POLICY BRIEF

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Tanzania's Universal Health Insurance Act, 2023: Implications on Health Financing

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Introduction

Increasing financial protection has been at the heart of reforms targeting the health insurance system in Tanzania for the last two decades (Figure 1 shows the major health insurance system reforms). Despite this, population coverage with health insurance has remained relatively low estimated at 15.3 per cent of the total population which includes 8 per cent by National Health Insurance Fund (NHIF), 6 per cent of the improved community health fund (iCHF), and 1.3 per cent by other private health insurance [1]. A significant share of total health expenditure is health household financing (25% and 27% in 2021 and 2022 respectively) and low share of health insurance financing (9% and 11% in 2021 and 2022 respectively) resulting in low financial protection in consumption of health services [2] [3]. This indicates that majority of the population (over 75%) rely on out-of-pocket [OOP] payments that expose them to catastrophic health expenditures. Legislation plays a key role in supporting a country's effort to make progress towards the realisation of Universal Health Coverage (UHC) by shaping health system design, implementation, and governance. This brief presents a detailed analysis of the Universal Health Insurance Act [2023][4] and its implications for the health financing policy in Tanzania mainland.

Textbox 1: OOP expenditure

More than **25%** *of health expenditure in Tanzania is financed through OOP payments.*

Figure 1: Major health insurance system reforms in Tanzania

1999
NHIF Act No. 8
NHIF established

2005
The National Social Security Fund [NSSF] established the Social Health Insurance Benefit [SHIB]

2016/17
NHIF amendments to include more civil servants, governance & beneficiaries; ammendments on CHF to form improved community health fund [iCHF]

2001
Community Health Fund [CHF] targets the informal sector rural households & managed by the district

2009
Tiba kwa Kadi [TIKA] the urban equivalent of the urban population

2023
Universal Health Insurance Act - introduces mandatory health insurance for all citizens and residents

Source: Lambin R. et.al, additions by the authors [2022]

The enacted 'Universal Health Insurance [UHI] Act of 2023 initiates health systems reforms to expand financial protection and improve access to quality health services for all Tanzania's mainland residents and citizens. This is the third iteration of reforms on the NHIF since its establishment in 1999. This legislation goes further to introduce multiple reforms including the introduction of mandatory health insurance, a regulatory mechanism through the Tanzania Insurance Regulatory Authority [TIRA], identification and financing of the poor, the development of a standard benefit package, the creation of the public health insurance fund, and complementary private health insurance.

The UHI Act [2023], provides for reforms in regulation, governance, health service delivery, and financing of health services to address the fragmentation of financing arrangements of existing health systems by combining the formal public health insurance and the iCHF. It further provides for the legal and policy frameworks to formalize the needed reforms in the journey towards progressive realization of the UHC goals. Previous NHIF reforms were inadequate to solve high out-of-pocket health expenditures, regulate the NHIF, enforce mandatory insurance, and hence its limitations in promoting access to health for all [2][3]. Furthermore, the health financing system in Tanzania is characterized by high fragmentation with many financiers and modes of financing that lead to significant inefficiency in the use of resources [5]. The various modes of financing in Tanzania include; OOP payments (with exemptions and waivers for those who cannot pay), and third-party payments financed by households, government, voluntary public community health funds, voluntary micro-health schemes, private health management organizations, private health insurance, public health insurance, and voluntary health benefits through pension funds.

The Act is intended to address factors constraining the availability of better services for all in Tanzania. We outline the UHI Act [2023], which affects four main functions of health financing including revenue raising, pooling, purchasing, and the development of health benefits packages as the country strives to make progress towards the attainment of UHC.

I. Effect of UHI Act on Resource Mobilization

The UHI Act [2023] seeks to raise more revenue for health through 3 ways; i) mandatory contributions, ii) extending contributions to the informal sector and iii) additional sources of funds. We discuss the implications of each of these provisions on health financing in the Tanzanian context.

Textbox 2: implications of the UHI Act (2023) on resource mobilisation for health

The objectives of the UHI Act stipulate inclusion of the entire population in the health insurance system. This is accompanied by mandatory contributions and increased government support and subsidies which will likely broaden the health resource base, extending contributions to the informal sector and additional sources of funds through earmarked taxes from (i) electronic transaction fees (ii) sources identified by the Minister of Finance from excise duty on alcoholic drinks, carbonated drinks, and cosmetics (iii) investment income (iv) gifts and donations from stakeholder with the aim to enhance resource mobilization in Tanzania.

First, the Act provides for mandatory health insurance for all people and obligates every formal sector employer to contribute to their employee's health insurance, and all foreigners aged 18 years and above. This broadens the scope of health insurance in Tanzania. However, evidence has shown that due to the socio-demographic context in most low-middle income countries (LMICs), mandatory health insurance may be difficult to enforce [6][7]. Informal labour arrangements are often characterized by unpredictable and irregular incomes, often not collected in structured ways.

Second, extending contributions to the informal sector is expected to broaden the health sector resource base significantly. However, as highlighted, this is often challenging to enforce in LMICs. For example, according to the National Bureau of Statistics [8], 14 per cent of the Tanzanian population is in the informal sector1[i]. This figure, however, does not encompass the population in the agricultural sector (61.9%) whose working arrangements are often sessional [9]. This means that tracking the incomes of these informal populations is likely to make it challenging to enforce mandatory health insurance. High rates of poverty further compound enforceability of mandatory contributions [7][10]. In Tanzania, 26.4 per cent of the population lies below the national poverty line [8], hence affordability of set premiums is likely to pose a challenge to a significant proportion of the population. This calls for increased government support for indigents (those who cannot pay) through various methods such as waivers, exemptions and government budgetary support, which is provided for in the Act.

To ensure enforceability, the Act provides stiff penalties of up to 10 per cent interest on the contribution rate for each year of contribution. [Section 37: 1]. Despite the penalties issued above, the Minister has also been given the leeway to waive or grant exemptions to the penalties on interest; a fact that has the potential to dilute the mandatory enforcement [Section 37: 2].

Third, the Act provides for additional sources of financing through earmarked taxes from (i) electronic transaction fees (ii) sources identified by the Minister of Finance from excise duty on alcoholic drinks, carbonated drinks, and cosmetics (iii) investment income (iv) gifts and donations from stakeholders. Table 1 shows summary of provisions of the Act that affect resource mobilization.

i Data on the informal sector is not accurately corrected and 14% is based on estimates from world bank and NBS during surveys.

Table 1: Summary of the provisions for resource mobilization for health

Characteristics of resource mobilisation	Provisions before the UHI Act [2023]	Provisions in the UHI Act [2023]
	Public sector salaries for targeted civil servants, contributions for households for community-based insurance schemes [urban & rural populations]	Multiple financing to include salaries of formal and informal [section 19;1-2; 22: 2 & also those in the informal sector [section 21: 2] Provides for additional financing through earmarked taxes [section 25: 1-3] - Earmarked taxes will be from; i) electronic transvaction fees (ii) sources identified by the Minister of Finance from excise duty on alcoholic drinks, carbonated drinks, and cosmetics (iii) investment income (iv) gifts and donations from stakeholders
Mandatory vs voluntary	Combination of voluntary contributions for the CBHIs & and informal sector while being mandatory to selected civil servants [Section 8; 9 [1,2]	Mandatory for all population [formal & informal sectors] while obligating the government to pay premiums for the poor and vulnerable populations [Section 5:1-5, 6: a-f, 25:1-3]

Source: analysis by the authors

II. Effect of UHI Act on Pooling

Text box 3: implications on pooling arrangements for health resources.

The UHI Act (2023) seeks to broaden the pools coverage to include the poor households through the creation of a fund to cater for the indigent population.

The new Act outlines that health insurance is mandatory for all people by targeting those in formal and informal employment [section 4, 5, 19, 22], creating community-based health insurance [CBHF] fund for those who do not have other insurance, and is financed both by government and individual contributions [section 15], creates a fund for the indigent [section 24, 25] mandating the government to pay a premium for the poor and vulnerable population, disabled and critical care diseases [section 25]. Section 4 of the Act [1,2] establishes a system of participation in the health insurance schemes for all citizens and residents. In effect, this provides for increased health insurance coverage, adopts the Community Health Insurance Fund [CHIF] as one of the schemes of NHIF, and provides for complementary private health insurance. This supports the strengthening of the pooling arrangements to ensure that the pool is big, and diverse and applies the principle of cross-subsidization [11]. Table 2 shows a summary of provisions of the Act that affect pooling.

Table 2: Summary of the provisions that affect pooling arrangements

Characteristics of the pooling arrangements	Provisions before the UHI Act [2023]	Provisions in the UHI Act [2023]
	Provisions in the UHI Act [2023]	The new Act proposes inclusion of all into the pooling arrangements
Consolidated vs fragmented pools	Multiple pools [covering formal, and informal sectors] and voluntary contributions [Community Based Fund [CBF] & Tiba kwa Kadi-TKK]	Promote the creation of a single pool [incorporating CBF]
Diversity of risk pools	Little cross-subsidization [no inclusion of the poor & and vulnerable population]	Creates a big and diverse pool providing room for cross-subsidization
Mechanisms used to allocate resources from pool to purchasing mechanisms	Fee for service and not based rigorous analytics	The new law provides for actuarial studies and other analytics to determine the benefit packages and provider payments mechanisms
Governance arrangements	Multiple schemes with varying governance arrangements that are not under a common regulator	Multiple schemes under a common regulator
Regulations of the schemes	No formal regulations of the scheme and hence dependent on the governance of the schemes	All insurance health schemes placed under the Tanzania Insurance Regulatory Authority [TIKA]

Source: analysis by the authors

III. Effect of UHI Act on Purchasing

Countries are working to make purchasing more strategic by using data to maximize health systems' performance when deciding which interventions to purchase, from whom, and how [12]. It should be noted that the UHI Act [2023] which is a principal legislation does not go into specific details regarding core purchasing functions (benefits package specifications, provider contracting and payment mechanisms) that subsidiary legislation (i.e. regulations) will aim to address.

Health services interventions: The UHI Act [2023] provides specific details of the essential services benefit package and community health insurance package in Schedule A and Schedule B respectively. The new Act further identifies that every member or beneficiary of health insurance is entitled to an essential services benefit package [section 13, 14, 18]. The Ministry of Health [MoH] will be responsible for controlling the quality of service providers [section 29]. The Minister of Health has also been mandated to establish a team to help review the benefit package [section 16]. Services to be offered include in-patient and out-patient services.

Provider selection: The Act does not go into details of provider selection and contracting as this shall be addressed at the regulations stage. The Act provides that beneficiaries of the mandatory insurance will seek health services from dispensaries to the national level [Section 14, 15]. Previously there existed informal contracting arrangements of public/private providers by the iCHF. Once the iCHF is fully under the NHIF as outlined in the UHI Act, formal contracts are likely to be established. This is will ensure harmony in the contracting arrangements. For example, before the new Act, Primary Health Care (PHC) facilities did not have formal contracts but hospitals under NHIF had formal contracts.

Provider payment mechanisms: The provider payment mechanisms (PPMs) have not been detailed in the Act as these will be addressed in the regulation's development. The Act provides that accredited health facilities will raise claims for services offered to bona fide members of the insurer [Section 38]. The regulator will provide guidelines on payments for guidelines to service providers and implement a mechanism for monitoring the quality of health services provided [section 7]. The Minister of Health is mandated to review PPMs, a window that may be used to review the existing PPMs. Currently, the NHIF utilizes fee-for-service both for in-patient and out-patient services at hospitals and selected PHC facilities. The iCHF utilizes capitation for outpatient services at PHC facilities. The change of governance of the iCHF will potentially trigger additional reforms on the PPMs to both PHC facilities and hospitals. Table 3 shows a summary of provisions of the Act that affect purchasing.

Performance monitoring: NHIF will continue to inspect providers and medical claims.

Table 3: Summary of provisions of the Act for purchasing of health.

Characteristics of purchasing arrangements	Provisions before the UHI Act [2023]	Provisions in the UHI Act [2023]
Provider payment mechanisms	**NHIF – mainly used fee for service and capitation for CBHIs**	**Not clearly articulated but mandates the minister to use data-driven evidence to determine appropriate PPMs**
Benefit specification	**Explicit benefit package of PHC, Hospitals with exclusions**	**Schemes shall provide the standard benefit package by the UHI Act, 2023 (section 35)**
Contracting arrangements	**Beneficiaries can select only public providers under iCHF. iCHF has no formal contracts with providers**	**Increased membership will require the expansion of the contracted providers. Once fully under the NHIF, formal contracts are likely to be established. This is will ensure harmony in the contracting arrangements**
Performance monitoring	**NHIF inspects providers and medical claims**	**NHIF will continue to inspect providers and medical claims**

Sources: analysis of the act by the authors

Conclusion

The Tanzania UHI Act [2023] sets up the country to address major gaps in health financing arrangements with the aim to influence the delivery of quality health services to the citizens and residents of Tanzania. Some of the immediate reforms within the Act include drafting of the regulations, consolidation of the pooling arrangements under the NHIF, enforcing mandatory health insurance, a regulatory mechanism through the TIRA, identification and financing of the poor, the development of a standards benefit package, the creation of the public health insurance fund, community health fund, and complementary private health insurance among others. This is likely to be followed by additional reforms at the national, NHIF and health facilities to ensure alignment with the objectives of UHC.

Amref, through its SPARC program, supports African Countries to implement reforms on SHP. In collaboration with Amref country offices, SPARC will continue offering high-quality technical assistance and building the capacity of policymakers at the national level and purchasing agencies like NHIF, Tanzania [12]. Subsequent briefs on Tanzania's UHI Act will document the journey of implementation and implications on the country's health system.

1. Ministry of Health, “Ministry of Health Budget Speech 2022/2023.” 2023.
2. Ministry of Health and Community Development Gender Elderly and Children, “National Health Accounts 2020 Analysis Report,” Dodoma, Tanzania, 2022.
3. Ministry of Health and Community Development Gender Elderly and Children, “Health Sector Public Expenditure Review 2021,” Dodoma, Tanzania, 2022.
4. United Republic of Tanzania, “Universal Health Insurance Act.” 2023.
5. Haazen Dominic, Making Health Financing Work for Poor People in Tanzania. 2012. Accessed: Feb. 15, 2024. [Online].
6. McIntyre D, M. K. Ranson, B. K. Aulakh, and A. Honda, “Promoting universal financial protection: Evidence from seven low- and middle-income countries on factors facilitating or hindering progress,” Health Res Policy Syst, vol. 11, no. 1, pp. 1–10, Sep. 2013.
7. World Health Organization., “Making fair choices on the path to universal health coverage: Final report of the WHO consultative group on equity and universal health coverage.,” 2014.
8. World Bank and National Bureau of Statistics, “Tanzania Mainland Houseland Survey 2017/18,” 2020.
9. United Republic of Tanzania, “Integrated Labour Force Survey 2020/21: Key labour market indicators for the United Republic of Tanzania,” 2021.
10. Alkenbrack S, K , Hanson, M. , Lindelow, and J. Macq, “When incentives are not enough: evidence from the impact of community-based health insurance on healthcare utilisation in rural Burkina Faso.,” Soc Sci Med, 2018.
11. Mathauer Inke, P. Saksena, and J. Kutzin, “Pooling arrangements in health financing systems: A proposed classification,” Int J Equity Health, vol. 18, no. 1, pp. 1–11, Dec. 2019.
12. World Health Organization, “The World Health Report 2000: Health Systems: Improving Performance.” Accessed: Feb. 15, 2024. [Online].
13. Strategic Purchasing Africa Resource Center (SPARC), “Policy Brief: Strategic Health Purchasing in Tanzania: A summary of progress and opportunities.” 2021.