Tanzania Health Insurance Regulatory Framework Review

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Background

Tanzania finances health care through a mix of general revenue (tax), social and private health insurance, direct payments by households (out-of-pocket - OOP) and foreign funding. While insurance funding is still a minor share of total funding, it has grown strongly in recent years.

This growth has been mostly driven by the development of the three social health insurance schemes National Health Insurance Fund (NHIF), the National Social Security Fund's (NSSF) Social Health Insurance Benefit (SHIB) and, the Community Health Funds (CHFs). These developments are strongly backed by the Government of Tanzania (GOT), which aims to cover 45% of the population with social health insurance by 2015. Private health insurance, while small in terms of membership, contributes substantially to the revenue of the premium private health care market.

The regulatory framework for health insurance currently in place is highly fragmented with separate regulation guiding different insurance operations, often without regard to the specific requirements of health insurance. There is also some uncertainty over the role of the different oversight institutions and their remit. These weaknesses pose challenges in using social health insurance as a means to moving towards universal health coverage.

Against this background, the Ministry of Health and Social Welfare (MOHSW) and the Social Security Regulatory Authority (SSRA) commissioned an in-depth review of the regulation governing social health insurance that was to lead to recommendations on how to improve and align existing regulation and design new regulation in order to facilitate the social health protection aims of the GOT. Providing for Health (P4H) through GIZ and SDC supported this enterprise.

Methodology of review

In a first step, an assessment framework based on generally recognized principles of law making (to be clear, specific, implementable, etc.) and stated policy objectives was developed. The latter was achieved through a review of several GOT documents including the Constitution, the Economic Growth and Poverty Reduction Strategy (MKUKUTA), the Health Policy and Health Sector Strategic Plan III, the Social Security Policy and others was conducted.

Three main objectives were identified:

- Universal coverage and social health protection;
- Sustainable, effective, efficient health financing for quality services;
- Good governance.

A wide range of (social) health insurance laws and subsidiary regulation, as well as other relevant health sector regulation, such as the Medical Practitioners Act and the Quality Improvement Framework, was then assessed.

Health insurance schemes in Tanzania

NHIF - Established by Act in 1999 under the Minister of Health. It covers formal public sector employees and, as of 2010, has opened up for the private sector. It covers about 2.5m people and has grown by an average of 11% per year. Premiums are 6% of the basic salary, shared 50-50 between employer and employee. Service coverage is comprehensive and the provider network includes all public plus selected private facilities. It uses fee-for-service for reimbursement of claims. Income has consistently exceeded expenditure and the NHIF has accumulated a large financial reserve.

NSSF-SHIB - Health benefit of the NSSF, added in 2006. With the overall NSSF, it is under the Minister of Labour. It aims at the formal private sector. The SHIB premium is included in the general 20% deduction by NSSF (split 50-50 between employer and employee), but only 10% have completed the separate enrolment and are thus able to access the benefit. SHIB individually accredits facilities and pays a capitation fee. A comprehensive set of services is included in the benefits.

CHF - With the system established by Act in 2001, district governments establish a CHF through by-laws. Coverage is about 3.5m people nationwide. Coverage ratios vary strongly between districts. District councils define premiums and the benefit package. Primary level services are included in all districts, services at the first referral level in some. A typical premium is TSH10,000 per family of six per year. The CHF is meant to serve as the vehicle for poverty based fee-waivers. GOT pays a 100% matching grant for each member to the council. All funds enter the council budget and there is no direct reimbursement to facilities. CHFs are managed b the local council administration.

Microinsurance schemes – Small, self-contained insurance schemes often set up by cooperatives or other non-profits. Often, benefits and premiums are limited and schemes face sustainability issues. Coverage is negligible nation-wide.

Private health insurance - A limited amount of commercial insurers offer risk-based (often by company) insurance to the formal sector. Benefit packages are often comprehensive and include services at premium providers. Premiums are accordingly high. Total coverage is below 150,000 and stagnant (while costs and premiums have escalated).

Walking a fine line

The review had to assess the adequacy and appropriatness of the health insurance legislation against the principles of good law-making and policy objectives and suggest improvements of the legal framework. It was explicitly intended not to make policy recommendations and/or prescriptions. Occasionally though, recommendations for the imporvement of the current framework rely on policy choices to be made. In these cases, the review provides guidance on what regulatory steps these policy choices may require.

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Findings

Health insurance and related legislation in Tanzania is technically sound. The various laws and their respective regulations adequately cover the individual health insurance schemes and health service delivery in the country. However, Tanzania is a dynamic country, and its laws and subsidiary regulations need to be adjusted to new and changing GOT policies, international treaties, and developments in society. Also, laws need to be developed with reference to one another. The current regulatory framework is not sufficiently up to date with policies and lacking coherence. These deficiencies can be divided into the following four broad areas: Policy, Regulators, Insurers and Governance.

Policy

- **The policy objective of social health protection is not reflected in the legislation.** There are no policies for equal access or a development path for this in place. Equitable financing is not implemented as payment methods differ and transfers between schemes are lacking. The largest part of the population continues to be without health coverage.
- **The health insurance system is highly fragmented.** There is no unified or harmonized regulation and oversight system that would cover different schemes. Different ministries and regulators are responsible for different schemes (see box on first page).
- **There is no policy on competition in health insurance.** For the public sector, NHIF has a monopoly, for the private and informal sector there is competition. The lack of a policy also means that no explicit regulation exists to deal with issues like risk selection and rating by private insurers, which could have adverse effects on consumers but also on social health insurance schemes.

Regulation

- **SSRA is not oriented towards health insurance.** The SSRA Act allows for health insurance subsidiary legislation but is in itself not oriented towards health insurance. This is especially clear with regard to cost containment and quality assurance. Private schemes are not covered by SSRA.
- **TIRA only covers general insurance aspects.** The TIRA Act covers private health insurance (but not health management organizations) and does not allow for establishing rules on health issues such as benefit packages, etc.

Insurers

- **Premiums are not adequately regulated.** The NHIF rate is fixed by law and cannot be adjusted easily to NHIF's financial position. NSSF charges one overall premium, SHIB does not have a separate account, complicating actuarial analysis.
- **Benefits are different.** NHIF and NSSF have different provider networks, accreditation guidelines and payment mechanisms, which may have consequences for members. The CHF is providing a much more limited menu of services.
- **No coordinated conflict resolution.** The CHF Act does not deal with the issue, and NHIF and NSSF operate their own mechanisms, instead of using a common ombudsman and a dedicated patients' rights Act.
- **No coordination in investment planning.** Most investments are through tax funds, and insurers have no influence on decisions despite paying for part of the running costs. On the other hand, they provide de-facto loans for investment to facilities outside of the MOHSW investment decisions.
- **SHIB contributions are compulsory, benefits not universal.** Many NSSF members do not access SHIB because of the separate enrolment requirement.
- **CHFs do not achieve the policy objectives** of universal coverage of social health protection, which is to do with weak or unenforceable regulation on governance and performance of the CHF. The MoU between MOHSW, PMO-RALG and NHIF intended to address these issues is not sufficiently clear and expires on 30 June 2012.

Governance

- **Conflict-of-interest rules are insufficient.** Rules exist for high-level staff but not for all critical positions, leaving good governance loop-holes.
- **Value-for-money audits are lacking**. The NAO has just opened a VFM unit, but insurance has not been targeted.

Recommendations

The review contains a comprehensive list of suggestions for changes to health insurance legislation. Here only some key recommendations are listed:

Streamline Ministerial and Regulatory responsibility. Integrate and/or coordinate the different responsibilities of MOHSW, MOL, PMORALG, and MOF as well as of SSRA and TIRA either by shifting responsibilities (amend Acts) or by agreeing Memoranda of Understanding between parties.

Develop a policy on health insurance competition. Standard arguments for competition are efficiency and patient focus, but risk rating/selection and rationing of care may be adverse side-effects. Tanzania needs to take an informed decision. Based on this, the roles of SSRA and TIRA need to be adjusted.

Establish an independent accreditation body (state agency or NGO). This body would be in charge of accreditation for all insurers and could assist the MOHSW in quality assurance.

Decide on future of CHF and its administration. The operations of the CHF and the role of the NHIF in supporting the CHFs need to be more clearly defined and a follow-up arrangement to the expiring MoU is to be found.

Clarify policy on population coverage. Define which fund is to cover which part of the population mandatorily and set up cross-subsidization mechanisms that would allow all funds to carry out their mandate.

Define a universal minimum benefit package. For effective social health protection, a common minimum benefit package should be distinguished from supplementary services.

Establish a forum to negotiate service reimbursements. Build a platform for negotiations between providers and insurers to agree prices. The absence of such a forum creates grievances on both sides.

Develop an investment policy and align funding. Coordinate the decisions of MOHSW and insurers so that investment and operational funding can be aligned.

Install a health insurance ombudsman. To protect consumer rights more effectively, align conflict resolution mechanisms and centralize the representation of insurance members.