The Essential Package of Health Services and Health Benefit Plans in Tanzania

About the health benefit plan crosswalk analysis

An Essential Package of Health Services (EPHS) is a broad policy statement that identifies the services that a government has prioritized. The government seeks to ensure that these essential services reach the population equitably. A health benefit plan (HBP) specifies an explicit set of services and the cost-sharing requirements for beneficiaries to access those services.

In 2015, the USAID-funded Health Finance and Governance (HFG) project completed a landscape analysis of the EPHS in the 24 USAID priority countries for Ending Preventable Child and Maternal Deaths (EPCMD).[1] The analysis found that the government in most of the countries intends for the public and/or private not-for-profit facilities in the country to deliver the services in the EPHS. It also showed that several governments were implementing major HBPs (such as social health insurance schemes) as a primary strategy for moving toward universal health coverage. Yet it remained unclear how the EPHSs and HBPs are formulated, how they are modified, and the extent to which they overlap.

HFG conducted a second landscape analysis in 2016 to identify existing HBPs in the countries, and the services they cover. It then did a crosswalk analysis – a mapping of items on one list to equivalent items on another list – of the services specified in the country's EPHS and those identified in an HBP. This companion analysis to the EPHS country snapshot documented the degree of alignment between the EPHS and HBP.

This brief presents HFG's findings and observations for policymakers and program managers seeking to promote alignment of services in the EPHS with services covered in the HBP and move toward universal health coverage.

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Photo: Two boys eat lunch together at a Morogoro village in Tanzania.
Credit: © 2013 Jennifer Applegate, Courtesy of Photoshare

[1] See HFG's series of country snapshots on EPHS here: https://www.hfgproject.org/ephs-epcmd-country-snapshots-series/

Health benefit plans in Tanzania

National Health Insurance Fund

The National Health Insurance Fund (NHIF) was introduced by the Ministry of Health and Social Welfare (MOHSW) in 2001.

The NHIF is funded by contributions paid jointly by employees and their employers, income generated from investments of the Fund, donations and grants in aid, fines and penalties payable, and funds appropriated by Parliament. The NHIF maintains a single, nationwide risk pool. The scheme covers civil servants and formal sector employees. Membership is mandatory for public sector employees and exemptions from paying premiums are made for the poor and vulnerable populations like people over the age of 60, people living with disability, and children.

NHIF members can seek health care at both public and private facilities at all levels, primary to tertiary. Eighty percent of network providers are government facilities, which include referral, regional, and district hospitals, health centers, dispensaries, pharmacies, and accredited drug dispensing outlets (ADDOs). Private health centers and dispensaries are also members of the NHIF network. Providers can apply to become a part of the NHIF network and applicants go through a rigorous accreditation process.[2] Providers generally are paid on a fee-for-service basis with a daily rate for select facilities, but the NHIF plans to introduce capitation payments for primary-level facilities in the future (Humba 2011). Although 80 percent of accredited facilities are government facilities, only about 44 percent of claims come from these facilities This could be because most NHIF members live in urban areas where many participating facilities are private (White et al., 2013). At the end of 2015 the NHIF had 3.2 million beneficiaries (6 percent of Tanzanians) (NHIF web 2015).

The MOHSW has expressed its commitment to achieve universal health coverage by initiating activities to increase population coverage of the social health insurance (MOHSW 2009).

Beneficiaries are entitled to the following benefits at all health service providers under contract with the NHIF.

- Registration and consultation fees
- Outpatient services: includes medicines and medical consumables.
- Investigation and diagnostic tests: includes investigations and diagnostic tests as per the Investigation List in the benefits package. There are more than 321 covered investigations including ultrasound, echocardiography, CT-scan, and MRI.
- Surgery: minor, major, specialized, and super-specialized surgical services
- Inpatient services: includes daily accommodation, investigations, medicines, and medical consumables dispensed while the member is admitted.
- Physiotherapy and rehabilitation services (inpatient and outpatient)
- Ophthalmology and optometry: includes one pair of corrective spectacles every three years for the principal member.
- Dental services: includes dental conservation procedures (fillings for caries), treatment of gum diseases, dental extractions, and root canal treatment.
- Medical/orthopedic appliances: supportive orthopedic and medical appliances including white canes for blind people, neck and thoracic spine collars, hearing aids, lumbar corsets and braces, walking crutches, and leg (ankle, knee, and above-knee) orthopedic supports (NHIF 2015).

The HFG team did not identify a detailed list of services covered by this scheme and therefore could not perform a corresponding crosswalk analysis. It is noteworthy that reproductive, maternal, newborn, and child health services were not explicitly listed but these services could fall under outpatient and inpatient service categories.

In 2009, the NHIF took over administration of the Community Health Fund (CHF) described below. However, the NHIF and the CHF operate in parallel; there is no cost sharing across the schemes (Chomi et al. 2014).

Social Health Insurance Benefit

The Social Health Insurance Benefit (SHIB) scheme was established in 2006 by the National Social Security Fund (NSSF) under the Ministry of Labor and Employment. It is overseen by the Social Security Regulatory Authority. Health insurance is one of the seven benefits the NSSF offers (White et al. 2013).

[2] See NHIF accreditation process here: *http://www.nhif.or.tz/index.php/accreditation/accreditation-procedure*

The SHIB is financed by NSSF contributions paid jointly by the employee and his/her employer. Membership is mandatory for all NSSF contributors who must register individually with SHIB to access benefits.

The SHIB seeks to empanel providers based on member preferences and contracts about 350 public and private service providers nationally. To be empaneled, providers must be accredited based on guidelines set by the MOHSW. All providers are paid on a capitation[3] basis. An urban hospital or specialized rural hospital is paid Tsh 36,000 (US$17) per capita and a rural hospital is paid Tsh 22,000 (US$10) per capita (White et al. 2013).

There is a three-month waiting period before a member can use SHIB benefits. The services covered are listed below:

Outpatient services:

- Consultations with clinical/medical officer, specialists, or consultants
- Basic and specialized investigations
- Minor surgical procedures
- Drugs in the Essential Drug List
- Referral to higher levels and special hospitals

Inpatient services:

- Accommodation
- Consultations with clinical/medical officer, specialists, or consultants
- Basic and specialized investigations
- Minor and major surgeries
- Drugs in the Essential Drug List
- Referral to higher levels and special hospitals

The following medical services are not covered by SHIB:

- Diseases or services covered under maternity benefits
- Free services/treatment provided by the Government such as immunization, tuberculosis and leprosy, cancer, HIV/AIDS, epidemics, mental illness, and diabetes mellitus
- Injuries where a third party is involved, such as a road accident where the vehicle is covered by vehicle insurance
- Cosmetics and cosmetic surgery
- Services/treatment for self-inflicted diseases/injuries like alcohol, drug, and tobacco abuse, attempted suicide, and criminal abortion
- Physiotherapy services at home
- Psychiatric diseases, except during an episode of acute illness within 7 day of care
- Medical examination for employment, school, and travel purposes
- Treatment due to diseases/condition arising from participating in an experimental study (therapeutic trials)
- Expensive specialized investigative procedures like MRI and DNA typing
- Services/treatment for injuries/conditions arising from active participation in riots, demonstration, unrest, and civil strife[4]

Community-Based Health Insurance: Community Health Fund and Tibakwakadi

The CHF was established in 1996 under the supervision of the MOHSW as a pilot scheme in Iguna district; the pilot scheme later became the model for nationwide coverage of the rural population. As mentioned above, in 2009 the NHIF assumed the supervision of the CHF and *Tibakwakadi* (TIKA) (White et al. 2013). The CHF covers rural populations at the district level; TIKA is the urban scheme equivalent. The two are similar in design and both are for the informal sector (Chomi et al. 2014).

Membership is voluntary; household residents in the districts where the CHF or TIKA operates are eligible to enroll. Premiums are set per household based on income. The government matches the household contributions one-for-one. Services are free for members at dispensaries, health centers, and select district hospitals (White et al. 2013). Households can select a public, private for-profit, or private not-for-profit provider from a network of available dispensaries. Premium exemptions are made for vulnerable groups. At the end of 2015 CHF had 6.7 million beneficiaries (12% of Tanzanians) (NHIF web 2015).

The CHF maintains multiple risk pools and cost sharing is restricted to the district. Premiums are collected from members at health facilities and are deposited in a CHF account. A percentage of these funds go back to the health facility to pay for commodities and maintenance. Council Health Service Boards provides institutional oversight at the district level and ensure accountability between health care providers and communities (Macha et al. 2014).

[3] Providers receive a fixed amount per enrolled member per defined period

[4] See SHIB benefits here: *https://www.nssf.or.tz/index.php/benefits/english/social-health-insurance*



About HFG:

A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a six-year (2012-2018), $209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.

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