Every facility has to apply for every new service offered to every purchaser for including it in the list of reimbursed services. They mentioned also the tendency of health insurers to exclude treatment of diseases that are considered to fall under the national public health system such as cancer, TB, mental disorder, etc. leading to claims deductions and impacting the relationship between insurers and service providers.

4. A private health facility can either invest directly from its own sources, borrow from commercial financial institutions or (only recently) borrow from NHIF (only those facilities that have a contract with NHIF). Public health facilities are supposed to prepare a plan with an accompanying budget

and submit this to the local government authority (in the case of primary facilities) or the MoHSW (in the case of referral facilities) which then process it for inclusion in the national Government budget from which investment monies are granted. Public facilities sometimes also receive laboratory or other equipment directly, equipment that has been centrally procured without much facility involvement in deciding what is needed.

5. The process of decision-making, including the criteria used, to establish fee schedules and levels was not clear. Health facilities treat members of different health insurance schemes, but they are confronted with different fee structures used to bill the insurers. NHIF does not allow any room for negotiation, and facilities have to accept the prices set. The SHIB payment system allows for negotiation due to its capitation modality. Private health insurers are receptive to the fees schedules that are set by health providers.

6. Standards and the procedure for accreditation by NHIF are only applied for private health facilities; public facilities are automatically accredited and quality assurance is handled by the MoHSW. The NHIF uses the MoHSW standard health facility guideline to determine the level of the health facility category (i.e. dispensary, health centre or hospital) and does not take into account the qualification of the service delivery staff. This approach was felt to be inadequate when applied to the private sector, where higher qualified staff may work in a facility than is foreseen by the MoHSW guidelines. While delivering care of a quality found in a referral facility, staff only get reimbursed for the quality of a primary facility. The group pointed out that there is a need to review the health facility guidelines to address current experiences and to take account of the technological advancement that is in place.

7. There is great concern about the rate of claims rejection, especially by NHIF, without insurers providing clear and sufficient reasons to providers for the rejections. NSSF – SHIB does not face this issue as it works by capitation, paying an agreed amount for each SHIB member who is registered at that facility. Actual attendance is irrelevant. It was also pointed out that while the insurers use the Standard Treatment Guideline (STG) as a basis for the services provided to members, the STG itself has not been reviewed for a long time. STG is seen by medical practitioners as being a 'static document'.

8. NHIF does not allow facilities to charge co-payments or top-up fees, while the facilities' fees do not always reflect the costs incurred in providing the service. SHIB only covers the agreed in-patient and outpatient tariffs. However, the private insurers provide for the possibility of topping up their fees and to get co-payment mechanisms from their members.

9. Although providers see deductions on their claims payments as one of their most frequent and serious problems with insurers, there has never been a well-defined body that acts on their complaints. Group members noted a lack of understanding regarding the possibility of submitting and registering complaints or appeals to SSRA or TIRA or to a Court of appeal, a lack of information and communication about these options being the main reason. The group members were aware of the medical provider forum of the NSSF. They think that NHIF is lacking such forum.

Annex 5. List of Attendants Pre-Dissemination Meeting, 21 March 2012

#	Name	Institution
1	Prof. J. Kanywanyi	P4H Consultant
2	Dr. J. Bultman	P4H Consultant
3	Kai Straehler-Pohl	P4H|GIZ
4	Birte Frerick	GIZ
5	Mariam Ally	MoHSW
6	Regina Ndakidemi	MoHSW
7	Anna Matowo	MoHSW
8	Michael Semiono	SSRA
9	Ansgar Mushi	SSRA
10	Lightness Mauki	SSRA
11	Irene Isaka	SSRA
12	Ibrahim E. Muhanna	Muhanna & Co (SSRA)

Annex 6. Attendance Dissemination Meeting 23 March 2012

#	Name	Institution
1	Kai Straehler-Pohl	P4H|GIZ
2	Kassim Tani	IHI
3	Denis Mosha	APHFTA
4	Josaphat Kanywanyi	UDSM/KMMM
5	Rehema Kabonga	SSRA
6	Michael Semiono	SSRA
7	Aisha Mariul	NSSF
8	Maryam Msuri	NSSF
9	Godriver S. Egina	Muhimbili NH
10	Ambrose Chanji	Aga Khan
11	Irenei Kiria	Sikika
12	Anthony Tavangu	TTU
13	Charles K. Otito	Muhimbili NH
14	Arnold Masmini	AAR
15	Inge Baumgarten	GIZ
16	Meinolf Kuper	GIZ
17	Rik Peeperkorn	ENL
18	Raymond K.	MOF
19	Margaret Ikongo	TIRA
20	Saidu Beyai	AKHST
21	Oscar Mkude	ATE
22	Mariam Ally	MoHSW
23	Regina Ndakidemi	MoHSW
24	Ansgar Mushi	SSRA
25	Sarah Kibonde Msilia	SSRA
26	Dr Elizeus Kahigwa	SDC
27	Dr E. Malangalila	WB
28	Michael Mugerwa	AKHST
29	Romana Sanga	MoHSW
30	Saidi L. Tofiki	MoCDGC
31	Sabas Licha	Mary Stopes TZ
32	Anna Matowo	MoHSW
33	Prof. J. Kanywanyi	P4H Consultant
34	Dr. J. Bultman	P4H Consultant

Annex 7 Meeting schedules and people met

1st MISSION MEETING SCHEDULE

Date & Time	Counter Part Name & Position
08/12/2011 09:00 – 11:00	R. Rutabanzibwa, Resident Representative ILO
12:00 - 12:00	Ansgha Mushi, Director SSRA
14:00 – 15:00	Maximillian Mapunda, Senior Health Economist WHO
10/12/2011 09:00 - 11:00	Team Meeting
12/12/2011 09:00 - 10:00	Dr. Deo Mtasiwa, Chief Medical Officer MOHSW
11:00 – 12:00	Sulaiman Subumahan, Managing Director Aga Khan Hospital
13:00 – 17:00	Inception Meeting
17:00 – 18:00	Ms. Mariam Ali, Head Heatlh Financing Unit, MoHSW
13/12/2012 09:00 - 11:00	Mr. Israel Kamuzora, Commissioner of Insurance, TIRA
11:30 – 13:00	Mr. Kaale & Mwinula, Ass. Commissioners of Labour – Soc Protection
14:00 – 15:00	Mr. Kain Mbaya, General Manager & Anold Masimi, Principal Officer AAR Medical Insurance
15:30 – 17:30	Mr. Francois A. Van der Merwe – CEO Strategis Insurance
15/12/2011 09:00 – 10:00	Dr. Otito & Sr. Mahalu, Administrators, NHIF Services at Muhimbili National Hospital
10:30 – 11:00	Ms. Justina Lyela, Director of Policy & Advocacy, Association of Tanzania Employers (ATE)
11:30 – 12:30	Dr. Ngonyani – Head of Quality Control, MOHSW
14:00 – 17:00	Dr. A. Mhina & Dr. N. Mwinyi – Principal Officers of NSSF-SHIB
16/12/2012 8:30 – 10:30	Auditor General Office
09:00 – 09:45	Hon. Jery Silaa, Mayor of Ilala Municipality
10:15 – 13:30	Mr. Emmanuel Humba – Director General - NHIF
14:00 – 15:00	Secretary General Teachers Union (CWT)
	Dr. Malangalila, Health Specialist World Bank
17/12/2011 09:00 – 11:00	Ms. Nsubili Phillip Njeru, Administrator – Amana Hospital
12:00 - 15:30	Dr. Mwajuma Mbaga, Head Buguruni Health Centre
15:30 – 17:00	Dr. Berizia. Secretariat of Association of Private Hospitals of Tanzani
17/12/2012 09:00 – 13:00	Team Meeting

2nd Mission

19/01/2012 09:30 - 11:00	Bakari Msulwa, Secretary General (CWT)
12:00 - 13:00	Ministry of constitutional Affairs/Attorney General's Office
14:00 – 15:00	Mr. Haverkamp Head of Pharmaccess
15:30 – 17:00	Team meeting
20/01/2012 11:00 – 12:00	Paul Gogo, CHF Specialist GIZ
12:00 - 13:00	Ms. Mariam, Head Heatlh Financing Unit, MoHSW
21/01/2012 09:00 - 12:00	Focus Group Discussion
23/01/2012 09:00 - 11:30	Mr Mtulia, NSSF=SHIB manager
14:00 – 16:00	NAO/CAG
24/01/2012 12:00 – 14:00	Ansgar Mushi, SSRA
25/01/2012 8:30 – 10:30	NHIF
12:00 – 13:30	Registrar NGOs, Ministry of Community Development, Gender and Children
26/01/2012 14.00 – 15.00	OSHA
27/01/2012 16.00 – 17. 00	Dr. Aggrey Mlimuka Managing Director - ATE
13:00 – 16:00	Team meeting

3rd Mission

Date & Time	**Counter Part** **Name & Position**
19/03/2012 9:00-11:00	Team Meeting
20/03/2012 10:00 – 18:00	Presentation at MOHSW Management Team & discussion
21/03/2012 09:00 - 12:00	Pre-dissemination MOHSW / SSRA
13:00 – 14:30	Ms. M.L.Mwamunyange, Commissioner of Budget MOF Mr.J.W.Mwilima, Assistant Commissioner of Buget
22/03/2012 9:00 – 11:00	Dr. K.M.Kapalata TUCTA
23/03/2012 09:30 – 14:30	Stakeholder dissemination meeting
15:00	Team Wrap-up

Annex 8 Assessment framework Dutch Council of State

"In assessing Bills and other requests for advice the Advisory Division uses an assessment framework made up of three elements: policy analysis, legal issues and technical aspects. This gives rise to the following questions:

Policy analysis

- *Is the problem being addressed one which can or should be solved by legislation?*
- *Will the proposed legislation be effective, efficient and balanced as regards costs and benefits?*
- *Will it be possible to implement and enforce the proposed legislation and to monitor its effects?*

Legal issues

Is the Bill compatible with higher law: the Constitution, international treaties (such as the human rights conventions) and European law?
Is it in accordance with the principles of democracy and the rule of law?
Is it compatible with the principles of good legislation, such as equality before the law, legal certainty, proper legal protection and proportionality?
Can it be easily incorporated into the existing legal system?

Technical aspects

Is the Bill well drafted from a technical point of view?
Does it establish a logical, systematic regime? "

This review was commissioned by the Ministry of Health and Social Welfare and the Social Security Regulatory Authority of Tanzania.

It was financially supported by partners of the Providing for Health (P4H) initiative, specifically Germany and Switzerland. P4H is a global network aimed at improving social health protection (SHP) and strengthening health financing systems to promote universal health coverage (UHC) in low and middle-income countries. P4H operates through an open network of partners, to date including the African Development Bank, France, Germany, the International Labour Organization, Spain, Switzerland, the World Bank and the World Health Organization. The purpose and focus of P4H is to support countries in developing effective, efficient, equitable and sustainable health and social protection systems for UHC and SHP, in particular for the poor and other disadvantaged populations.