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POTENTIAL FOR FINANCING HIV SERVICES THROUGH HEALTH INSURANCE SCHEMES IN TANZANIA

This publication was prepared by Bryant Lee, Amos Kahwa, Arin Dutta, Rosemary Silaa of the Health Policy Project.

USAID FROM THE AMERICAN PEOPLE

PEPFAR U.S. President's Emergency Plan for AIDS Relief

HEALTH POLICY PROJECT

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Potential for Financing HIV Services Through Health Insurance Schemes in Tanzania

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This publication was prepared by Bryant Lee,[1] Amos Kahwa, [2] Arin Dutta, [1] and Rosemary Silaa[1] of the Health Policy Project.

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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
CHF	Community Health Fund
HIV	human immunodeficiency virus
HPP	Health Policy Project
LGA	local government authority
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
NACP	National AIDS Control Program
NEHCIP	national essential health care interventions package
NGO	nongovernmental organization
NHA	National Health Accounts
NHIF	National Health Insurance Fund
NSSF	National Social Security Fund
OOP	out-of-pocket
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
SHIB	Social Health Insurance Benefit
SNHI	single national health insurer
SSRA	Social Security Regulatory Authority
TIKA	Tiba kwa Kadi (pay by card) scheme
TIRA	Tanzania Insurance Regulatory Authority
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	U.S. Agency for International Development

BACKGROUND

In 2015, HIV prevalence in Tanzania (mainland) was estimated to be 5.1 percent among adults (ages 15 and above)—a decline from 2005, when the comparable value was 6.4 percent. An estimated 1.46 million Tanzanians are currently living with HIV, and approximately 54,600 new infections and 36,750 AIDS deaths occurred in 2015 (GOT, unpublished). In 2015, the National AIDS Control Program (NACP) of the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) revised the national antiretroviral therapy (ART) targets. The new targets would allow Tanzania to achieve the Joint United Nations Programme on HIV/AIDS (UNAIDS) 90-90-90 "fast-track" target of 81 percent of all people living with HIV (PLHIV) on ART by 2020. Currently, HIV programming in Tanzania is heavily dependent on donor funding, with 97.5 percent of all key financing needs in 2011 supported by external sources (GOT, 2011).

Figure 1: HIV Prevalence by Socioeconomic Characteristics Tanzania 2011-12

Socioeconomic Characteristics of those tested	HIV Postive	Number
Employment (past 12 months)		
Not employed	3.3%	2,888
Employed	5.5%	14,847
Residence		
Urban	7.2%	4,720
Rural	4.3%	13,025
Wealth Quntile		
Lowest	4.0%	2,925
Second	3.9%	3,216
Middle	5.0%	3,287
Fourth	5.3%	3,693
Highest	6.6%	4,624

Source Tanzania HIV and Malaria Survey 2011/12

There is a desire among stakeholders for sustainable financing mechanisms to sustain the benefits of high coverage levels of ART and other high-impact HIV interventions over the long term. Development partners' support for Tanzania's HIV response is expected to decline in the future, as economic growth and rising per capita income levels continue. Tanzania's high level of donor dependence, together with the expectation of decreasing donor support highlights the growing importance of domestic resource mobilization for HIV.

HIV prevalence in Tanzania is higher among those employed, living in urban areas, and from higher wealth groups.

Based on recent population-level survey data, the demographics of Tanzania's HIV epidemic suggest that HIV prevalence is higher among those employed, living in urban areas, and from higher wealth groups (See Figure 1). This suggests that HIV is disproportionally affecting middle-class Tanzanians. Future financing options should consider solutions that leverage the ability to pay of certain groups, even as vulnerable and poorer groups are financially protected.

Growing emphasis has been placed on health insurance as a sustainable financing option. Research has been conducted on a set of sub-Saharan countries to determine the overall viability of financing HIV and AIDS services through health insurance (Talib and Hatt, 2013). In Kenya, a study assessed the opportunity space to expand HIV care and treatment in the private sector, which owns 51 percent of health facilities. The study explored solutions to barriers in the health insurance market that could increase insurance-based financing of HIV care, such as addressing knowledge gaps among insurers and improving data for the design of appropriate insurance products (Gatome-Munyua et al., 2015).

In Namibia, a middle-income country, ART has been covered by the private health insurance industry for some time, although premiums are high and rely on substantial employer contributions (Van der Veen et al., 2011; Schellekens et al., 2009). The Okambilimbili program was a pilot scheme in Namibia supported by the PharmAccess Foundation, which ended in 2009. The program provided low-cost health insurance for low-income workers, including a defined set of HIV and

AIDS treatment and care benefits, administered through private health insurers. Group members, composed of 40,000 people, contributed monthly premiums into a risk equalization fund, while their employers contributed at least an additional 50 percent subsidy (Janssens et al., 2008).

Many governments in lower-middle-income countries are demonstrating an interest in including HIV and AIDS benefits in their national health insurance scale-up strategies. In Vietnam, the government has examined the potential liabilities of including HIV and AIDS care and treatment services as part of the benefit package for the country's social health insurance scheme (Nguyen et al. 2014). The proposal put forward by the Vietnam Authority for AIDS Control under the Ministry of Health aims to expand health insurance coverage to include 92 percent of ART patients by 2020, financed by a mix of premiums and subsidies from the government budget (Ministry of Health {Vietnam}, 2016). The government of Vietnam is proceeding with legislative and administrative steps to achieve this goal. For this scenario to succeed, PLHIV must be identified, connected to care, and enrolled in the social health insurance scheme.

Financing HIV and AIDS services through health insurance could be a long-term solution for Tanzania. Health insurance can pool risks of having to pay for health-related expenses across a population and across differing states of health. Contributions to insurance schemes are often established based on ability to pay or an assessment of the risk the individual represents. Redistribution within large health insurance schemes that collect flat or ability-to-pay premiums implies that those who are sick, such as PLHIV, or poor can be effectively cross-subsidized by those who are healthy or who pay higher insurance premiums. Pre-payment mechanisms such as health insurance also protect beneficiaries from unexpected out-of-pocket (OOP) payments to access healthcare services at service delivery points. Such OOP expenditures can be catastrophic for poor households. When executed at scale, health insurance programs can also drive greater efficiency in healthcare financing by reducing costs and offering better incentives for providers. Based on findings from Kenya, there is general willingness to pay for affordable health insurance packages in East Africa (Gatome-Munyua et al., 2015).

The 2011/12 National Health Accounts (NHA) show that health insurance financed only 5 percent of total health expenditure, with 25 percent financed by households' OOP expenditures, 49 percent by development partners, and 21 percent by domestic public sources.

Tanzania has a developing health insurance market, which is described further below. The 2011/12 National Health Accounts (NHA) show that health insurance financed only 5 percent of total health expenditure, with 25 percent financed by households' OOP expenditures, 49 percent by development partners, and 21 percent by domestic public sources. The NHA also found that insurance financed less than 1 percent of HIV and AIDS spending (MOHCDGEC, 2015). Developing a single, unified risk pooling mechanism via a single national health insurer is the major pillar of Tanzania's draft Health Financing Strategy (MOHCDGEC, 2015a).

Objectives of this Analysis

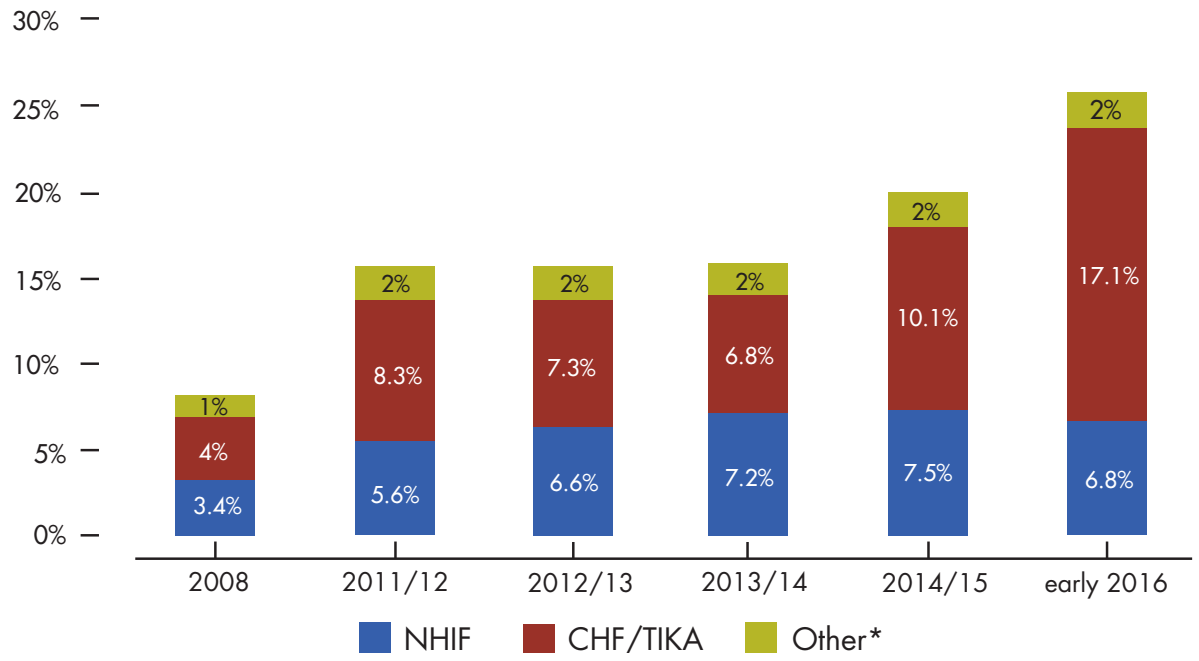
The USAID- and PEPFAR-funded Health Policy Project (HPP) conducted this analysis to explore the current status of benefit packages and the feasibility of incorporating HIV services, including ART, into insurance schemes in Tanzania. We used structured interviews of insurance providers to collect qualitative data and also gathered secondary data from insurers and other sources to provide a basis for profiling different schemes and insurers. Our main objectives were to understand what services and benefits are currently being covered and what barriers prevent insurers from including HIV services within benefit packages, and to offer conclusions on the plausibility of financing HIV services through health insurance in Tanzania. Unlike previous studies, which looked only at the private insurance sector, this analysis also includes schemes managed by the National Health Insurance Fund (NHIF) as well as a micro-insurance provider.

1.2 Introduction to Health Insurance in Tanzania

As of early 2016, public and private health insurance schemes in Tanzania collectively covered around one-quarter (25.8 percent) of Tanzania's population[1]. This is comparable to Kenya, where 20 percent of the population was covered with health insurance in 2014 (Gatome-Munyua et al., 2015). The NHIF is the largest health insurance scheme in Tanzania in terms of membership and premiums collected. The NHIF was introduced in 1999 as a mandatory social health insurance scheme covering public sector employees. Since then, it has expanded to cover the formal private sector as well. The NHIF currently accommodates voluntary membership from individuals in the informal sector. Formal sector payroll deductions are shared between employer and employee, with each contributing 3 percent of the employee's salary. Membership patterns are discussed below. Around 97 percent of total premium contributions for FY 2013/14 originated from public sector employers and employees, 3 percent from the private sector, and a negligible amount from voluntary individual members. Growth in the NHIF has been steady, with premium revenue rising by 78 percent between FY 2011/12 and FY 2014/15 (from TZS 161 billion to TZS 286.7 billion). Claims paid under the NHIF increased 179 percent over the same period, from TZS 56 billion in FY 2011/12 to TZS 156.7 billion in FY 2014/15 (Kahwa, A. 2016).

The Community Health Fund (CHF) was enacted as a scheme in 2001 to provide coverage in rural areas, especially for informal sector workers. Since 2009, the "Tiba kwa Kadi" ("pay by card") scheme (TIKA) has been in operation in urban areas. CHF and TIKA were introduced to provide some financial protection to rural households, increase funds available to primary health facilities, and increase the overall share of individuals covered by some form of health insurance. In these schemes, contribution levels per adult member vary by local government authority (LGA), and total collections are matched by the central government based on LGA application. Since 2009, the NHIF has managed the CHF. Membership for the CHF/TIKA was 1,370,754 households as of January 1, 2016. Overall, between the NHIF and CHF, the total beneficiary population has increased 90 percent since FY 2011/12, reaching an estimated 11.7 million by early 2016. The last government-supported scheme, targeting formal and

Figure 2: Health insurance landscape in Tanzania: population-level coverage (estimated)



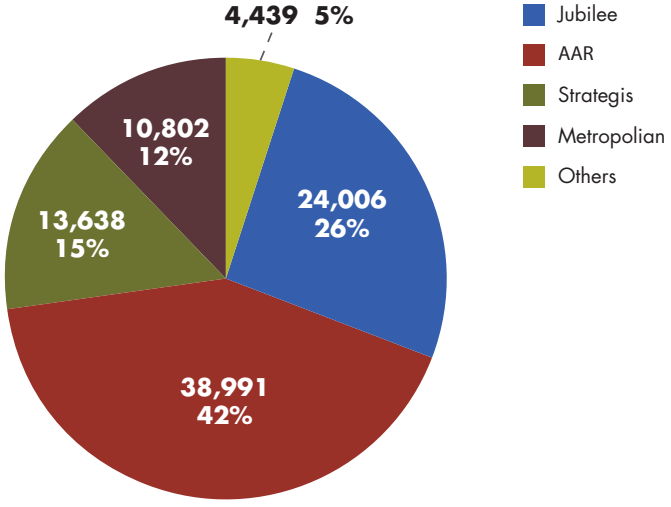
Source: NHIF, Tanzania Insurance Revenue Authority (TIRA), HPP data collection and interviews. *Other: NSSF-SHIB, private health insurance. Community-based health insurance and micro-insurance not included

[1] Based on HPP analysis using reported data from the NHIF and private health insurers, and estimate for NSSF-SHIB.

semi-formal private sector employees, is the Social Health Insurance Benefit (SHIB) scheme, which was started in 2005 as a voluntary benefit from the National Social Security Fund (NSSF). Participation in the SHIB among all NSSF members remains very low (See Figure 2).

The private health insurance sector currently covers 1.4 percent of the population (MOHCDGEC. 2015b) and is composed of eight companies that offer a range of plans that private sector companies provide to their employees. Voluntary plans for individual clients are also available. Between January and December 2014, private health insurance premiums increased 17 percent, compared to 2013 (calendar year), when they grew 25 percent. In 2013, gross private health insurance premiums written was TZS 78.7 billion, which increased to TZS 92 billion in 2014. Out of all the general insurance classes in the private sector, the health insurance business represents a 19 percent share in terms of gross premium, and had the poorest underwriting result in 2014, with a sector-wide loss of TZS 3.8 billion (TIRA, 2015). The aggregated loss ratio for the private health insurance sector (net claims incurred/net premiums earned) for the calendar year 2014 was 70 percent (TIRA, 2015). Market share in terms of gross premium written by firm is shown in Figure 3. Additionally, there are several micro-insurance schemes, for example EdgePoint's BimaAfya, which are relatively inexpensive, offer limited benefits, and can deploy innovative methods to secure clients.

Figure 3: Private health insurance market share, by gross premiums written, TZS millions



Source: TIRA Annual Report 2014. * Others comprise Heritage, Resolution, Milembe, and G.A.

The health insurance landscape in Tanzania may change significantly given planned near-term reforms to CHF as well as the long-term vision of health financing reform. As a major component of its draft health financing strategy, the Government of Tanzania is currently planning to introduce a single national health insurer (SNHI) to defragment the different risk pools in the country. If related legislation passes by 2017, the SNHI will eventually be mandatory, the benefits of which will be increased pooling, revenue mobilization, and risk sharing. Components of this strategy include developing a minimum benefits package available to all members and increasing efficiency through an improved purchasing mechanism. Much remains to be done before such legislation is passed, such as sensitizing stakeholders to the benefits of the SNHI.

1.3 Methods and Structure

For this study, HPP used a questionnaire developed in consultation with the MOHCDGEC. HPP conducted structured interviews with eight insurance providers, government-supported as well as private, to understand their willingness to include HIV services in their benefits packages. The insurance scheme operators also shared their views on obstacles to adding coverage of HIV services, and identified relevant knowledge gaps. HPP also conducted a desk review of key documents and secondary data sources. Finally, HPP sought the opinion of key policy influencers at the MOHCDGEC and PharmAccess.

In Section 2, HPP presents a set of health insurance provider profiles that detail benefit package(s) and the nature of HIV and AIDS services covered, if any. These provider profiles are intended to be broadly comparable. In Section 3, we synthesize responses from insurers on their willingness and capacity to cover HIV and AIDS services. This includes issues such as affordability, sustainability, and enablers that relate to inclusion of HIV services in their schemes. The report concludes with a discussion and prognosis for the question of HIV services in the insurance sector in Tanzania (Section 4).

Glossary for Insurance Scheme Profiles

Member	Primary health insurance policy holder.
Beneficiaries	Sum of members and their dependents covered under the health insurance scheme.
Client Locations:	Geographic description of where the majority of members are located.
Premium Written:	Gross income that is derived from premiums paid by members for the insurance policy.
Claims Paid:	Payment made by the insurance company to providers on behalf of the client based on the terms of the insurance policy.
Claims Ratio:	Also known as the medical loss ratio, this is the total payments made by an insurance company in the form of claims divided by the total revenue earned from premiums.
Male to Female:	The ratio of male to female beneficiaries covered under a company's health insurance (if reported).
Premium Rate:	The monthly or annual amount that must be paid to remain a current member of the health insurance plan. Can be individual- or household-based. The rate listed in the company profile box is the annual rate of the most popular package.
Contribution:	Ratio of the insurance premium that is split between the employer and the employee for schemes based on formal sector employment.
HIV Prevalence:	Percentage of the scheme beneficiaries for an insurance provider who are living with HIV.
Benefits Package:	The package of services covered by a health insurance plan and the financial terms of such coverage, including cost share and limitations on amounts of services.

2. INSURANCE PROVIDER PROFILES

2.1 Private Insurance Schemes

Jubilee Insurance Company

Company Narrative: Jubilee is a multinational private insurance company founded in 1937 with a mission to protect the future of its customers by enabling people to overcome uncertainty. In addition to Tanzania, Jubilee operates in Kenya, Uganda, Burundi, and Mauritius. In Tanzania, Jubilee operates countrywide, but most of its beneficiaries are urban-based. Jubilee offers a range of products including life, vehicle, fire, and accident insurance and currently holds an 18 percent share of the private health insurance market. Jubilee clients are private companies, corporates, and middle- and high-income individuals purchasing their own voluntary insurance. The company offers a comprehensive benefits package under four main products with coverage increasing in relation to premium price. Each of the benefits packages cover some HIV and AIDS services, but none of the packages include antiretroviral medications (ARVs).

JUBILEE INSURANCE COMPANY COMPANY PROFILE FY 2014	
Members	26,000*
Client Locations	Country Wide
Premiums Written	24.1 billion (TZS)
Claims Paid	N/A
Premium Rate	2,167,917 (TZS)
Contribution	Variable
HIV Prevalence	Unknown
*Jubilee estimate	

BENEFITS PACKAGE [TZS]	ROYAL	EXECUTIVE	ADVANCED	PREMIER
Limit per year	80 million	50 million	30 million	15 million
Bed (up to limit)	Private Room	Private Room	General Ward	General Ward
Inpatient benefits	Drugs, surgery, nursing care, physiotherapy, gynecological illness, theatre charges, ICU/HDU, parent lodging, ambulance, pathology, radiology, accidental dental and optical			
	Paid in full	Paid in full	Paid in full	Paid in full
Fees for physician, specialist, procedure, anesthetist	Customary and reasonable			
Pre-existing and chronic (Y2), cancer (Y3), organ transplant (Y2)	5 million	5 million	4 million	3 million
Psychiatric (Y2)	3 million	3 million	3 million	3 million
Outpatient limit	1.5 million	1.5 million	1.2 million	0.8 million
Outpatient benefits	Consultation fees, pathology, x-rays, MRI, CT scan, drugs, gynecological, pre-existing and chronic (Y2), cancer (Y3) psychiatric (Y2) Paid in full up to limit			
Maternity Benefits - Normal Delivery and Caesarean section	1.2 million	1 million	N/A	N/A
Funeral	1.5 million	1.2 million	0.8 million	0.8 million
Personal accident	8 million	8 million	8 million	8 million

HIV AND AIDS COVERAGE		
HIV services	Yes	Treatment for opportunistic infections related to HIV and AIDS become part of the benefits package only beginning in year 2 of coverage. HIV services covered include counseling and testing, investigation. ARVs or HIV-specific laboratory services are not covered.
Treatment	Yes	
Diagnostics	Yes	
Counselling	Yes	

AAR Health Insurance Company

Company Narrative: AAR is a multinational private health insurance company founded in 1984, operating in Kenya, Tanzania Uganda, and Zambia. In Tanzania, AAR has offices in Dar es Salaam, Arusha, and Mwanza. Although AAR operates countrywide, most of its beneficiaries are urban-based. AAR is one of the largest insurance providers in Tanzania, holding 54 percent of the market share for private health insurance. The company offers a wide range of medical and non-medical insurance products tailored to three market segments, with coverage increasing depending on premium price. Most AAR clients are privates companies, corporates, and middle- and high income individuals purchasing their own voluntary insurance. HIV and AIDS service inclusion can be negotiated for (exclusive of ARVs), but are not part of AAR's basic health plans (AAR Insurance, n.d.).

AAR HEALTH INSURANCE COMPANY COMPANY PROFILE FY 2014	
Members	87,000*
Client Locations	Country Wide
Premiums Written	39.0 billion (TZS)
Claims Paid	24.0 billion (TZS)*
Premium Rate	1,166,550 (TZS)
Contribution	Variable
HIV Prevalence	Unknown
*AAR estimate	

BENEFITS PACKAGE [TZS]	GOLD	SILVER	BRONZE
Limit per year	50 million	30 million	8 million
Bed (up to limit)	Private Ward	Private Ward	General Ward
Inpatient benefits	Accidents, emergencies, intensive care and theatre costs, ancillary charges, prescribed medicine, surgery, internal prostheses, x-rays, MRI, and CT scans, ICU and critical care		
	Paid in full	Paid in full	Paid in full
Fees for physician, specialist, procedure, anesthetist	Customary and reasonable		
Dialysis	9 million	7.5 million	5 million
Chronic illness	0.5 million	0.3 million	0.2 million
Psychiatric treatment	2.5 million	2.25 million	2.25 million
Outpatient limit	1 million	0.8 million	0.6 million
Outpatient benefits	Primary consultations and treatment, medicines, x-rays, pathology, diagnostic tests, specialist fees, physiotherapy, radiology, radiotherapy and chemotherapy, oncology tests, MRI and CT scans, surgery, antenatal treatments and examinations, Post-hospitalization treatment Paid in full up to limit		
Maternity benefits	3 million	2.5 million	2 million
Optometry and dental	0.4 million	0.3 million	0.25 million
Funeral and rehabilitation	0.5 million	0.4 million	0.3 million

HIV AND AIDS COVERAGE		
HIV services	No	Coverage for treatment for opportunistic infections related to HIV and AIDS must be negotiated for on an individual basis by the customer and are not included under the basic health insurance packages. Higher rates will be charged for this additional coverage on a case by case basis.
Treatment	No	
Diagnostics	No	
Counselling	No	

Strategis Insurance Company

Company Narrative: Strategis is a private health insurance company founded in 2002 that aims to provide appropriate and affordable plans for employees and families delivered by an extensive provider network. In Tanzania, Strategis operates countrywide, holding a 16 percent share of the private health insurance market. Most of the company's beneficiaries are urban-based. The company offers benefits packages under five market segments ranging from very basic to top-end executive international covers. Plans have the flexibility to be customized to accommodate customers' unique requirements. The schemes do include some HIV services, but do not cover ARVs.

STRATEGIS INSURANCE COMPANY COMPANY PROFILE FY 2014	
Members	29,248*
Client Locations	Urban
Premiums Written	13.6 billion (TZS)
Claims Paid	5.5 billion (TZS)*
Premium Rate	2,167,917 (TZS)
Contribution	Variable
HIV Prevalence	Unknown
*Stategis estimate	

BENEFIT PACKAGE [USD]	PRESTIGE	SUPREME	EXECUTIVE	CLASSIC	PRIME
Limit per year	200,000	100,000	50,000	25,000	10,000
Bed (up to limit)	Private	Private	Private	Standard	Standard
Inpatient benefits	Specialist theatre ward, medicines, internal prostheses (subject to limit), MRI, CT scans, surgery Paid in full	Paid in full	Paid in full	Paid in full	Paid in full
Fees for physician, specialist, procedure, anesthetist	Customary and reasonable				
Chronic illness (cancer, organ transplant, dialysis)	37,500	25,000	15,000	10,000	7,500
Outpatient limit	1,250	1,000	600	450	300
Outpatient benefits	Primary consultations and treatment, medicines, radiology, pathology, Diagnostic tests and procedures, specialists Paid in full up to limit				
Maternity benefits	2,250	2,250	1,500	1,250	1,000
Neonatal care	15,000	12,500	10,000	7,500	2,500
Funeral	1,000	750	500	375	250
External medical appliances and physiotherapy	250	200	150	125	125
OPD chronic illness	500	500	250	250	250
Optical and dental	250	200	150	125	125
Repatriation of remains	2500	1500	1500	1000	N/A

HIV AND AIDS COVERAGE		
HIV services	Yes	Plans do offer treatment for opportunistic infections related to HIV and AIDS. HIV services covered include counseling, testing, and investigation. ARVs and HIV-specific laboratory services are not covered.
Treatment	Yes	
Diagnostics	Yes	
Counselling	Yes	

2.2 Government-Supported Insurance Schemes

National Health Insurance Fund

Provider Narrative: The NHIF is the largest formal sector scheme, and targets public sector employees. The NHIF was introduced in 1999 under NHIF Act No. 1. NHIF members mandatorily contribute 6 percent of their base salary. This contribution is equally shared between employees and employers, including the government (3% each). In recent years, the law has been amended to allow individuals and non-public companies to participate in the scheme. All government facilities are automatically accredited as NHIF providers. The NHIF reimburses services providers on a fee-for-service basis. The NHIF offers a comprehensive health package but this package does not include HIV and AIDS or any other services that are subsidized by government programs (NHIF, n.d.).

NATIONAL HEALTH INSURANCE FUND COMPANY PROFILE FY 2014/15	
Beneficiaries	3,338,755*
Client Locations	Country Wide
Premium Written	286.7 billion (TZS)
Claims Paid	156.7 billion (TZS)
Male to Female	50%/50%
Premium Rate	Variable
Contribution	3% / 3%
*as of January 1, 2016	

BENEFITS PACKAGE [TZS]	STANDARD BENEFITS
Limit per year	No limit for included services
Bed	Covers for daily admission costs per hospital fee schedule
Inpatient benefits	Medicines and medical supplies, investigations and diagnostic tests, surgical services, physiotherapy and rehabilitation, dental and oral services Paid in full up to limit
Fees for registration and consultation	Paid in full
Services offered through special permit	Cancer chemotherapy, immunosuppressant medicine for organ transplant patients, hemodialysis and erythropoietin for renal failure
Outpatient benefits	Medicines and medical supplies, investigations and diagnostic tests (including echocardiography, CT-scan, MRI), physiotherapy and rehabilitation, eye and optical services, dental services Paid in full for included services
Maternity benefits	Normal delivery, ultrasound
Retirees benefit	Comprehensive services offered to principle members and spouses
Medical/Orthopedic Appliances	Cane/crutches, neck and thoracic spine collars, hearing aids, lumbar cossets and braces

HIV AND AIDS COVERAGE		
HIV services	No	The NHIF does not offer any HIV and AIDS benefits under its scheme except treatment for opportunistic infections
Treatment	No	
Diagnostics	No	
Counselling	No	

Community Health Fund (CHF/TIKA)

Provider Narrative: Supervised by the NHIF, the CHF and TIKA are voluntary, community-based prepayment schemes under the district and municipal councils. The CHF scheme mainly targets the rural population and is managed at the council level, while the TIKA scheme is tailored for the urban, informal population. CHF contributions range from TZS 5,000–30,000 annually per household (with households assumed to comprise six members). TIKA has individual enrolment and premiums are typically higher than CHF premiums. Households voluntarily contribute the flat rate and the government provides a matching grant of the same amount. For FY 2014/15, TZS 1.9 billion in CHF matching funds were allocated, but only TZS 1.1 billion was disbursed. As a result of the accumulation of undisbursed funds in FY 2014/15, disbursed funds in FY 2015/16 exceeded the allocated amount. Premium amounts for CHF/TIKA are decided by the district authority after consultation with community members. Once they become members of the scheme, individuals can access health services without paying user fees at the point of service. Benefits packages under the CHF/TIKA differ across district councils but are typically limited and offer only primary healthcare at dispensaries and health centers (Mtei and Mulligan, 2007). When CHF members are in need of referral care, their only option is out-of-pocket payment. HIV and AIDS services are not included in the benefits package. The iCHF Kilimanjaro, a variant of this scheme supported by the Dutch nongovernmental organization (NGO) PharmAccess covers an additional 277,458 beneficiaries. iCHF Kilimanjaro offers slightly more under its benefits package, including service at some private facilities and more coverage for inpatient services.

COMMUNITY HEALTH FUND COMPANY PROFILE FY 2014 /15	
Beneficiaries	8,224,524*
Client Locations	Country Wide
Premium Written	13.5 billion (TZS)
Claims Paid	N/A
Male to Female	N/A
Premium (annual)	10,000 (TZS) (median)
*as of January 1, 2016	

BENEFITS PACKAGE [TZS]	STANDARD PACKAGE UP TO DISTRICT LEVEL
Limit per year	No limit for services determined by District Council in agreement
Bed	Covers for daily admission costs at health center level
Inpatient benefits	Consultation with clinical officer, dispensing and essential drugs, investigation
Fees for registration and consultation	Paid in full up to district hospital level
Outpatient limit	Determined by District Council
Outpatient benefits	Consultation, basic investigation, dispensing drugs and essential drugs
Maternity	Covered

HIV AND AIDS COVERAGE		
HIV services	No	The CHF/TIKA does not offer HIV and AIDS benefits under its scheme
Treatment	No	
Diagnostics	No	
Counselling	No	

Redesigned CHF—Dodoma Model

Provider Narrative: The Dodoma Model is a modified CHF in the Dodoma Region. The Dodoma Model is the result of a 2011 agreement between Tanzania and the Swiss Agency for Development and Cooperation to support development of an innovative CHF. The redesigned CHF is operating in seven districts in Dodoma and an agreement has been reached to extend the model to two other regions. The Dodoma Model's benefits package is similar to the CHF package. Modified features include access to services up to the district hospital level and member identification cards. The package includes outpatient, inpatient and maternity benefits up to district level. Enrolled households can seek free services at any of the 250 health facilities and hospitals in the Dodoma region. Unlike the CHF model, Dodoma Model benefits include some HIV services such as counseling, testing, and investigation.

DODOMA MODEL COMPANY PROFILE FY 2014/15	
Beneficiaries	166,002*
Client locations	Dodoma Region
Premium collected	533.3 million (TZS)
Claims paid	297.7 million (TZS)
Male to female	48% / 52%
Premium (annual)	15,000 (TZS)
HIV prevalence	2.9%
*as of January 1, 2016	

BENEFITS PACKAGE	LIMITED PACKAGE UP TO THE DISTRICT LEVEL
Limit per year (TZS)	No limit for services determined by District Council in agreement
Bed	Covers for daily admission costs up to the district level
Inpatient benefits	Consultation with clinical officer, dispensing and essential drugs, investigation
Fees for registration and consultation	Paid in full up to the district hospital level
Outpatient limit	Determined by District Council
Outpatient benefits	Consultation, basic investigation, dispensing drugs and essential drugs
Maternity	Covered

HIV AND AIDS COVERAGE		
HIV services	Yes	The Dodoma Model covers some HIV and AIDS services, including counseling, investigation, testing, and treatment of opportunistic infections.
Treatment	Yes	
Diagnostics	Yes	
Counselling	Yes	

Social Health Insurance Benefit

Provider Narrative: The SHIB is tailored for the formal sector to support the Tanzanian government's efforts to increase access to healthcare services. The SHIB mainly focuses on private employees, parastatals, and NGOs. SHIB services are offered to members of the National Social Security Fund (NSSF) as a benefits package. The SHIB is not a stand-alone health insurance scheme, but rather is one of seven benefits provided by the NSSF. NSSF members' contribution is 20 percent, which is mandatorily shared between the employee and employer. A portion of these collections is used to fund health insurance benefits for NSSF members. The network of SHIB providers is limited. Nationally, approximately 350 public and private service providers are individually contracted to provide services to SHIB beneficiaries.

The SHIB pays providers based on standard capitated fees (White et al. 2013). The benefits package does not include HIV and AIDS services because these services are offered by the Government of Tanzania (NSSF, n.d.).

SOCIAL HEALTH INSURANCE BENEFIT COMPANY PROFILE FY 2009/10	
Beneficiaries	205,500
Client Locations	Countrywide
Premium Collected	2 billion (TZS)
Claims Paid	1.43 billion (TZS)
Premium Rate	Variable
Contribution	10%/10%
HIV Prevalence	Unknown

BENEFITS PACKAGE	STANDARD BENEFIT OFFERED BASED ON CAPITATION
Bed	Covers for daily admission costs per hospital fee schedule based on capitation
Inpatient benefits	Consultation with clinical officer, specialist or consultant, basic and specialized investigation, minor and major surgeries, dispensing of drugs and essential drug list, dispensing drugs on discharge, referral to higher level special hospital
Fees for registration and consultation	Paid in full
Maternity	Covers medical treatment costs for ailments directly related to pregnancy
Outpatient limit	No limit for included services
Outpatient benefits	Consultation with clinical officer, specialist or consultant, basic and specialized investigation, minor surgical procedures, dispensing of drugs and essential drug list, referral to higher level special hospital Based on capitation

HIV AND AIDS COVERAGE		
HIV services	No	SHIB does not offer any HIV and AIDS benefits under its scheme
Treatment	No	
Diagnostics	No	
Counselling	No	

2.3 Micro-Insurance Schemes

EdgePoint - BimaAfya

Company Narrative: EdgePoint Company Ltd., based in Dar es Salaam and operating since 2012, is a digital integration company that creates mobile platforms that provide digital solutions to government agencies, service providers, enterprises, and individuals. EdgePoint's main product is mobile micro insurance known as BimaAfya, launched in 2015 in partnership with the private insurance company Jubilee. BimaAfya enables users to register, select coverage, and pay premiums for an insurance policy managed by Jubilee, as well as to access their benefits, all from their mobile phone. BimaAfya, like all EdgePoint products, is designed as an affordable solution for the informal sector that will increase financial inclusion for the low-income population. BimaAfya was built to eliminate 99 percent of insurance administration costs that hinder the creation of affordable policies. Once registered, users get a 10-digit number that they can use for customer validation, to access their policy benefits, and to pay claims to hospitals using mobile money platforms operated by telecom companies in Tanzania (Vodacom, Tigo, Airtel). The benefits package is still limited due to low contribution, but some HIV and AIDS services are included. EdgePoint generates income by keeping a percentage of the premium payment as revenue. The company is currently looking for commercial financing to scale up uptake of its micro-insurance product in Tanzania.

EDGEPOINT - BIMAAFYA COMPANY PROFILE FY 2014/15	
Members	6,700
Client Locations	Country Wide
Premium Written	N/A
Claims Paid	N/A
Male to Female	47%/53%
Premium Rate	35,000 (TZS)
Contribution	-
HIV Prevalence	Unknown

BENEFITS	IV	III	II	I
Coverage period	12 months	6 months	3 months	1 month
Premium per period	35,000	20,000	7,000	2,700
Total limit	140,000	115,000	65,000	60,000
Inpatient coverage	120,000	100,000	50,000	50,000
Outpatient coverage	20,000	15,000	15,000	10,000
Maternity coverage	20,000	15,000	N/A	N/A

HIV AND AIDS COVERAGE		
HIV services	Yes	Some HIV and AIDS services are included in the benefits package such as treatment for opportunistic infections, counseling and testing, investigation, and prevention of mother-to-child transmission (PMTCT) (consultation and testing, but not ARVs).
Treatment	Yes	
Diagnostics	Yes	
Counselling	Yes	

3. INSURERS' WILLINGNESS AND CAPACITY TO COVER HIV AND AIDS SERVICES

HPP interviewed executives from the eight insurance providers profiled above to get their opinions on the subject of providing coverage for HIV services as part of their benefits packages. Interviewees' responses are reported in the figures below. The numbers in the charts generally represent how many of the eight respondents concurred or disagreed with a statement.

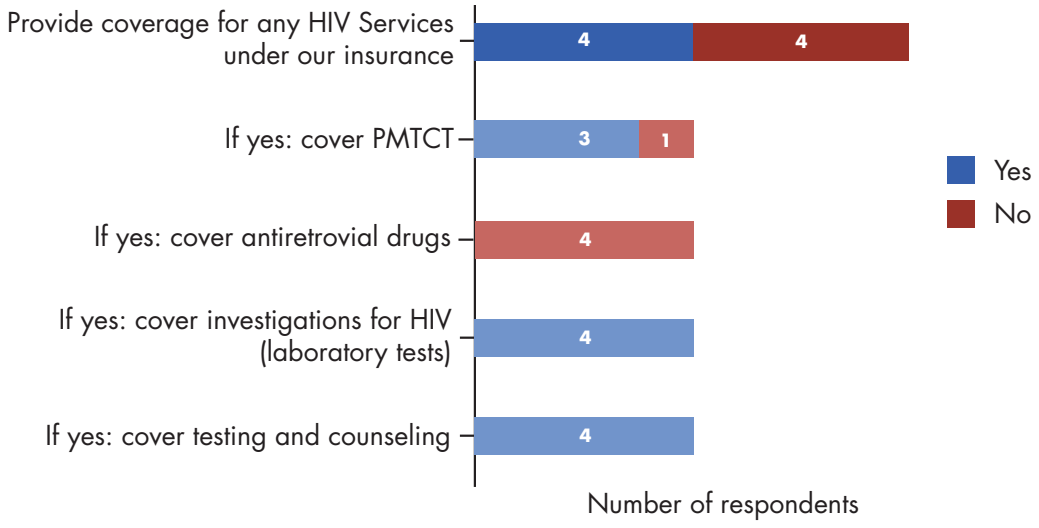
3.1 HIV and AIDS Coverage in Insurance

All of the private health insurance providers, one micro-insurance provider (EdgePoint), and one government-supported provider interviewed (the CHF-Dodoma model) offered HIV and AIDS services under their schemes. Although they recognize that HIV and AIDS services are provided for free in government facilities, these health insurance companies appear to offer HIV services in their packages (See Figure 4). Qualitative responses suggest a justification from a business standpoint based on public relations and maintaining customer satisfaction by providing clients with a wide range of possible health services. In this sample, none of the government supported schemes, which represent the vast majority of insurance beneficiaries in Tanzania, offer HIV and AIDS services. The only exception is the Dodoma Model—a modified version of the CHF, the rollout of which is being supported by an external donor (Swiss Agency for Development and Cooperation). Insurers that do cover HIV and AIDS services typically offer treatment for opportunistic infections related to HIV, HIV testing and counseling, investigation, and PMTCT, but do not cover the provision of ARVs. This suggests discordance, as PMTCT involves provision of ARVs. It may be possible that respondents considered testing for HIV in antenatal and maternity care as PMTCT, a possibility that was not further probed. AAR was the only provider interviewed that showed flexibility towards including ART services, but this added benefit must be negotiated under a customized scheme for an additional cost that was not disclosed.

3.2 How is HIV and AIDS Categorized by Insurance Providers?

Health insurance is typically purchased in low-income settings that have adverse selection bias to cover the risk of treatment for individualized and acute care conditions. Often, long-term treatment of chronic conditions is not covered by health insurers, or is identified as a pre-existing condition, which can lead to additional costs for insurance beneficiaries in the form of higher premiums. Insurers may aim to balance these issues actuarially to account for the certainty of persistent and repeated claims associated with chronic conditions. The MOHCDGEC categorizes HIV and AIDS as a communicable disease. Insurance companies seem to have followed this lead in their treatment of HIV and AIDS (See Figure 5). Interviewees' comments suggest that opportunistic infections in PLHIV are not regarded as HIV-related. Rather, these are categorized as other infectious diseases, enabling opportunistic infections to qualify for inclusion in health insurance benefits.

Figure 4: HIV and AIDS Coverage in Insurance Schemes Surveyed



3.3 Insurance Providers' Knowledge of the Health Insurance Landscape

Generally, there was limited knowledge of the contribution of health insurance to financing total health expenditure in Tanzania (See Figure 6). Those interviewees demonstrating knowledge of this issue perceived the contribution of insurance towards financing health to be much higher than what was actually reported in the country's most recent national health accounts (NHA). Knowledge about the contribution of health insurance to HIV-related expenditures (a contribution that is in fact low), was almost entirely missing among respondents. This suggests a misconception or general lack of awareness among insurers that may make advocating for inclusion of HIV and AIDS services in insurance schemes more challenging.

3.4 Rationale for Not Covering for HIV and AIDS Services

Public provision of HIV services:

One of the main reasons cited by insurance providers for excluding HIV and AIDS services from their benefits packages is that such services are provided for free by

Figure 5: Categorization of HIV and AIDS (N: number of respondents)

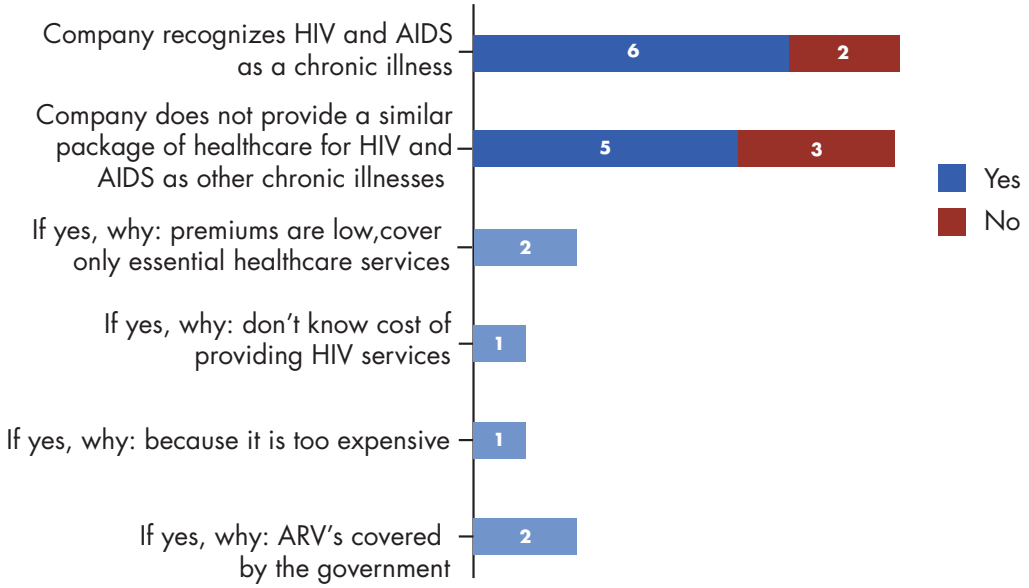
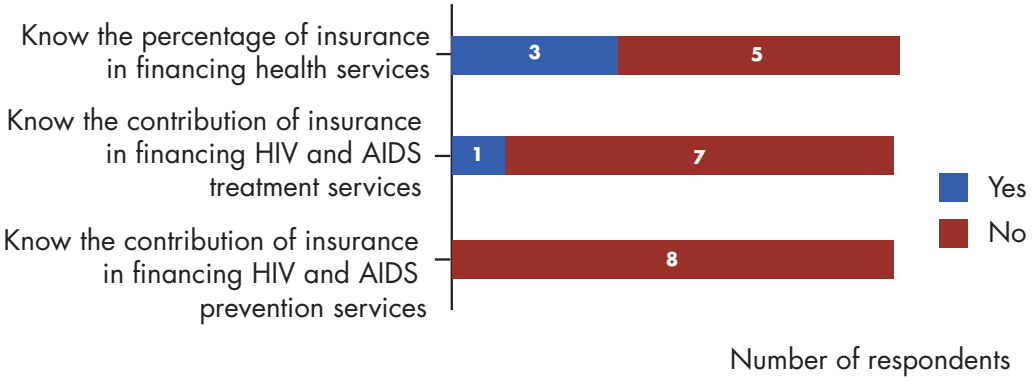


Figure 6: Knowledge of Insurance Landscape



the government (See Figure 7). From the perspective of insurance providers, this is a disincentive for including HIV services in their benefits packages. According to respondents, the health needs of HIV-positive beneficiaries are covered by the government *and there is no actual demand*—even for the opportunistic infection treatment that they do cover, which is also provided free of charge in the public health sector. Because the government is covering these services, insurance providers do not consider coverage for HIV and AIDS services to be a priority area, nor do they feel a sense of urgency to act to expand their benefit packages to include these services.

Premiums collected are not seen as sufficient to fund HIV services:

For schemes such as the CHF that cater to the informal sector and less wealthy households, the majority of whom live in rural areas, premium payments per household are minimal—around TZS 10,000 per year in most districts. Even with matching grants, the funds collected are insufficient for deep coverage. The related benefits package was designed to focus on the most essential healthcare services. HIV and AIDS care and treatment was considered to be outside this scope, even

Figure 7: Reasons for Not Including HIV and AIDS Services in the Benefits Package

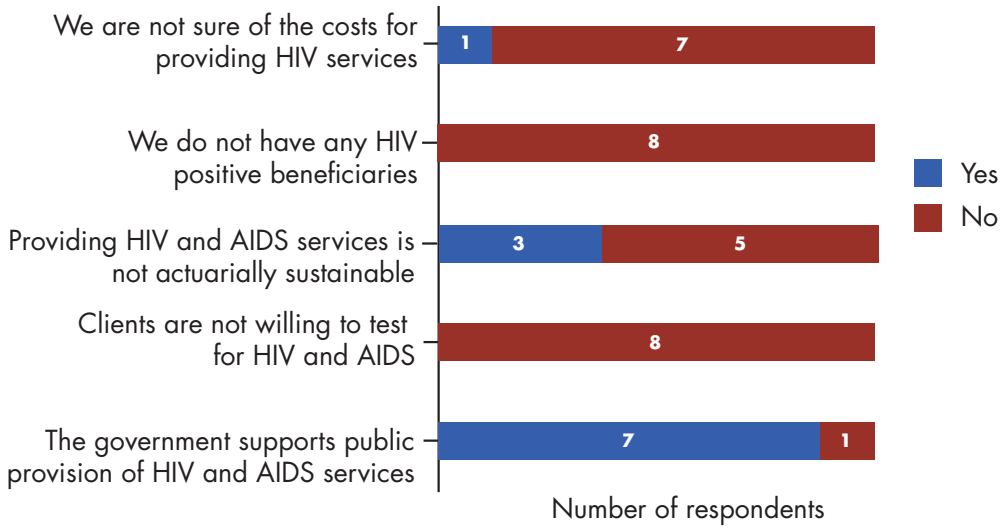


Figure 8: Willingness to Cover HIV and AIDS Services in the Future

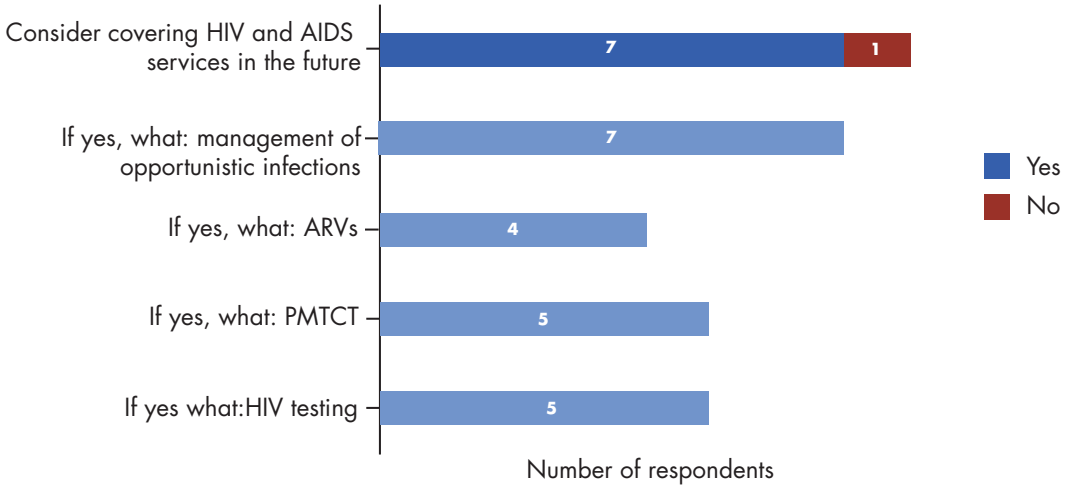


Figure 9: Enabling Factors That Would Help Increase Coverage of HIV and AIDS Services (N: number of respondents)

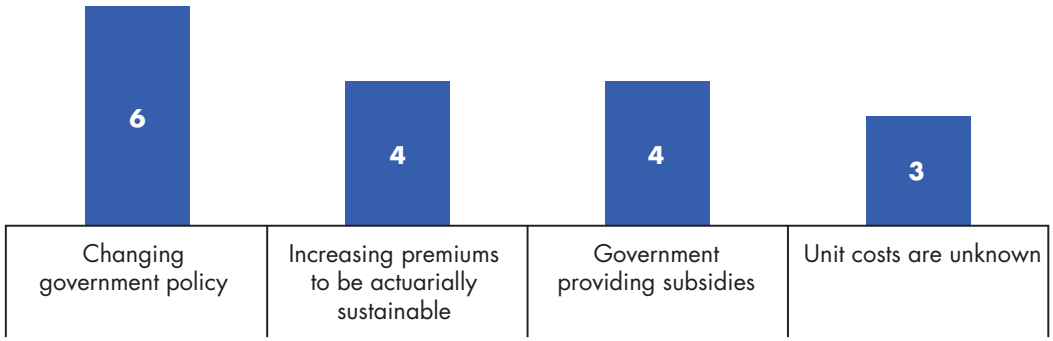
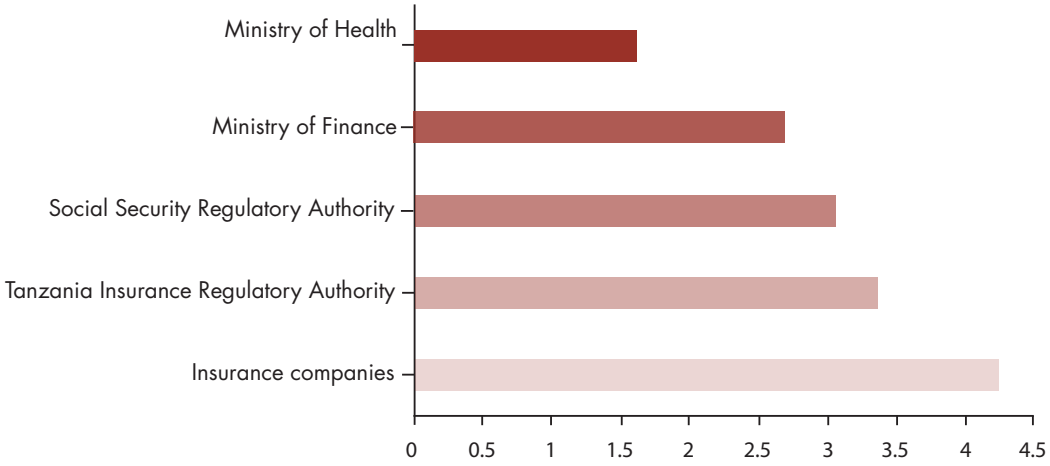


Figure 10: Stakeholders that Can Help Ensure HIV and AIDS Services are Included in Health Insurance *Average rank: 1 (highest) to 5 (lowest)*



though these services are part of Tanzania's national essential health care interventions package (NEHCIP).

Knowledge gaps on the cost of HIV services:

Interviewees' responses showed that there is a knowledge gap among insurers related to HIV services. Insurers lacked information and data on what claims might be generated for HIV services, the related liability to insurers, and even the underlying number of PLHIV in the scheme's membership pool. These information gaps make it difficult for insurers to assess the actuarial risk of including HIV services, which might help them adjust premiums across the risk pool for overall sustainability. Only one respondent had any substantive knowledge of the cost of HIV and AIDS services. The knowledge gap among insurers is related to perception of HIV-related services as the government's responsibility, and the belief that premiums are insufficient to fund HIV services. There was a general impression among respondents that costs per patient for HIV and AIDS services are high, but insurers were unable to quantify this. This uncertainty appears to have deterred some companies from including HIV in their benefit packages. Therefore, one response for policymakers may be to share information on the service provision costs of HIV-related services across a variety of provider settings and geographical zones to help inform actuarial and feasibility analyses as have occurred in other countries such as Vietnam. For example, AAR responded that HIV and AIDS care and treatment was too expensive to be covered by general health insurance schemes. Jubilee reported that its health insurance business in Tanzania was at best breaking even; it was often subsidized by other general insurance areas in the insurer's portfolio.

3.5 Insurers' Willingness to Cover HIV Services and Related Enablers

All stakeholders interviewed stated that they are willing to include HIV and AIDS services in their benefits packages in the future (See Figure 8). For such an initiative to move forward, respondents felt that there needed to be a policy change and perhaps provision of a government subsidy to private insurers for the costs and likely liabilities entailed in including HIV and AIDS services in their benefits packages (See Figure 9). Success would also depend on getting the information needed to ameliorate knowledge gaps related to the costs and long-term liabilities of providing HIV and AIDS services. Also, insurance providers, even those that do cover HIV and AIDS services, are not currently tracking HIV prevalence among their beneficiaries or annual claims paid for any included HIV and AIDS services, such as the treatment of opportunistic infections, or HIV testing. Anecdotal evidence provided suggests that sometimes claims for HIV-related services such as opportunistic infections are filed as "infectious disease care," and covered under the category of other diseases. Only the CHF's Dodoma model scheme had any knowledge of the prevalence rate among its beneficiaries, reporting that 2.9 percent of its clients were accessing HIV and AIDS care and treatment benefits each year. The lack of data creates additional challenges in estimating the effort, risk, and costs needed for insurers to effectively cover HIV and AIDS services for their clients

Respondents felt that it is important to have discussions among stakeholders and to discuss the advantages, disadvantages, and importance of including HIV and AIDS services in insurance schemes and how to achieve this. The MOHCDGEC and the Ministry of Finance and Planning were the stakeholders that respondents felt would be most important to involve in these discussions (Figure 10). Local government, NGOs, and the Association of Health Insurance Companies in Tanzania were also mentioned as other stakeholders to engage.

4. DISCUSSION AND CONCLUSION

4.1 Summary

Despite the fact that the Government of Tanzania has acknowledged HIV and AIDS as a high priority disease, current financing of HIV and AIDS services remains heavily donor dependent and is likely to remain so in the medium term. In addition, financing for HIV services from any form of insurance—which could otherwise be developed as a long-term sustainable financing solution—is nearly negligible. Tanzanian respondents interviewed for this report believe that the government must work with partners to encourage health insurance providers to get involved in financing HIV services. This can be achieved by improving their understanding of the demand for and costs of covering such services, and by having government provide input to insurers to support their efforts to design insurance products that accommodate the needs of PLHIV with an ability to pay.

On the demand side, which we did not cover in this report, findings from a recent survey in Kenya suggest that informal sector workers are aware of their health risks and the direct and indirect value of procuring health insurance, but lack clarity on what insurance terms they may be able secure (Gatome-Munyua et al., 2015). They have a general mistrust of private insurance companies and view the products offered as expensive and designed for wealthier groups. Informal sector workers interviewed indicated interest in affordable, comprehensive products with flexible payment options (Gatome-Munyua et al., 2015). This suggests there is a need to sensitize informal sector community members and change their perception of the health insurance market. There is also a need to sensitize PLHIV with an ability to pay on the possibility of accessing some HIV and AIDS services through insurance that can reimburse both public and private sector health providers.

In Tanzania, health insurance coverage is currently about 26 percent of the population, with most beneficiaries belonging to the government-supported schemes, especially the CHF/TIKA schemes, which already target the informal sector. Still, coverage in this population remains low due to several reasons, including lack of access to the CHF in certain districts, lack of knowledge among communities on the importance of health insurance, and poor quality of health services for those who are already insured, discouraging sign-up or renewals (White et al. 2013). Further data that segregates the insurance market in Tanzania was not currently available from local insurers. Given the correlation of wealth, education, and employment with HIV prevalence, there may be long-term opportunity for some PLHIV who are most able to pay to use insurance membership to access certain HIV services. However, a majority of Tanzanians work in the agricultural sector (66.3%) followed by other informal sector jobs (21.7%) (National Bureau of Statistics, 2014).

Only 7.9 percent work in the formal sector. Therefore, those more vulnerable (i.e., the uninsured) still represent the bulk of PLHIV by demographic logic. Health financing reform, discussed below, may offer a more comprehensive solution that can expand health insurance coverage among rural and informal sector groups, which would, by extension, benefit PLHIV. Current schemes catering to the informal sector mostly cover primary and low-complexity secondary healthcare, and largely exclude HIV services, highlighting a need to expand and deepen future benefit packages.

4.2 Future Directions

The effort to establish a single national health insurer is the long-term strategy proposed by the MOHCDGEC. This recognizes that currently risk pools in Tanzania are fragmented and health insurance schemes are regulated and promoted by two different authorities. The NHIF and NSSF-SHIB are regulated by the Social Security Regulatory Authority (SSRA), with the CHF under the NHIF and also under the jurisdiction of local government authorities. The private health insurance sector is regulated by the Tanzania Insurance Regulatory Authority (TIRA). These different regulatory bodies are operating with different visions and priorities. The SSRA focuses more on the effectiveness of a social safety net for the covered population, while the TIRA focuses more on the business environment and regulatory aspects of its member organizations and treats health insurance no differently than other insurance domains such as property or motor vehicle insurance. The lack of a uniform vision for what health insurance should cover and how it should protect Tanzanians from the financial impacts of ill health is a reason why, so far, the need to include vertical disease programs in insurance benefits packages has not been effectively articulated. These conflicting priorities and ongoing fragmentation make consolidation, in all its forms, an important step toward achieving Tanzania's goal of universal health coverage and more sustainable long-term financing for HIV and AIDS care and treatment.

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