REGULATION OF PRIVATE HEALTH INSURANCE: OPERATION AND ITS OUTCOMES ON ENROLLMENT AND HEALTH SERVICES UTILIZATION OF BENEFICIARIES IN DAR ES SALAAM

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By

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A Dissertation submitted in Partial Fulfillment of the requirements for the Degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences

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July, 2010

CERTIFICATION

The undersigned certifies that he has read and hereby recommends for submission a dissertation entitled: **"Regulation of Private Health Insurance: Operation and its outcomes on enrollment and health services utilization of beneficiaries in Dar es Salaam"** in partial fulfillment of the requirements for the degree of Master of Public Health of the Muhimbili University of Health and Allied Sciences.

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(Supervisor)

Date: 09/11/2010

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I, **Flora Minja,** declare that this dissertation is my original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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My endless gratitude goes to my family who despite missing my attention during the busy time of my course gave me continuous support. The accomplishment of this study involved many other individuals who may not have been mentioned here, to you all, I say "Thank you".

DEDICATION

This work is dedicated to my beloved husband George and our son Sean.

I also dedicate it to my parents Drs Fredrick and Liana Minja for their continuous support throughout my life.

ABSTRACT

Regulation is often seen as a potential solution to addressing the many problems which take place in the private production, financing and delivery of health services. For Private Health Insurance (PHI) markets to be able to meet public health objectives of equity, affordability and universal access to healthcare, and avoid insurance adverse effects of moral hazard, adverse selection and risk selection, their regulation needs to be effective (Al-Khatib, 2007).

In this context, this study was conducted to explore the effectiveness of the existing regulatory framework of the PHI market and its outcomes in terms of succeeding to avert risk selection, adverse selection and moral hazard. Consumers' involvement in regulation of the PHI market in Dar es Salaam was also explored.

A cross-sectional analytical study using both qualitative and quantitative methods was conducted with 200 beneficiaries and seven representatives from both the regulatory authority and five private health insurance companies being interviewed. Information on how the PHI market operates with the existing regulatory framework and factors affecting effectiveness was obtained.

The results indicated that regulation of the PHI market was done by the Tanzania Insurance Regulatory Authority in the same way as for other insurance markets with no regulations specific to health insurance. Apart from licensing and finances, there were no regulations on coverage, enrollment, premiums, benefit packages or provider payment mechanisms. The capacity of the authority to regulate the PHI market was found to be low in terms of lack of sufficient resources including personnel and expertise. Risk selection, adverse selection and moral hazard were

found to be practiced in the market and consumer involvement in regulation was found to be low.

The findings provide information that may be used to guide regulators and policymakers on issues that require regulation in the existing PHI market in order to attain equity, affordability and increase access to healthcare. Further studies on how to involve consumers' more in regulations are also required to ensure they are adequately protected.

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LIST OF ABBREVIATIONS

ISD…….. .Insurance Supervisory Department

MUHAS……...Muhimbili University of Health and Allied Sciences

NHIF…….National Health Insurance Fund

PI……...Principal Investigator

PHI……....Private Health Insurance

RA…….Research Assistant

SPSS…….Statistical Package for Social Sciences

TIRA…… Tanzania Insurance Regulatory Authority

AAR…….African Air Rescue

DEFINITION OF OPERATIONAL TERMS

Universal access to health care - Is the situation where the whole population of a country has access to good quality health services according to needs and preferences, regardless of income level, social statues or residency.

Insurance Regulatory framework - Connotes laws, rules or guidelines through which governments control the practice of insurance markets. In this case, the Insurance act of Tanzania incorporates the laws and guidelines governing the PHI market and the healthcare delivery provided by PHI.

PHI regulatory tools - These are the instruments that are used to evaluate that the PHI market is adhering to the rules/laws in place. These include guidelines, human and financial resources, inspection guidelines, infrastructure and extent of authority regulations.

Frequency of regulation – In this study, frequency refers to the number of times actual checking is done to see whether the PHI industry is adhering to the laws in place.

Adherence to regulations - This refers to PHI companies abiding by laws, regulations or guidelines in the process of providing health insurance services

Beneficiary - Refers to the person who receives benefits from a benefactor. In this study, beneficiaries are the employees of the institutions and organizations who are insured by the PHI companies and are the end users or recipients of the healthcare benefits, and the benefactor is the PHI companies.

Effectiveness of regulation – In the context of this study, effectiveness of regulation refers to the extent to which the regulations are able to control and/or hinder the adverse outcomes of the PHI activities/operations.

Outcomes of regulation – In this study, this refers to the level to which regulations are is able to avoid the adverse effects of insurance. These adverse effects of insurance include moral hazard, adverse selection, cream skimming and raising healthcare costs.

Moral hazard - Refers to the tendency for insured individuals to use more services than if they were not insured. It occurs when the behavior of the insured person changes since s/he no longer bears the full costs of that behavior, and hence the insured individual has motivation to ask for more services or pricier services that s/he does not require.

Risk selection or "cream skimming" - In this study is said to occur when insurers try to maximize profit by discouraging unhealthy individuals from purchasing insurance or by finding ways to insure only those low risk or healthy individuals.

Adverse selection – In the context of this study is said to occur when insurers have less information about an individuals' health than the individual themselves. The individual who wishes to apply for insurance generally knows more about the extent and nature of the risk that s/he faces than does the insurer and is more likely to secure insurance if that risk is perceived to be greater than normal. This leads to the insurance company enrolling more high risk individuals and raising prices of premiums.

CHAPTER ONE

INTRODUCTION

1.1 Background

Health care financing remains a significant challenge in most developing countries. With an increasing role in financing health care, private health insurance (PHI) is emerging and receiving increasing attention especially in developing countries around the world where other alternatives of health financing mechanisms have not efficiently accommodated people who could afford private health expenditure. However, it is apparent that leaving health care to a free market mechanism does not lead to an efficient health system. Incomplete consumer information, market distortions and supplier-induced demand and other factors in the insurance market lead to inefficiency and cost escalation (Teerawattananon et al 2003, Al Khatib 2007).

In many parts of the world, PHI has been noted as one of the important mechanisms of health funding, contributing more than 20% of total health spending in countries like Brazil, Chile, Namibia, the United States of America, Uruguay, South Africa and Zimbabwe (Sekhri and Savedoff, 2005). These countries include developed and developing nations thus indicating that PHI can become significant financing mechanism even in developing countries. Nevertheless, when not properly regulated, irrespective of whether it is a developed or developing country, evidence has revealed that some features may emerge including moral hazard, adverse selection, risk selection (cream skimming) by insurers and supplier induced demand of health care services (Al-Khatib, 2007), which may lead to escalating costs of healthcare and eventually result in inaccessibility of health care among users. Countries with well developed PHI markets have had

to continuously adapt their regulatory mechanisms where they found them inadequate to deal with the issues impeding universal access to good quality healthcare (Colombo and Tapay, 2003; Soderlund and Hansl, 1999). This suggests the importance of having an effective regulatory framework from the introduction of the health insurance market.

Insurance regulation refers to the laws, rules or guidelines through which governments control the practice of insurance markets (Daniels, 2008). In the PHI context, regulation is considered to be happening when the government deliberately tries to influence the activities of individuals or actors in the market by manipulating variables such as price, quantity and quality (Kumaranayake, 1998). Generally the goal of regulation should be to protect consumers and to promote the public interest (Skipper Jr and Klein, 1999). For PHI, the objective of regulation is usually to achieve the public health objectives of equity, affordability and access to health care services by all individuals and to protect the consumers from adverse effect (including risk selection or "cream skimming", adverse selection and moral hazard) which may arise in the insurance market (Feldman, Escribano and Pellise, 1998). Thus, it has been said that if PHI is to meet public healthcare objectives, it needs to enhance the efficiency of health provision while providing fair and comprehensive cover (Soderlund and Hansl, 1999).

In Tanzania, healthcare delivery was the responsibility of the government during the time from independence in 1961 to the mid 1980's while the country was practicing a variant of the social economy. At this time healthcare services were provided free of charge for all individuals at the point of use and private health care was banned. During the late 1980's and early 1990's it was observed that the government was not able to finance and provide enough quantity and adequate quality of health care services.

In an attempt to deal with the crisis, health sector reforms were introduced in 1993. These resulted in introduction of user fees, decentralization of services and the government lifted the ban on the private sector in health care delivery. The private sector started being looked at positively as a partner to the government in providing health care and in the broader context of health sector reforms, private health sector activity increased significantly (United Republic of Tanzania, 1994, Kumaranayake et al, 2000). The rapid increase in private health sector activity supported the introduction of private health insurance markets (Sekhri and Savedoff, 2005). And as a consequence, in Tanzania, PHI grew as a response to the rapidly increasing private health care facilities following the health sector reforms in 1993 and trade liberalization that also happened around the same time.

Also as a response to the economic liberalization policy, the entire insurance market grew leading to the parliament introducing the Insurance Act of 1996. This act was put in place to govern the activities of the insurance market in general and was overseen by the Insurance Supervisory Department (ISD) until late 2009 when the Insurance Act of 2009 was introduced. In line with the act, an autonomous authority, the Tanzania Insurance Regulatory Authority (TIRA) was created to supervise the insurance market.

The PHI industry in Tanzania, like in other countries, if not regulated would lead to adverse effects like risk selection, adverse selection and moral hazard and ultimately increasing cost of health care. Regulation of insurance in Africa is mainly through various domestic legislations creating regulatory authorities/agencies to superintend insurance businesses (Daniels, 2008), and regulations of PHI market by the government largely differ between countries based on their requirements. The regulation requirements depend on three main issues, the development stage

of the country, the size of the PHI industry and government's institutional capacity in implementing the regulation (Kumaranayake et al, 2000).

Effectiveness and ineffectiveness of regulation depends on the extent to which regulations are able to hinder the adverse outcomes of the PHI market activities. Studies in countries with advanced PHI markets have shown that if the market is not effectively regulated, it will work to maximize profit and be characterized by risk selection, adverse selection, moral hazard and other insurance adverse effects (Colombo and Tapay, 2003; Soderlund and Hansl, 1999). Few studies have been done in Tanzania on the PHI market; however one study that noted the PHI industry was in the infancy stage and growing also indicated emerging elements of insurance adverse effects in the market and found a gap in knowledge regarding the regulation of the PHI market in Tanzania (Mahamba 2009).

Consequently, in response to this gap this study explored the existing PHI regulatory framework and its effectiveness on enrollment and recruitment in terms of presence or absence of the adverse outcomes of PHI markets. These adverse outcomes of interest are risk selection, adverse selection and moral hazard.

1.2 Problem Statement

Regulation of the private health insurance industry has been recognized as a necessity even in the countries that have well developed private health insurance markets such as USA and Latin America. Health economics theories indicate market failure characteristics in the healthcare markets including private health insurance. This has been confirmed by studies which indicate

that without effective government intervention, PHI markets will not be able to efficiently match supply to demand (Lee and Mills, 1985).

Sekhri and Savedoff (2005) have shown that ineffective regulation of private health insurance can lead to the private health insurance market to operate with the objective of maximizing profits instead of increasing access to healthcare. In order for regulations to be effective, they need to be established either before a market is introduced or as early as possible after introduction as it may become difficult to implement once it is well established. In South Africa, reregulation of the private health insurance industry had to be done in 2000 following initial deregulation, due to findings that medical schemes operations were leading to increasing health inequalities (Soderlund and Hansl, 2000). Unregulated health insurance markets lead to unwanted insurance outcomes such as risk and adverse selection, moral hazard and escalating health care costs (Al-Khatib, 2007). Mahamba (2009) found that in Tanzania the private health insurance market was still in its infancy stage, but growing significantly, also with a potential of the health insurance market effects mentioned above.

Since the introduction of the private health insurance industry in Tanzania, regulation of the private health insurance market has been done using the General Insurance Act as a guide; there is however, no specific regulatory act for the PHI market to regulate the industry. Until the end of 2009, the 1996 Insurance Act was used for regulating both the health and the non health insurance markets. The Act mainly addressed the issues of entry into the market and company solvency, but there are no specified areas that address how to prevent the adverse outcomes of PHI market operations that may occur in the process of providing the service. In 2009, the 1996 Act was revised and a new Insurance Act was introduced. In spite of the revision, the new act

still does not include regulations that are specific to the health insurance industry. This implies that it does not address the adverse features of the health insurance industry that may arise due to ineffective regulation of the health insurance market. Because the private sector is known to be working with the aim of maximizing profit, it would be possible that the private health insurance industry may also be functioning with the aim of maximizing profit and therefore producing the features of the known insurance evils; risk selection, cream skimming, adverse selection and moral hazard leading to increasing costs of health care.

Furthermore, while most of the private healthcare providers in Tanzania like privately owned hospitals, health laboratories and pharmacies each have specific regulations governing their activities; the private health insurance market does not have any specific regulations dedicated entirely to governing it.

Studies on regulating private health care providers like pharmacies and private hospitals and clinics have been done in Tanzania (Kumaranayake et al, 2000; Mujinja et al, 2000). Although privately owned pharmacies have specific regulations, studies have shown that the regulation is ineffective (Kumaranayake et al, 2000, Mujinja et al 2000). However, little has been documented and information is lacking on the way the current regulatory framework of private health insurance in Tanzania operates and its effects on enrollment and health services utilization of beneficiaries.

The characteristics of the private health insurance industry of risk selection, moral hazard and adverse selection found by Mahamba (2009) could therefore be either due to deficiencies in the regulatory framework currently being used or to the private health insurance industry working to

maximize profits. Knowledge on how the existing regulatory framework of PHI influences these characteristics is important to guide the regulators on how to address the unwanted outcomes.

This study intended to find out how the present regulatory framework of PHI works in Tanzania and its outcomes specifically addressing its effects on healthcare utilization and enrollment of members, and whether the absence of a clear regulatory framework specific to the PHI industry could be hindering the attainment of the public health objectives of universal health care.

1.3 Rationale

It is known that effective regulation of PHI increases access to healthcare by increasing the number of people covered and reducing out of pocket payment (Sekhri & Savedoff, 2007). It is argued that currently the private health insurance market in Tanzania is operating with characteristics that are contrary to the objectives of health financing mechanisms desired by the government of improving healthcare provision to all.

Thus, these study findings may be used to:

- Add on knowledge on how the private health insurance market operates with the existing regulatory framework
- Highlight how the PHI market acts either in line with or against the regulations
- Generate information to inform regulators and policymakers on the strength/weakness of the existing regulatory framework in terms of the outcomes in attaining the goal of increasing access to healthcare

1.4 Research Questions

1. How is regulation of PHI being done in Tanzania?

2. How are consumers involved in regulation of PHI companies in Dar es Salaam?

3. What is the "effectiveness" of the existing PHI regulatory framework in Tanzania?

4. What are the outcomes of the existing PHI regulatory framework on enrollment/recruitment of members and healthcare utilization among PHI beneficiaries in Dar es Salaam?

1.5 Objectives

1.5.1 Broad Objective

The broad objective was to assess how regulation of private health insurance is done by the existing regulatory framework and its outcomes on recruitment, enrollment and health services utilization of beneficiaries in Dar es Salaam.

1.5.2 Specific Objectives

1. To document what is being regulated in the PHI system by the existing regulatory framework in Tanzania.

2. To examine the tools used and frequency of regulation of the PHI industry in Tanzania.

3. To explore the adherence of the PHI companies to the current regulations governing the activities of the PHI market in Dar es Salaam.

4. To explore the beneficiaries' understanding on PHI regulation in Dar es Salaam.

5. To find out the outcomes/effects of the existing PHI regulatory framework on recruitment, enrollment and healthcare utilization of PHI beneficiaries in Dar es Salaam.

CHAPTER TWO

LITERATURE REVIEW

2.1 Private Health Insurance and the role of regulation

Achievement of adequate health care financing mechanisms to attain universal financial coverage of healthcare services is one of the major issues facing countries worldwide. Health insurance is playing an increasing health financing role in both developed and developing countries (Sekhri and Savedoff, 2005). The essential purpose of health insurance is to provide "access to care with financial risk protection"(Kutzin, 2001). Generally the risks (which in the case of health insurance are medical expenses) are shared by many people thus providing protection against a possible event (Lee and Mills, 1985). This mechanism applies to both privately and publicly funded insurance mechanisms and usually entails paying of premiums to a health insurance entity in return for compensation of medical expenses that will be incurred for illnesses which could occur in future and lead to financial loss by insured members. It involves the collection of funds, pooling of funds and purchasing of services (Sekhri and Savedoff, 2005).

As health is considered a public good, it is usually preferred that healthcare be provided by public systems (governments). However, due to the public system being overburdened and unable to deliver, people have had no option but to pay for health care out of pocket. Literature indicates up to 60% of healthcare in Africa being paid by patients out of pocket, causing many to fall into the poverty trap (WHO, World Health Report 2006) thus indicating a need for financial mechanisms that reduce out of pocket payment like private health insurance. Increasingly, however, experience with the private sector has indicated a number of problems with the quality,

price and distribution of private health services and thus led to a growing focus on the role of government in regulation (Kumaranayake et al 2000). This implies that the private sector and specifically PHI cannot be ignored as a financing mechanism, but instead can be harnessed to serve the public interest if governments implement effective regulations and rules (Drechsler and Jutting, 2005). The World Bank's 1993 World Development Report in health noted that PHI regulation is key in achieving universal healthcare:

"Strong government regulation is also crucial, including regulation of privately delivered health insurance to encourage universal access to coverage and to discourage [perverse] practices that lead to overuse of services and escalation of costs." (World Bank, 1993).

In private health insurance the financial resources are channeled directly to the risk-pooling institution with no or relatively little involvement of the government (Drechsler and Jutting, 2005). It is thus argued that due to this the PHI market is subject to a significant number of market failures because of the fact that PHI companies have their own objectives and are believed to be working with the aim of maximizing profits rather than serve the publics' interest (Colombo and Tapay, 2003; Soderlund and Hansl, 2000). Studies reveal that in un-regulated market, PHI companies tend to have strategies which are profit-maximizing in nature (Drechsler and Jutting, 2005; Kumaranayake *et al*, 2000; Hongoro and Kumaranayake, 2000). Given the nature of health as a partially public good, private health insurance therefore, requires an efficient and effective institutional and regulatory framework to prevent market failures, protect consumers from dishonest insurers and ensure the public's interest in preserving the health of its citizens and possible policy objectives to address the unequal distribution of income and health risks (Roberts 2004; Sekhri and Savedoff, 2006).

Failure of governments to establish appropriate regulatory mechanisms have led to the PHI market operating mainly "for profit" as can be seen in some areas of Latin America where private health insurance is well established. Of note, Chile introduced the aspect of private health insurance in its health sector reforms in the early 1980's with the objective of increasing consumer choices and expanding private health services provision (Bertranou, 1999). It is however, being said to have established priority based on economic aspects instead of public health requirements, and due to poor regulation severe inequalities in health coverage have resulted, leading to citizens perceiving their health system as socially unjust (Host,Laaser and Hohmann, 2004). The formation of the ISAPREs an organization which run like a private health insurance led to adverse selection where better – off individuals were covered leaving the high risk, poor and elderly to be covered by the public service providers (Kumaranayake, 1998).

Review of literature indicates that active government intervention in the insurance market leads to the overlapping of features of the public and private insurance mechanisms and it has been documented that the difference between public and private health insurance is often overstated since well regulated PHI markets share many characteristics with public health insurance systems (Sekhri and Savedoff 2005) and as a result serve the public interest. For example, in Australia effects of the government intervention have been noted, where private health insurance plays a prominent role in the health care system and in private hospitals, insurance covers 44% of the population - one of the highest percentages of private coverage across OECD countries (Colombo and Tapay, 2003). This achievement is due to strict government regulations which has promoted equity of both access to and financing of private coverage resulting in overall increased coverage of PHI (Colombo and Tapay, 2003; Frech and Hopkins, 2002). Similar effects were noted where literature on PHI markets in Latin America revealed that the

government intervention on improving market performance increased the health care coverage in countries like Uruguay. However in Argentina, Brazil, Colombia and Peru severe inequalities in health care coverage were reported (Colombo and Tapay, 2004); this was mainly caused by incomplete establishment of regulatory framework governing PHI activities (Drechsler and Jutting, 2005).

South Africa is one of the few countries where private health insurance is relatively well established with up to 18% of the population being covered by medical schemes (Soderlund and Hansl, 2000). The deregulation of South African Mutual Health Insurers (Medical Schemes) in the period after 1985 was followed by re-regulation of risk-pooling by the South African government in the year 2000 following findings that the Medical Schemes were operating with characteristics of risk selection, adverse selection and premium cost escalation. All these were leading to increasing health inequalities thus underlining the need for appropriate effective regulation of the PHI market.

It can thus be concluded that effective regulation of the PHI market is a basis for achieving public interest and avoiding the market failures associated with the PHI market, which include risk selection, adverse selection and moral hazard.

2.2 Effective regulation of PHI

Different countries have different ways of regulating the healthcare sector. Based on the requirements, Nigenda et al, 1997 defined three different modes of regulation which are independent self regulation; state sanctioned self regulation and direct state regulation. The direct state regulation in PHI can take different approaches and literature has shown three basic

types of government regulatory mechanisms in insurance. One approach emphasizes competitive markets with minimal intrusion with respect to market forces and insurers' decisions. The second approach relies on more restrictive regulation of market forces and sheltering of private insurers from competition and the third is where countries assign the provision of insurance to the government (Skipper Jr. and Klein 1999). All these different approaches target multiple variables in the health sector in general and the PHI market also shares these variables that need to be addressed by regulation. The variables include market entry, market structure, competitive practices, remuneration or payment mechanisms and consumers' role in regulation (Nigenda et al, 1997, Kumaranayake and Lake, 1998; Teerawattananon et al, 2002).

Generally factors that have been documented as affecting the effectiveness of regulation include capacity and ability to regulate; power to enforce regulations; whether the regulatory authorities are decentralized and autonomous; whether the authorities are independent or operate under ministries; legislations matching the current practice; adherence to regulations and consumers knowledge of their rights and their involvement in regulations (Sekhri and Savedoff, 2006; Mujinja et al 1999).

While a substantial proportion of healthcare in low income countries is privately provided, government capacity to develop and enforce regulations effectively is often extremely limited (Kumaranayake et al, 2000). This can be attributed to the fact that many low income countries lack institutional capacity to design, establish and administer a strong regulatory framework and also regulatory activities are quite costly (Sekhri & Savedoff, 2006). Managing a private market has a cost, and in the context of scarce public resources, policy makers have to choose between

either investing in regulation or directly funding public programs to meet their policy objectives. "Private" does not mean "free" in terms of public resources and the choice of how regulation is done should be based on the benefits outweighing the cost (Sekhri and Savedoff, 2006).

Effective regulation is a complex and challenging process that requires a combination of technical expertise, administrative and legal capacity, and political support. Appropriate regulatory strategies and processes need to be developed and decisions made about what and how to regulate. Regulatory approaches that are preferred are those that can mobilize resources for healthcare, promote financial risk protection, protect consumers and reduce inequities (Roberts et al 2004; Sekhri and Savedoff, 2006). Daniels, 2008 documented that in most African countries direct state regulation utilizes various domestic legislations creating regulatory authorities/agencies to superintend insurance businesses. For example in Nigeria, the National Insurance Commission is the insurance regulatory body and in Tanzania, prior to 2009 it was the Insurance Supervisory Department. However since then an autonomous body, the Tanzania Insurance Regulatory Authority has been established which has the power to enforce regulations and to prosecute or punish insurance companies that do not adhere to regulations. Studies on health sector regulation in Tanzania and Zimbabwe found that much of the existing regulation occurs through legislation and focuses on individual inputs rather than health system organizations; aims to control entry and quality rather than quantity, price and distribution and fails to address the market level problems of anticompetitive practices and lack of consumer rights (Kumaranayake et al, 2000).

Kumaranayake (1998) summarized some reasons why regulation may be ineffective and they can be broadly grouped into the categories of capacity, information, self interest and context.

Capacity includes the quantity and quality of personnel to enforce regulations, regulatory tools, frequency of regulation/inspection, financial and other resources that are determined to some extent by the regulatory institutional context. With information, up to date and reliable information is necessary for regulation to be effective. In Chile, the weak regulatory capacity allowed private insurers to deny coverage to high-risk individuals (World Bank, 1993). While no study could be found specifically on the regulation of PHI in Tanzania, studies done on other healthcare markets like the pharmaceutical market found shortage of qualified staff, financial resources and transport required to carry out inspections was compounded by confusion among members of the regulatory body about who should carry out inspections and how often thus making regulation ineffective. Self interest of the pharmaceutical sector was another factor noted as leading to failure to adhere to known regulations, since the financial incentives (more profit) the pharmacy shops got from selling medicines without prescriptions and selling medicines that they were not allowed to sell led to the increasing lack of adherence and ultimately rendered regulations ineffective (Mujinja et al, 2000). The study by Mujinja et al (2000) found that in Tanzania, as in other developing countries, lack of capacity and ability to regulate might be major factors contributing to regulation being ineffective.

2.3 Outcomes of regulation

Desired outcomes of effective regulation of PHI include high coverage of the population on insurance schemes, equity and absence of PHI adverse effects of risk selection, adverse selection and moral hazard in the market. It has been found that in Tanzania, PHI is the only form of risk pooling mechanism available and provides coverage to those who are employed mainly in the private sectors (Mahamba, 2009). Risk selection and adverse selection occur mostly at the time

of enrollment while moral hazard is at the time of utilization of health services, thus regulations aimed at issues influencing recruitment, enrollment and health services utilization will help to attain desired outcomes.

2.3.1 Outcomes on enrollment of clients/beneficiaries

Studies indicate that PHI enrollment can be either voluntary or mandatory in nature depending on the regulations that are in place in that country, however, in most cases enrollment on PHI schemes is voluntary. In many developing countries especially in Africa, enrollment is usually voluntary (Daniels, 2008) however in other developing countries in Latin America, enrollment is mandatory (Drechsler and Jutting, 2005). For instance, Uruguay and Colombia require mandatory enrollment in PHI schemes, which has led to enhanced coverage than at the time when it was voluntary. With a long record of having regulated mandatory health insurance; Uruguay has managed to cover more than 60% of the population on PHI (Drechsler and Jutting, 2005; Sekhri and Savedoff, 2006). On the other hand, even in developed countries like Australia, PHI can also be mandatory where those who earn high incomes are mandated to purchase private health insurance (Colombo and Tapay, 2003). Nevertheless, studies have shown that having mandatory insurance does not mean there are no adverse effects, for instance, in Switzerland where enrollment is mandatory; risk selection is still evident in major insurers (Ven et al, 2007).

Trautwein (2002) found that in the United States of America (USA), regulations of PHI differ from one state to another, however generally they are very firm on issues that are regulated. Dependence is mainly on voluntary enrollment to PHI to provide coverage, and regulations instruct most of the PHI companies to provide community rating or disallow fully risk-rated

premiums. Individual coverage is also available with a selection of different plans, to allow people to select cover as per their needs (Trautwein, 2002). Despite being heavily regulated, the PHI markets in developed countries including the USA still have features of adverse selection and cream skimming (Ven et al, 2007; Trautwein, 2002).

2.3.2 Outcome of premiums regulation

Lately in Australia, regulations were implemented that required those with personal incomes more than US$ 30 000 or family income over US$ 60 000 per year to purchase private insurance. To encourage enrollment, the regulations banned insurers from risk rating premiums and directed them to implement open enrollment which compels insurers to accept all applicants with no discrimination. The Australian government also used another policy approach to encourage enrollment where a 30% tax refund is provided to those who purchase private insurance and introduction to a life time community rating plan where those who join after 30 years of age are supposed to pay a premium above the basic rates for each year they remain uninsured. This approach encourages individuals to enter the risk pool earlier and stay there (Colombo and Tapay, 2003). These reforms have increased PHI coverage by 15 % in a three years period (Frech and Hopkins, 2002; Colombo and Tapay, 2004) and reduced the chances of risk selection.

In countries where there is reduced or lack of regulation of PHI industry, usually the market would tend to have approaches especially during enrollment of members, which are profit maximizing in nature. These approaches were evident in a study done in South Africa that looked at the pattern of PHI coverage in respect to regulation. It was found that the country prior to 1989 had regulations of PHI where health insurers were obligated by law to community rate their premiums during enrollment, and were not allowed to leave out the high risk people

(termed 'medically uninsurables') from cover. This improved equity and coverage. However, when regulations were removed, the insurers risk rated the premiums to enrollees with higher premiums, and excluded individuals with easily identifiable high risk factors such as age and disability (Soderlund and Hansl, 2000). This necessitated the government to re-regulate the insurance industry so as to improve coverage of private health insurance (Soderlund and Hansl, 2000; Pauly et al, 2006). This study was indicates the significance and relevance of regulating the market right from the process of enrollment of customers to the point of utilization of health services. Similar observations apply even to countries with diversified PHI markets like Jordan, where lack of effective control mechanisms failed to restrain the effect of moral hazard and contributed to cost and premium escalation in the PHI market (Al-Khatib, 2007).

2.3.3 Outcomes on health services utilization

A study done in Tanzania by Mahamba (2009) indicated that all companies involved in private health insurance (PHI) provision in the country are for profit companies with most of their clients being employees of large and medium companies. His findings indicated that the PHI companies targeted the formally employed group for recruitment as potential members. He found that these companies intentionally targeted employees in private firms, embassies and NGO's who comparatively earn higher salaries/wages than those working in the public sector. He also found that the PHI companies had risk selection mechanisms where individuals who were young and healthy were recruited as observed in his study where 75% of enrolled consumers were less than 39 years of age. These strategies appear to be meant to maximize profit in insurance business. He also documented that consumers more than 55 years of age and those with pre-existing and chronic illnesses were denied coverage during enrollment or were required to pay

more than the normal premium. The study revealed some degree of moral hazard in utilizing health care services when a consumer is insured as some consumers admitted to seeking health care services more frequently after being insured and occasionally demanding services other than those prescribed thus indicating that being insured influences the health care services utilization in Tanzania (Mahamba, 2009). Only one company was found to be utilizing HMO services in an effort to counteract the effects of moral hazard.

Based on these findings, one would argue that the existing regulatory PHI regulatory framework in Tanzania is ineffective in regulating recruitment and enrollment of members or the PHI market is not adhering to the existing regulations. And hence studies are required on how to improve effectiveness.

CHAPTER THREE

METHODOLOGY

3.1 Description of the study area

This study was conducted in Dar es Salaam, Tanzania. Dar es Salaam was chosen because most of the PHI companies operate their business and have their headquarters in the city. Also, because the city is a focus of business activities, it has many companies and organizations that have enrolled their employees and/or themselves in private health insurance companies. Dar es Salaam, one of the regions of Tanzania is located on the coast of the Indian Ocean. It has three administrative districts namely Ilala, Temeke and Kinondoni. It is Tanzania's largest city and its communications, and economic center. The Dar es Salaam Region was estimated to have a population of 2,497,940 by the official census of 2002, with a population growth rate of 4.39% annually. It is therefore estimated that Dar es Salaam currently has a total population of about 4 million.

It has also been estimated that 3 - 5% of the population of Tanzania is employed in the formal sector and forms part of the client base of the PHI companies. According to the Tanzania Insurance Regulatory Authority (which is under the Ministry of Finance) by June 2010, there were a total of eighteen insurance companies registered in Tanzania. Of these, six insurance companies offer private health insurance; and these are AAR Insurance Tanzania Ltd, Strategis Insurance, Momentum Insurance, Phoenix Assurance, Prosperity Life Care and Jubilee Insurance Company Ltd. However, only AAR and Strategis Insurance are registered as specialists in health insurance, while for the other companies health insurance is not the main business but one of

their products. Prosperity Life Care's license was revoked recently leaving five companies that were operational at the time of the study.

3.2 Study design

An analytical cross sectional study was conducted in June 2010. This type of study was chosen as it appropriate for answering exploratory and descriptive research questions related to what exists at a certain time as was relevant for this study (Krysik and Finn, 2007). Both qualitative and quantitative data collection approaches were used to gather the information. The qualitative approach was used for gathering information on the regulatory framework in use, tools, frequency and adherence of the PHI companies to regulations; while the quantitative approach was used to explore information on the beneficiaries' understanding on their rights, PHI regulation and the outcomes of regulation.

3.3 Study populations

Three different populations were involved in the study.

The first study population involved the regulatory authority which was changed from the Insurance Supervisory Department in late 2009 to an autonomous authority - Tanzania Insurance Regulatory Authority (TIRA) under the Ministry of Finance.

The second study population included the PHI companies in Dar es Salaam. According to TIRA there were five insurance companies registered to provide private health insurance by then. These are Strategis Insurance Tanzania Ltd, AAR Insurance Tanzania Ltd, Momentum Tanzania, Phoenix Assurance and Jubilee Insurance Company Ltd. Of these, Strategis Insurance Tanzania

Ltd and AAR Insurance Tanzania are registered as specialists in health. Only AAR Insurance Tanzania Ltd has its own health facilities.

The third study population comprised of beneficiaries of the PHI companies. These were mainly employees in institutions and organizations (clients) which were insured by the PHI companies.

3.4 Sample size and sampling procedure

3.4.1 Regulatory Authority

As there is only one insurance regulatory authority, the Tanzania Insurance Regulatory Authority (TIRA) and it had no functional departments dealing specifically with PHI, there were no strict criteria for the sample size. The target was to interview at least one individual from TIRA. Purposive sampling was used to get a key informant to be interviewed from the regulatory authority. The purposive sampling was used to select informants who were knowledgeable and had rich information on matters relating to regulation, registration, supervision and market operations of PHI. In this study an in-depth interview was conducted with a senior regulator as appointed by the Commissioner of Insurance.

3.4.2 PHI companies

Since there were only five PHI companies operating in Tanzania at the time of the study, all the PHI companies were involved in the study. The target was to interview representatives from all private health insurance companies operating within the market at the time of study. Again purposive sampling was employed to find informants who were knowledgeable on issues relating to operations of the PHI companies in relation to how they are regulated. At least one individual who was well informed from the senior management of each PHI company were involved as they were most likely to be well versed with insurance matters.

Inclusion criteria: All PHI companies operating in the healthcare market in Tanzania with operations in Dar es Salaam so that information generated applied to all the companies.

Exclusion criteria: All social, micro-insurance organizations, governmental insurance funds and PHI companies operating in Dar es Salaam as the intention was to get information from the "for profit" insurance companies.

3.4.3 Beneficiaries

All institutions and organizations which are clients of the PHI companies based in Dar es Salaam were included.

All principal members (employees) of the institutions, companies and organizations which were clients of the PHI companies were included in the study. The goal was to have interviews with at least 165 beneficiaries.

Sample size calculation for beneficiaries

Minimum sample size was calculated by the formula

$$n = z^2 p(100 - p)/ €^2,$$

$$= (1.96)^2 50 (100 - 50)/8^2 = 150 + 15 (10\%) \text{ non respondents} = 165$$

Minimum sample size = 165

Where

n = desired sample

z = standard normal deviate value of 1.96 which corresponding to 95% level of confidence

p = proportion of 50% was used as no proportion of knowledge of regulation among PHI beneficiaries could be found in the literature.

ϵ = margin of error, 8%

Inclusion criteria - Principal members of institutions/organizations that are clients of PHI companies that are based in Dar es Salaam were included since they were believed to have better knowledge regarding regulations and their benefit packages compared to their dependants.

Exclusion criteria - Those principal members who were enrolled but did not reside in Dar es Salaam or were not at work during the interview period were excluded. All dependants of the employees and self insured individuals were excluded since it would have been difficult to locate their residences in Dar es Salaam and some are children who would have been unable to respond to the interviews.

Sampling procedure for PHI beneficiaries – The number of client companies and beneficiaries covered by each PHI was not available as the companies refused to provide this information because they consider it classified. Previous studies on PHI market in Tanzania also did not indicate this information.

Nevertheless, a list of some of the client organizations of each PHI company was requested from the managers of the PHI companies. From this list, 2 organizations were conveniently selected from each PHI company to ensure that each organization chosen had more than 25 principal members. From each of the selected organizations, 20 principal members were selected by simple random sampling from lists of principal beneficiaries obtained from the organizations. Thus a sample was obtained by interviewing at least 40 beneficiaries from each PHI company.

3.5 Data Collection Procedure

Permission to conduct study

A letter requesting permission to conduct the study was presented to the Commissioner of Insurance together with a letter indicating ethical clearance had been granted from the Research and Publication Ethical Committee of Muhimbili University of Health and Allied Sciences (MUHAS). Permission to conduct the study was received by way of a letter and introductory letters to the PHI companies were also obtained from the Commissioner of Insurance.

3.5.1 Recruitment of research assistants

Three research assistants were recruited to assist in the data collection process. They were trained on the study objectives, data collection processes and selection criteria. They were trained on ethical considerations like obtaining verbal/written consent and ensuring confidentiality by conducting the interviews in a private room. They were also familiarized with the data collection instruments and how responses are recorded.

3.5.2 Data collection Tools

Data was collected from participants using both qualitative and quantitative data collection instruments. Qualitative interviews were the main method of data collection using semi-structured interview guides that were used to conduct in depth interviews with the regulatory authority and PHI representatives. Interviews with the beneficiaries were conducted using interviewer administered questionnaires. All the tools were initially written in English then translated in to Kiswahili to ensure that questions were easily and clearly understood by the

respondents. The language used during interviews depended on the respondents' selection of language that they were most comfortable in communicating.

3.5.2.1 Pre-testing of data collection tool

Before actual data collection, pre-testing of the data collection tools was done by the principal investigator and research assistants to test for clarity of questions. Modifications were done to the tools to ensure the information sought will be generated by the tools. The pre-testing was done on 20 NHIF members who work at the Muhimbili National Hospital.

3.5.2.2 The qualitative data collection method and variables collected:

This method was used for the regulatory authority and PHI companies representatives by way of in depth interviews using a semi-structured interview guide. Tape recording was done during in depth interviews to capture the information. The two interviews guides had four main sections in common which were: How regulation is done and what is being regulated, adherence of PHI companies to regulations and outcomes of regulations in terms of enrollment, recruitment by insurers and health care utilization by beneficiaries. The last section was on capacity of the regulator. Both the regulatory authority and PHI companies' qualitative guides had similar questions so as to provide the views of the regulatory authority and the PHI companies on the same issues.

- **How regulation is done and what is being regulated**

This section provided information on how regulation was done (with questions on whether there is a department specific to health insurance, presence of professional insurance conduct bodies, whether supervision is done by on-site inspections or reporting, contents of the reports and

frequency of inspections or reports), the issues being regulated (with inquiries on market entry, market operations like claims payments, solvency, service providers, claims payment, benefit packages, premiums), tools used in regulation, frequency of inspection, prerequisites for market entry of PHI companies, autonomy of the regulator and involvement of beneficiaries in regulation.

- **Adherence to regulations**

This section generated information on what was the level of compliance to regulations and what were the consequences should PHI companies fail to abide by regulations in terms of penalties or fines, types of penalties, duration of penalties, enforcement of penalties and costs of enforcement.

- **Outcomes of regulations in terms of enrollment and recruitment strategies utilized by insurers and health care utilization of beneficiaries**

This section included questions that provide information on whether there is risk selection and the approaches being used to counteract moral hazard. This involved whether applicants had to state pre-existing conditions on membership forms, if pre-enrollment medical examinations were being done and if the companies were mandated to provide medical insurance to anyone who requested it as long as they could pay the premiums. There were also questions on whether there was any regulation of the enrollment of clients, the types of benefit packages, the setting of premiums, the use of selected health facilities for treatment and freedom that beneficiaries have in choosing facilities for health care.

- **Capacity of regulations**

This part included questions on the sufficiency of the regulatory authority in regulating the PHI market in terms of adequacy of resources like financial resources, number of personnel, ability and skills of personnel available. Also information on challenges facing the authority and ways to address them was generated.

3.5.2.3 Quantitative data collection and variables collected:

This was done using an interviewer administered questionnaire to the beneficiaries to gather data on the beneficiaries' understanding of PHI regulation and effects/outcomes of (in) effective regulation in terms of member enrollment and healthcare utilization. The questionnaire had both closed and open ended questions. The sections included socio demographic information of the beneficiaries, beneficiaries' health insurance profile, outcomes of regulation and their insight regarding PHI regulation.

- **Socio demographic information**

This section generated data on socio demographic information of the beneficiaries including age, sex, marital status, education level, number of years employed with the present company, employment level (rank), monthly income, number of individuals who depend on the consumer for healthcare costs.

- **Beneficiaries health insurance profile**

This section mainly generated information on the membership status of the consumer and their spouse, the name of the insurance company and coverage of dependants.

- **Outcomes of regulation**

The outcomes of interest were whether there is risk selection, adverse selection and moral hazard practiced by insurance companies and consumers respectively. This section had questions on identification of how enrollment happens with the PHI company, who identified the benefit package, if medical examination was done before enrollment, knowledge regarding premium and it's affordability, whether rejection of renewal happens and freedom of choosing health facilities by beneficiaries. Moral hazard by beneficiaries will be inquired upon by questions on comparison of the beneficiaries' behavior and attitude before and after the coverage with health insurance, on health services utilization frequency, request for extra services, limits of bills, if there were co-payments and presence of limitation on services.

- **Consumer's insight on regulations**

This section had questions on who would they seek to address complaints regarding their insurer, their knowledge of the presence of a regulatory authority, the name of the authority and the basic functions they expected the authority did.

3.6 Data management and analysis

After the data collection process, on the same day, qualitative data generated from the in depth interviews were verified by the Principal Investigator (PI). During transcription, the information was checked for consistency by reviewing the tape recorded data. The information was then read carefully and sorted by the PI. It was then organized, categorized and coded while searching for repetitive patterns and meanings of the data collected. Information was analyzed using Tesch's method of analysis where patterns were identified, then sorted into categories and themes that were relevant to the study.

The information that was collected was systematically categorized into three main themes followed by sub-themes. The first theme was regulation and control of the PHI market under which the sub-themes of who does the regulation, how regulation is done and frequency of regulation, the issues being regulated (including market entry, operations, premiums, benefit packages and health service providers), tools used in regulation, adherence to regulation and capacity of the regulatory authority. The second theme was consumers' involvement in regulation accompanied by sub-themes of handling of consumers' complaints, consumer rights organizations, education of consumers by PHI companies and their knowledge of insurance issues and the last sub-theme was education of consumers by TIRA and their awareness of PHI regulations. The third theme was on outcomes of regulation. Sub-themes include recruitment and enrolment of clients, affordability of premium, age limits and medical examination on enrolment, health facility selection and consumers health services utilization.

The quantitative data questionnaires were checked for consistency and accuracy during and after collection and necessary corrections were made to ensure completeness of the data. It was then coded and entered and analyzed using the Social Science Statistical Software (SPSS) computer software package, version 13.0. Data was then summarized by way of frequency distribution tables and figures followed by cross tabulations for presentation of different variables. Associations were tested by Chi square tests and obtaining p values. P values less than 0.05 were considered significant.

3.7 Ethical considerations

Ethical clearance was sought and obtained by way of a letter from the Research and Publication Ethical Committee of Muhimbili University of Health and Allied Sciences (MUHAS). Thereafter, permission to conduct the study was requested from the Commissioner of Insurance,

Tanzania Insurance Regulatory Authority (TIRA) before carrying out the study. Participants were informed that participation was voluntary and verbal and/or written consent was sought from every study participant after explaining to him/her the aim and objectives of the study. The respondents were assured of confidentiality of the information they provided and that the information obtained would only be used for research purposes and would not be by any means disclosed to other people. They were also informed that the study findings will be helpful in informing policy makers of any iniquities occurring in the PHI market so they can find ways to evade and control them. Respondents were informed that they were free to withdraw from the study at any point in time.

3.8 Study Limitations

a) Generalization of results - The use of only Dar es Salaam based PHI clients and convenient sampling of clients from which beneficiaries were selected, might have affected the results as they cannot be generalized for all the clients of PHI market in Tanzania. Thus external validity for the outcomes of regulation might be affected. Nonetheless, there is internal validity as the beneficiaries within each organization were selected randomly.

b) Hawthorne effect – Since the issues that were enquired upon were sensitive, the responses given could have been only because respondents knew they were being studied and they perceived that is what the interviewer wished to hear. Checking questions were incorporated to try and overcome this effect.

CHAPTER FOUR

RESULTS

4.1 Socio – demographic characteristics

The study was conducted in June 2009 and this chapter indicates the results obtained from analysis of both qualitative and quantitative data. Qualitative and quantitative findings were used to corroborate different issues and to draw inferences The qualitative results are from interviews conducted with representatives from TIRA and five PHI companies that were involved in the study and the quantitative results are from 200 beneficiaries who participated in the study.

Beneficiaries were interviewed on issues related to regulation of PHI companies. A total of 200 beneficiaries who are members of the PHI companies were interviewed with a majority 110 (55%) being males. Their socio demographic characteristics are summarized in Table 1. Most of the beneficiaries (87%) were aged between 21 and 40 years old with a mean age of 33.1 years (standard deviation ± 7.8 years) with more than half of the interviewees 115 (approximately 58%) reporting that they had completed tertiary education. Of those interviewed, about 57% were married and almost two thirds (65%) were normal non supervisory/non managerial staff at their respective workplaces.

Table 1: Socio demographic profile of beneficiaries

Characteristic		N=200	Percentage
Sex	Male	110	55
	Female	90	45
Age groups	21-30 years	91	45.5
	31-40 years	83	41.5
	41-50 years	17	8.5
	51-60 years	6	3.0
	61-70 years	3	1.5
Education level	Completed Primary school	4	2.0
	Completed O-level	32	16.0
	Completed A-level	49	24.5
	Completed Tertiary Education	115	57.5
Marital status	Married	113	56.5
	Never married	79	39.5
	Widow/widower	5	2.5
	Separated/divorced	3	1.5
Position of employment	Managerial	36	18.0
	Supervisory	34	17.0
	Non-supervisory/ Others	130	65.0
Total		**200**	**100**

4.2 Regulation and control of the PHI market

4.2.1 Who does the regulation?

All the companies visited reported that regulation of all insurance business in general was done by the Tanzania Insurance Regulatory Authority (TIRA), which has become an autonomous agency of the government since the end of 2009. This was confirmed by a respondent from TIRA who said:

> *"The Tanzania Insurance Regulatory Authority is responsible for regulating all insurance companies carrying out insurance businesses."*

It was found that, as reported by the regulator, insurance business is divided into two classes' namely general insurance business and long term assurance business and private health insurance is part of the general insurance and regulated in the same way as other non-health insurance business. It was reported that there was no specific division or department under TIRA for regulating health insurance business, however, the Department of Surveillance and Research within TIRA is responsible for regulating all insurance companies.

Not all PHI companies respondents were aware of other professional insurance conduct/ethics bodies which also assist with regulation of the market however a respondent from TIRA named the Insurance Institute of Tanzania, Association of Tanzania Insurers, Association of Insurance intermediaries (insurance agents and insurance brokers) and Association of Tanzanian Loss

Adjusters and Surveyors as bodies whose members are supposed to adhere to the code of conduct as per the regulations.

4.2.2 Process and frequency of regulation

The study shows that regulation of PHI companies was done by both Off-site examinations and On-site inspections of the companies. The off-site monitoring was mainly done by the regulatory authority reviewing reports submitted by PHI companies. All companies are required to submit quarterly returns, audited annual returns, published annual financial statements and actuarial valuation reports where applicable. The content of these reports focuses mainly on finances.

The PHI companies' interviewee's reported that they were not aware of a specific schedule for On-site inspections. Some of the companies reported to not have been inspected for almost 2 years prior to the interview. Most of them reported the scarcity of inspectors (staff) as the main reason for the inspections not to be carried out regularly. A respondent from Strategis Insurance said:

> *"Sometimes inspection is done once per year but there is no particular schedule of how many times per year the inspectors will come. I think at the moment they may have a problem of shortage of staff so that may be the reason they do it only once. For example the whole of last year they didn't come"*

A respondent from TIRA however claimed that

> *"....normally inspection depends on the risk profile of the company. During the off-site analysis which is performed regularly, risk assessment of the companies is done with the*

high risk ones being detected. Those are then followed by on-site inspections taking place at least once a year for companies that appear as high risk."

One company respondent reported that prior to on-site inspections; the authority sends a letter to the PHI company indicating the dates when the inspectors would be visiting and attach a check list of documents they wish to see and a questionnaire that should be completed by the company and returned to the authority prior to the inspections. The inspections were reported to take 15 days and were done mainly to ensure that regulations are being followed as a respondent from AAR confirmed by saying:

"The inspection might be a complete inspection for all aspects of the company or it could just be focused on specific areas that they want to check on. The inspections tend to help a lot in unraveling issues for the company to deal with and correct if there is need for correction but mainly it is just to confirm that regulations are being followed as per the act."

4.2.3 What is regulated?

The study shows that the issues that are regulated in the PHI market generally entry/registration and operations of the companies in the market.

A. Regulation of Market entry

It was reported by most respondents that market entry was greatly regulated by the authority. One of the respondents from Jubilee Insurance commented further by saying:

"Registration of the company is one of the main things that are heavily regulated. A lot of details are required prior to being registered."

It was also reported by all the PHI companies that the prerequisites for a PHI company to be registered in the market were mainly on financial issues and senior management of the company. A respondent from Momentum Tanzania reported the following:

> *"We just needed sufficient capital mainly and other purely financial requirements. Apart from these, qualified senior management officials and the regular company registration just as you would initiate any company but after all these, you will still need the commissioner's approval to operate."*

Among the financial prerequisites that were mentioned were:

1. Minimum capital requirement to enable the companies to transact non-life insurance business. This was reported to be Tsh one billion (1,000,000,000) for the year 2010 and subject to change every year as stated by the authority.

2. Educational qualifications and expertise for the company senior managers. The qualifications required were reported to be for the Chief Executive Officer (CEO) and Chief Financial Officer (CFO) and specified as follows by a respondent from TIRA;

   "The Chief Executive Officer or Principal Officer of the PHI company has to be a member of Associate Chartered Insurance Institute and hold a degree or advanced diploma in Insurance from a recognized institution and eight years of post qualifications experience. The Chief Finance Officer should be a Chartered Public Accountant or holder of ACCA with five years' post qualification experience."

3. Submitting the company's strategic plan for 3 to 5 years.

4. Ensuring at least a third of the company shares are owned by a Tanzanian citizen.

5. Completion of the regular business registration requirements.

Furthermore, it was reported that even when all other requirements were completed, a PHI company could not start operations prior to being registered by TIRA as corroborated by a respondent from Momentum Tanzania who said:

> *"...you actually cannot operate even if you have all the requirements unless you get the registration certificate from the commissioner."*

The information collected also shows that there is no accreditation of PHI companies being done by TIRA. It was reported that registration of the company is the main requirement for a company to operate insurance business in Tanzania, and that it does not matter whether a company has other national or international accreditation. The registration acts mainly as permission to operate in Tanzania as a respondent from Phoenix Insurance explained:

> *"An insurance company is an insurance company, there is no grade given to it that it operates at a certain level by TIRA. You may have separate accreditation like ISO accreditation and get a certificate of credibility but this is not a prerequisite by the regulatory authority. TIRA just provides you with a certificate to operate."*

B. Regulation of the PHI market operations

It was reported that the market operations that are mainly regulated are more concerned with finance. A respondent from TIRA reported that the authority uses risk based supervision (RBS) model of choice (with the acronym CARAMELS) to regulate the insurance market operations. In this model the areas that are assessed include capital (including solvency), asset quality,

reinsurance arrangements, management and corporate governance (which includes the qualifications of senior management, claims and complaint handling issues as well as other market issues), earnings, liquidity and subsidiaries plus related party transactions. This was confirmed by a respondent from Strategis Insurance who said:

> *"Since insurance is a financial business there is a need for additional regulation which is to protect insurance policy holder's rights, and to unscrupulous operators from coming in, taking people's premiums and disappearing with them, thus the strict financial regulation."*

C. Regulations of premiums, benefit packages and health services providers

All the PHI companies reported that there were no regulations governing the setting of premiums for beneficiaries. The premiums for different products are set in line with the risks of either the individual or the group in question and services covered by the package. A respondent from AAR corroborated that information by saying:

> *"In this country, it is a free market for anything except for regulated products like petroleum. Otherwise you can come up with your own product, you set your own price and if there are people to buy it, they buy it, and so premiums are not regulated."*

The same was confirmed by an interviewee from TIRA who reported that premiums are not regulated.

Regarding benefit packages, the respondents from PHI companies also reported that the contents of benefit packages were also not regulated and there were no rules set by the regulator regarding

a minimum set of basic services that a benefit package should contain. It was also reported that were limits on quantity of services provided as per the different benefit packages depending on the premium. Nonetheless, the study found that while PHI companies are free to design their own products, the products or benefit packages have to be submitted to the Commissioner at the time of registration and any new products should be submitted to the authority for approval prior to being sold. This was reported in almost all companies, for instance a respondent from Strategis Insurance reported that:

> *"Benefit packages are filed when you register your company, also when you come up with a new plan you have to file it with the insurance regulator. That is again just like any other insurance plan not just health insurance. This is called a file and use plan. You file it and if within 15 days you do not get an objection from the regulator you can use it."*

It was also reported that almost all the benefit packages that had been submitted by the insurance companies had not received any objections.

Furthermore the PHI respondents reported that usually benefit packages are chosen (most of the time) by the beneficiaries or employers who wish to insure their employees. The respondent from Momentum indicated that the content of the benefit package depended on the ability of the employer (budget) on meeting health care costs of their employees.

All PHI companies reported that they have contracted health service providers in different parts of the country to provide healthcare services to their members. Three main factors for the provider to be contracted by an insurance company were narrated:

1. A provider must be registered with the Ministry of Health (MOH)
2. A provider must provide good quality of services
3. The geographical location of the provider in relation to presence of beneficiaries who would wish to utilize the providers' services in the area.

Apart from the registration of the facilities by the MOH, it was reported that there is no regulation of the prices of health services provided by the providers that are used by the beneficiaries of the PHI companies, in this case the hospitals, health centre's, dispensaries or pharmacies. This was reported by all the insurance companies as one of their major challenges because the price of services was rising uncontrollably and influenced the price of the premium. All the PHI companies' respondents reported that because of the absence of standard pricing the companies had to increase their premiums regularly to keep up with the health services prices. As a respondent from AAR Insurance noted that:

> *"Unfortunately here the health care providers are not accredited and prices not standardized. But in those markets where there is a health funder's board, every provider is available to everybody; you don't accredit your own providers and the board makes sure that the prices are standard and there is no overpricing. To me this is the biggest challenge; there is no regulation at all that manages providers in relation to health insurance."*

4.2.4 Tools used in regulation

The study found that the main tool used in regulation of PHI companies is the Insurance Act No. 10 of 2009. Further it was found that the Insurance Act confers upon the Commissioner of

Insurance powers to ensure compliance with its provisions and ensure that insurance business is conducted on the basis of sound insurance principles. While there are regulations available for life and non life insurance business, it was reported that there are no acts or guidelines specific for health insurance business only. This was confirmed by an interviewee from Jubilee insurance who said:

> *"The 2009 Insurance Act and the Act supplement are the ones that are used for regulation by the Commissioner and we are supposed to abide by them. They came into effect and started being used in January 2010. Unfortunately there no legislations specific to health insurance and the act is for all insurance practice in the country."*

One of the respondents interviewed noted that basically whatever the PHI companies do is guided by the Act; it stipulates all what the companies are allowed and not allowed to do. The study also found that there are other Acts which deal with health insurance for example the National Health Insurance Fund (NHIF) Act however this was found to be solely for NHIF. The Social securities act also has parts that focus on medical insurance but not as private health insurance regulation tools. It is only the Insurance Act of 2009 that is used to regulate the PHI market.

4.2.5 Adherence to regulations and penalties for non compliance

The results show that majority of the PHI companies adhere to regulations. All PHI companies that were interviewed had already submitted the reports that were required to be submitted by the month of June, including the previous quarterly report, the annual returns and the published statement of accounts. This was substantiated by an interviewee from TIRA who reported that

usually the PHI companies comply with the requirements. Necessary actions for non-compliance as stipulated in the Act, were reported to be usually taken should the PHI companies fail to comply with the regulations; and the Commissioner has been given powers to impose penalties. The penalties that can be imposed can be in the form of fines. This was confirmed by a respondent from Momentum Tanzania who said:

> *"If you fail to submit the required reports in time you will be fined ten million shillings, however if you have problems you have to write a letter and communicate to the Commissioner in advance presenting why you expect to send your information late so he can take that into consideration, however if you cannot do this you will have to pay."*

Other penalties imposed on failure to comply with regulations reported to be seizure of documents, court action/prosecution; and it was also reported that where necessary the companies can be put under receivership as the Commissioner has quasi judicial powers to cancel the licenses of PHI companies or even take over and run the company.

4.2.6 Capacity of the regulatory authority

There were a different views expressed by the interviewees regarding the capacity of the regulatory authority. While some of the PHI companies respondents reported that they believed the regulator had sufficient capacity to regulate PHI companies, some affirmed that there was insufficient capacity. A respondent from AAR responded by saying:

> *"....they have to do more as most of the expertise is channeled towards general insurance rather than health insurance, but the potential to develop that expertise is huge. Send*

them to developed markets so that they learn. So the capacity in terms of expertise on health insurance regulation is still lacking."

We found that apart from expertise and skills, the number of staff was found to be insufficient. It was reported that there were only six (6) inspectors at TIRA who are supposed to inspect all the insurance companies; and there were no inspectors specifically for private health insurance companies. Furthermore, it was also reported that there was only one TIRA office in Dar es Salaam and inspection activities of PHI companies' offices located outside Dar es Salaam was done by the same inspectors who travel to the locations in the regions. A respondent from TIRA confirmed this by saying:

"……the numbers of inspectors is not sufficient. TIRA offices are currently only in Dar es Salaam however there are plans for decentralizing regulation activities and opening offices in other regions of the country."

4.3 Beneficiaries involvement in regulation

4.3.1 Handling of beneficiaries' complaints

All five PHI companies had an internal complaint handling process in place for issues that were raised by customers. It was reported that the current regulations, that came into effect in 2009, have specified that each PHI company should have a claims handling process specifying how a consumer/client should approach the company if he/she is aggrieved and what steps should be taken thereof. The regulations require PHI companies to have a complaints register that can be inspected by the regulator whenever required. Furthermore, the current Act has provided for the services of a special tribunal technically known as "Ombudsman services" whose main function

is to resolve disputes arising between policy holders and insurers on the contracts of insurance. The insurance Ombudsman will function as a quasi-court under a retired judge of the high court of Tanzania. An interviewee from Phoenix confirmed:

> *".....over and above this, the insurance Act itself of 2009 which came into effect in January 2010, has provided for an ombudsman. This is like a court in itself, if the client is aggrieved, he can go to this ombudsman for reprieve"*

PHI companies were asked on how they handle their member's complaints, the results showed that the companies had internal procedures for handling customer complaints. The study found that most of the complaints that were brought by customers were resolved internally with very few instances of complaints being referred to the regulatory authority. A respondent from one of the companies reported that insurance is a heavily fraud prone business, and when there is evidence of forgery or an attempt for a forgery, the issue was not given consideration at all. However, an interviewee from Jubilee Insurance confirmed that some complaints were forwarded to the regulatory authority by beneficiaries as members of the public are free to go to the regulator whenever they have grievances and he said:

> *"The regulator is the custodian of the policy holder's rights', he has a responsibility to find out what happened, and he also has a right to match registers. So having heard one side, he will also ask us our side. He will then always suggest the way forward and if there is some room, try to amicably resolve it, and we would explore all avenues so that we do not leave a complaint open."*

Beneficiaries were asked about whom they would seek to see to present their complaints if they had any against their insurer for instance where they feel they were unfairly of wrongly treated. Most of them 141 (70.5%) responded that they would go to the Human Resources Department (which usually deals with all issues regarding health affairs of the employees) or take up the matter with the insurance company. Table 2 shows the responses from beneficiaries on the same question.

Table 2: Beneficiaries selection of institution to address complaints against insurer

Institution named to address complaints against insurer	**n**	**%**
Human Resources Office	141	70.5
My Insurer	20	10.0
Employer	13	6.5
TIRA/ISD (Regulatory Authority)	9	4.5
Police Station	9	4.5
Court	6	3.0
Health Services Provider	2	1.0
Total	200	100

Respondents from TIRA reported that by the end of 2008 a total of 228 complaints had been received and handled by the Insurance Supervisory Department, the regulator at that time. The study found that during the year ending on 31st December 2008 a total of 228 complaints from beneficiaries had been received and handled by the then Insurance Supervisory Department

(ISD). These were mentioned as for all types of insurance as they have no specific register for health insurance. TIRA reported that most complaints received from companies beneficiaries were on delays in settling of their claims by the respective companies.

4.3.2 Consumer rights organizations

The insurers were interviewed on the presence of consumer rights organizations in Tanzania, none of the respondents from the PHI companies had heard of any health insurance consumer rights organizations. A respondent from AAR Insurance said:

> *"I am not aware of any consumer rights group in Tanzania, because if it was there, it would be very vocal because there are so many consumer issues, in terms of the quality of products, that we have not just for health insurance but insurance in general that you would have found surfacing and coming out in a very vocal way."*

The same was also confirmed by a respondent from TIRA who did know of any organizations for health insurance consumer protection.

4.3.3 Education of beneficiaries by TIRA and PHI companies

Respondents from the regulatory authority also reported that they provide consumer education and have a strategy that they are implementing. This strategy was reported to be aimed at informing current and potential beneficiaries on insurance products and services, not only of the available ones offered by the insurance companies but also on the insurance regulatory and supervisory mechanism. The authority reported to have had conducted public education events

in various places like the Dar es Salaam International Trade Fair which takes place in July every year and other such places. A respondent from TIRA said:

> *"Normally we participate in various exhibitions like Sabasaba, Nanenane and Wiki ya Utumishi wa umma, where we meet with various potential and current policyholders and inform them of various issues regarding insurance and their rights."*

While the authority reported to have consumer education, only 45 (22.5%) of the beneficiaries interviewed reported to have ever heard of a governing or supervisory body for PHI business, the majority had not heard (Table 3). Of the beneficiaries enrolled on the scheme for less than 2 years about 17 (19.3%) had ever heard of existence of the regulatory authority while26 (28%) of those enrolled between 2 to 5 years had heard. Only 2 (10.5%) of the beneficiaries who had been enrolled more than five years had ever heard of the regulatory authority. Chi square test for association between hearing of existence of regulatory authority and duration of enrollment provided a p-value of 0.16 indicating no statistically significant association (Table 3).

Table 3: Beneficiaries awareness of existence of PHI regulatory authority and their duration of enrollment in the current scheme

Variable	Aware of regulatory authority			P-value
	Yes n (%)	No n (%)	Total n (%)	
Duration of enrollment in current scheme				
Less than 2 years	17 (19.3)	71 (80.7)	88	
Between 2 and 5 years	26 (28.0)	67 (72.0)	93	0.16
More than 5 years	2 (10.5)	17 (89.5)	19	
Total	**45 (22.5)**	**155 (77.5)**	**200**	

Of those who had heard, when asked to mention the name of the regulatory authority, 47% were able to mention the correct name of the existing authority (Table 4). Insurance Supervisory Department (ISD) was mentioned by 29% of the respondents which is the name of the previous governing authority, while about 9% mentioned the National Health Insurance Fund (NHIF), National Social Security Fund (NSSF) and the Ministry of Health (MOH).

Table 4: Distribution of beneficiaries' response to mentioning the name of the governing body of PHI market

Name of the governing body mentioned by beneficiaries	n	%
TIRA	21	47
ISD	13	29
Don't remember/Don't know	5	10.5
Others (NHIF, NSSF, MOH)	4	9
Regulatory body	2	4.5
Total	**45**	**100**

Furthermore, the results showed (Table 5) that as the level of education increased, more beneficiaries had heard of the existence of regulatory authority. Of the beneficiaries who had completed tertiary education 39 (33.9%) had heard of the regulatory authority while none of those who had completed primary education had ever heard of it (Table 5). Very few of those who had completed O-level and A-level had heard of the regulatory authority. Association was tested by Chi square test and a p-value of < 0.01 was obtained indicating a statistically significant association.

Table 5: Beneficiaries awareness of existence of PHI regulatory authority and their level of education

Variable	Aware of presence of regulatory authority			P-value
	Yes n (%)	No n (%)	Total	
Education level				
Completed Primary school	0 (0)	4 (100.0)	4	
Completed O-level	2 (6.3)	30 (93.8)	32	**0.000**
Completed A-level	4 (8.2)	45 (91.8)	49	
Completed Tertiary Education	39 (33.9)	77 (66.1)	115	
Total	**45 (22.5)**	**155 (77.5)**	**200**	

Hearing of the existence of the regulatory authority appeared to increase with higher level of employment about 47% of those employed at managerial level had heard of the authority compared to 18% of those employed at non-supervisory level (Chi square test, p-value < 0.01).

Table 6: Beneficiaries awareness of existence of PHI regulatory authority and their position of employment

Variable	Aware of presence of regulatory authority			P-value
	Yes n (%)	No n (%)	Total n	
Level of employment				
Managerial	17 (47.2)	19 (52.8)	36	**0.000**
Supervisory	5 (14.7)	29 (85.3)	34	
Non-supervisory/others	23 (17.7)	107 (82.3)	130	
Total	**45 (22.5)**	**155 (77.5)**	**200**	

The PHI companies' interviewees reported to having programs for educating beneficiaries. It was reported by a respondent of the PHI companies that once a person is enrolled, and the benefit package established, the PHI companies were responsible for educating the beneficiaries. An interviewee from one of the PHI companies responded that they regularly inform and update members on issues regarding their insurance, benefit packages and service providers to use. It was reported that normally when the beneficiaries are not educated about their coverage properly and in a language they would understand they might not be aware of their rights and might have expectations that are not the same with what is provided. It was further reported that one of the PHI companies provides their members with membership guides that are in both Kiswahili and English. The guide explains on the benefit package and what beneficiaries need to do in a given situation.

Another PHI company respondent reported that all of their health insurance business comes through brokers, thus the brokers were required and expected to educate the members on the benefits and coverage and what to do in case they encounter problems. Four of the PHI companies also reported having a Customer Service Department whose responsibility is to educate their members. An interviewee from AAR Tanzania was quoted saying:

> *"Within the company we have a customer service team that does that. For example we now have put a customer service charter. Some of our people right now are out of the country for training on specific modules that we want to put in place. After this, we do a launch and share information with our customers for instance if you have got a*

complaint, here is where you must go, here is the suggestion box or here is the e-mail address, you can be anonymous, you can say your name, whichever way you wish."

When beneficiaries were asked if they knew the services covered in their benefit packages, 145 (72.5%) of the respondents indicated that they were aware of the covered services (Table 7). Of those enrolled for less than 2 years, 77.3% knew of the covered services however only about half (52.6%) of those enrolled for more than 5 years were aware of the services covered by their benefit package.

Table 7: Beneficiaries' awareness of services covered and their duration of enrollment in current scheme

Duration of enrollment in current scheme	**Awareness of services covered by benefit package**			**P-value**
	Know	**Don't know**	**Total**	
	n (%)	**n (%)**	**n**	
Less than 2 years	68 (77.3)	20 (22.7)	88	
Between 2 and 5 years	67 (72.0)	26 (28.0)	93	0.09
More than 5 years	10 (52.6)	9 (47.4)	19	
Total	**145 (72.5)**	**55 (27.5)**	**200**	

4.4 Outcomes of regulation on recruitment/enrollment of clients and beneficiaries health services utilization.

The outcomes of regulation of interest were to see whether there was risk selection, adverse selection or moral hazard occurring in the PHI market.

4.4.1 Recruitment and enrollment of clients/beneficiaries

It was reported by all PHI company respondents that enrollment is voluntary, and there are no individuals or groups of people who are mandated by law to have private health insurance. A respondent from Strategis corroborated this:

> *"I have not heard of anybody who is forced to have health insurance except of course for the government employees who get NHIF. But there is no similar arrangement for private health insurers. Employers and individuals are free to voluntarily choose to join or not to join any insurer of their choice."*

The PHI companies and TIRA respondents all reported that there was no law or regulation that compels insurers to accept anyone who seeks insurance and can pay the premiums. It was reported that the insurers are free to reject consumers' coverage should they wish to do so.

We also found that insurance policies are renewed annually. Respondents from the PHI companies reported that beneficiaries were not usually refused to renew their policies unless they chose to leave and seek insurance elsewhere.

Figure 1 shows that of the beneficiaries interviewed, 43% reported that they had to renew their membership in the scheme annually. It also shows that about a third (35%) of the beneficiaries reported that they did not have to renew their policies while 22% did not know whether their policies are renewed or not. Enquiring on whether beneficiaries had ever been refused membership/renewal with an insurance company, the study found only 2 (1%) beneficiaries who agreed. The reasons for refusal were reported to be unable to pay the premium and wanting to reduce the number of dependants covered by their policy.

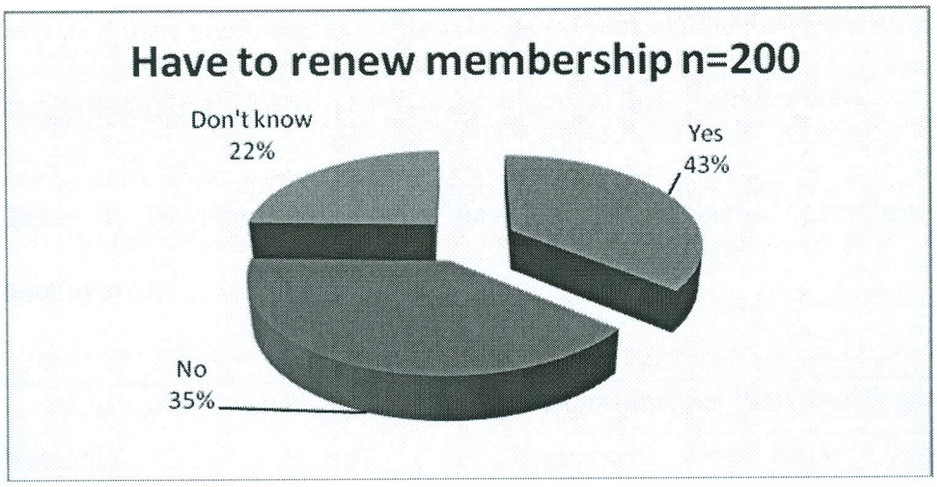


Figure 1: Distribution of beneficiaries on being required to renew membership annually

All PHI companies had membership application forms that all enrollees are required to complete. In the forms, apart from the personal details, the individuals are required to mention any chronic existing illnesses that they have. This information depended solely on the honesty of the individual being enrolled. We found that no part of the enrollment process is being regulated by the regulatory authority.

4.4.2 Affordability of premiums

Interviews revealed that while the beneficiaries were corporate/group members, some paid their own premiums while others had premiums paid by their employers as one of their employment benefits. Table 8 indicates the beneficiaries' responses to whom paid the premium for the health plan they were enrolled in. About 175 (88%) of the interviewees reported that their employer paid their premiums while 19 (9.5%) paid the premiums by themselves and 6 (3%) were not aware who paid their premiums. All those in the managerial positions (36 beneficiaries) knew

who paid their premiums and approximately 11% paid their own premiums while 9.2 % of those in non supervisory positions also reportedly paid their own premiums.

Table 8: Distribution of who pays the beneficiaries' premiums and their level of employment

Variable	Who pays premiums for their health plan				P-value
	Self n (%)	**Employer** n (%)	**Don't know** n (%)	**Total**	
Level of employment					
Managerial	4 (11.1)	32 (88.9)	0 (0)	36	
Supervisory	3 (8.8)	30 (88.2)	1 (2.9)	34	0.8
Non-supervisory	12 (9.2)	113 (86.9)	5 (3.8)	130	
Total	**19 (9.5)**	**175 (87.5)**	**6 (3.0)**	**200**	

We also found that for those who did not pay premiums themselves, as their level of employment increased, affordability of paying premiums also increased (Table 9). Half of those in managerial positions (50%) reported being able to afford premiums while only about a quarter 19 (16.1%) of those in normal non supervisory positions reported they were able. A statistically significant association was found on doing the Chi square test (p-value of less than 0.01).

Table 9 also shows that for those beneficiaries who did not pay their own premiums, with increasing income levels, ability to afford paying premiums increased. Almost half (46.3%) of those with more than Tsh 1 million monthly income reported being able to afford paying premiums compared to 15.6% of those with income less than 500,000 per month. Chi square test indicated a statistically significant relationship (p-value 0.02).

Table 9: Socio economic characteristics and affordability of paying premium for beneficiaries who did not pay their premium themselves

Socio economic characteristic	Affordability of buying a premium			P-value
	Yes n (%)	No n (%)	Total n	
Employment level				
Managerial	16 (50.0)	16 (50.0)	32	
Supervisory	12 (38.7)	19 (61.3)	31	**0.000**
Non supervisory/others	19 (16.1)	99 (83.9)	118	
Beneficiaries' income				
Less than 500,000 TZS	10 (15.6)	54 (84.4)	64	**0.02**
Between 500,000 and 1 million TZS.	18 (23.7)	58 (76.3)	76	
More than 1 million TZS.	19 (46.3)	22 (53.7)	41	
Total	**47 (26)**	**134 (74)**	**181**	

4.4.3 Age limits and medical examination as a requirement on enrollment

In general, all PHI companies reported not requiring pre enrollment medical examinations except in a few exceptions which were reported to be:

1. If individuals were more than 50 years old
2. If they had stated having a pre existing chronic condition on the application form
3. If it was suspected for any reason that the individual has not responded honestly on the application form

A respondent from Momentum Tanzania, whose company only enrolls group policies said:

> *"No, they do not generally have to do a medical examination since as I said earlier, we enroll only groups thus their risk is shared, however we expect anyone with a pre existing condition to state it on the application form but we do not risk rate an individual separately or ask them to pay more premium if they have a pre existing condition."*

However respondents from other companies who had individual member policies reported that for individual policies, the existence of the chronic condition would lead to increased premium however for group policies; it would depend on the group size and how many individuals had stated having a chronic condition.

About 34.5% of the beneficiaries reported to having been requested to undergo a medical examination prior to enrollment (Table 10). Age of the individual did not appear to have any specific influence on being requested to undergo a medical examination for those less than 60 years old. However, all (100%) those more than 60 years old reported that they were required to undergo a medical examination before they were enrolled.

Table 10: Beneficiaries required to undergo pre enrollment medical examination by age group

Age group	Required to have medical examination			P value
	Yes n (%)	No n (%)	Total	
21-30 years	29 (31.9)	62 (68.1)	62	
31-40 years	29 (34.9)	54 (65.1)	54	
41-50 years	6 (35.3)	11 (64.7)	11	0.20
51-60 years	2 (33.3)	4 (66.7)	4	
61-70 years	3 (100)	0 (0.0)	0	
Total	**69 (34.5)**	**131 (65.5)**	**200**	

This was also corroborated by a respondent from Jubilee Insurance who said:

> *"Yes, the limit for enrollment is 60 years, if anyone is over 60 years, then it becomes negotiable depending on the size of the group and how many of the employees are over 60 years. However all those over this age will be asked to do a medical check up"*

A respondent from AAR Insurance further reported that consumers who were seeking individual coverage and were over 60 years were unlikely to be enrolled.

4.4.4 Health facility selection by Insurers

All PHI companies had their own selected list of providers with whom they had formal agreements/contracts to provide healthcare services to their members. A respondent from one of the companies reported that beneficiaries' ability to choose which health care provider to go to for services depends on their policy. Most of the PHI companies responded that their members

are free to utilize any provider on their accredited list of service providers; however all reported that they did not encourage their members to use providers that were not on their accredited provider list. This was explained to be due to the insurance business being heavily prone to fraud and unscrupulous providers providing members with receipts for services they did not provide. A respondent from AAR said:

> *"The circumstances of using a non accredited provider have to be explained, unless it was an emergency, then it is very difficult for us to be able to give reimbursement because this is where the fraud comes. In Dar es Salaam for example, most of the providers are accredited so why should a member go to a non accredited provider? What are the circumstances? Those situations are very difficult and 90% of times we reject such claims."*

Interviews conducted with the beneficiaries confirmed the companies' respondents' reports as more than half of the beneficiaries (68 %) reported that they had a choice of where to seek services when they fall sick (Figure 2). However 30% reported not having choice and on further inquiry about 80% of them indicated that their insurer determined the health facility for them to utilize.

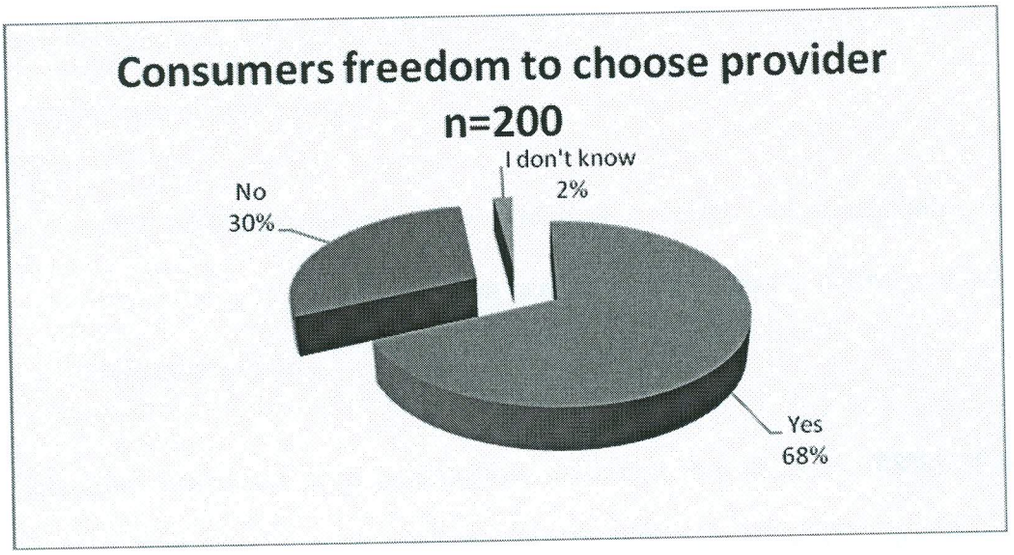


Figure 2: Beneficiaries freedom to choose health facility to use when sick

On enquiry on whether they utilize providers as primary or referral centre's, three of the PHI companies reported that left the freedom to use the providers as either a primary or referral centre to the beneficiaries, as a respondent from Strategis was quoted saying:

> *"..... there are those centre's that have only primary services available, so they are naturally primary health centre's, we don't designate them as primary centre's. We just designate them as a provider. There are others that have secondary services also and inpatient services, but the members have freedom to choose where they will go within the associated providers list."*

One PHI company reported to having a sister company operating as a Health Management Organization (HMO) that owns its own health facilities and in an effort to control costs, depending on their policies, beneficiaries are required to utilize these health facilities as primary

providers and can only go to another facility when referred from there. A respondent from this company was quoted saying:

> *"we have a sister company, which is a HMO and runs clinics, so it gives us an opportunity to understand what are the dynamics in the delivery of health in the country and control costs."*

Data from interviews with beneficiaries indicated that majority (88%) of beneficiaries used private hospitals more frequently when they were sick, followed by health centers (8%). Only very few beneficiaries reported using public hospitals and dispensaries respectively as the type of facility they utilized more frequently (Figure 3)

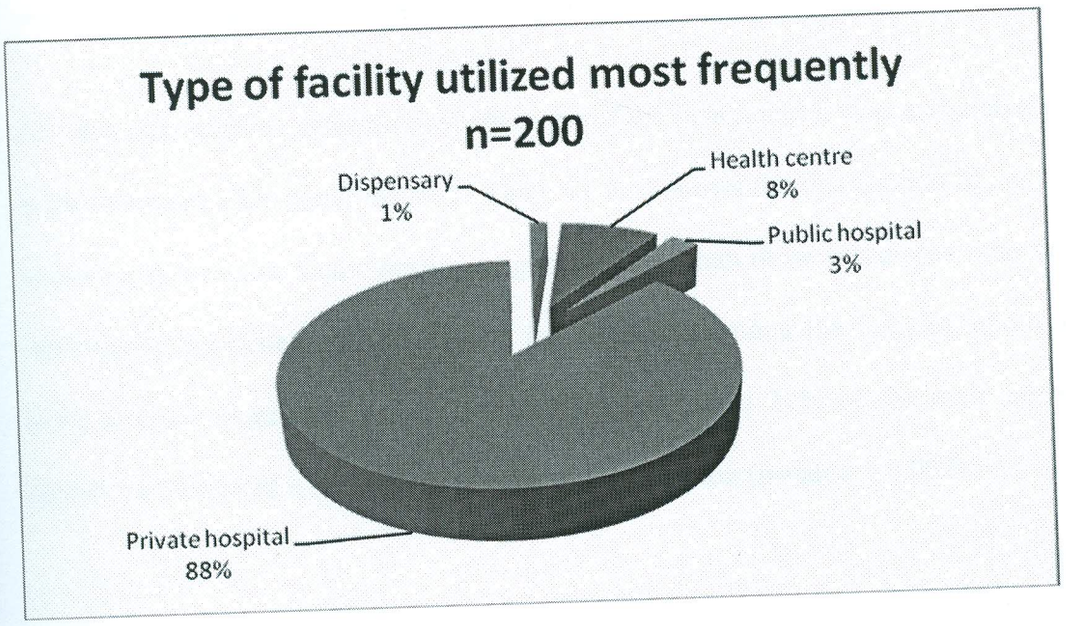


Figure 3: Type of health care providers utilized most frequently by beneficiaries

4.4.5 Beneficiaries health care utilization

Interviews with beneficiaries indicated that the behavior of some beneficiaries at the time when insured and not insured differed (Table 11).

An attempt was made at assessing whether age of the beneficiaries influenced requesting more treatment/investigations when they were insured as compared to when uninsured. When comparing the time when insured to the time they were not insured, 31% of the beneficiaries admitted to requesting extra treatment or investigations more than those prescribed to them after being insured (Table 11). Of those who requested extra services, more than half 56 beneficiaries (64.3%) were aged between 21 and 40 years. Only about a third 1 (33.3%) of those more than 60 years requested extra medicines or investigations.

We also attempted to determine whether sex of the benericiaries was associated with requesting extra treatment after being insured. Table 11 also shows the distribution of sex of beneficiaries and request for extra medicines/investigations more than those prescribed after being insured as reported by the beneficiaries. Results indicated that among the females, about 42% requested extra services more after being insured as compared to 21% of the male beneficiaries. Chi square test indicated a statistically significant association (p-value = 0.002).

Table 11: Socio demographic characteristics of beneficiaries and requesting extra medicines/investigations more after being insured

	Requested extra medicines/investigations			P-value
	Yes n (%)	No n (%)	Total n	
Age group				
21-30 years	30 (33.0)	61(77.0)	91	
31-40 years	26 (31.3)	57 (68.7)	83	0.88
41-50 years	4 (23.5)	13 (76.5)	17	
51-60 years	1 (16.7)	5 (83.3)	6	
61-70 years	1 (33.3)	2 (76.7)	3	
Sex				
Male	24 (21.8)	86 (78.2)	110	**0.002**
Female	38 (42.2)	52 (57.8)	90	
Total	**62 (31)**	**138 (69)**	**200**	

Table 12 indicates beneficiaries' responses to seeking treatment more frequently when insured as compared to when uninsured by age and sex. The results indicated that 53 (26.5%) of those interviewed admitted to seeking treatment more frequently while 133 (66.5%) reported not seeking treatment more frequently. The rest did not know. About 32% of those with age between 21 to 30 years reported seeking treatment more frequently followed by those with the age group 31 to 40 years. Only 1 (33%) of those aged more than 60 years admitted seeking treatment more frequently. Those between 31 to 40 years reported the least percentage (16.7%) of individuals seeking treatment more frequently after being insured

Table 12: Socio demographic characteristics of beneficiaries and seeking treatment more frequently after being insured

	Seeking treatment more frequently				P-value
	Yes n (%)	No n (%)	Don't know n (%)	Total n	
Age group					
21-30 years	29 (31.9)	55 (60.4)	7 (7.7)	91	
31-40 years	20 (24.1)	58 (69.9)	5 (6.0)	83	0.72
41-50 years	2 (11.8)	14 (82.4)	1 (5.9)	17	
51-60 years	1 (16.7)	4 (66.7)	1 (16.7)	6	
61-70 years	1 (33.3)	2 (66.7)	0 (0)	3	
Sex					
Male	21 (19.1)	79 (71.8)	10 (9.1)	110	**0.022**
Female	32 (35.6)	54 (60.0)	4 (4.4)	90	
Total	**53 (26.5)**	**133 (66.5)**	**14 (7.0)**	**200**	

The study also found that some of the methods used to control costs by the PHI companies are placing limits on bills, having limits of services provided during a certain period and co-payments/cost sharing.

Figure 4 indicates the distribution of respondents' responses regarding the type of restrictions that have been placed on their health services utilization. About 52.5% of all interviewed beneficiaries reported that they had limits of services that they could use for a certain period,

while 65% had limits on their bills. Only about 13.5% of the respondents reported that they had co-payment or cost sharing arrangements.

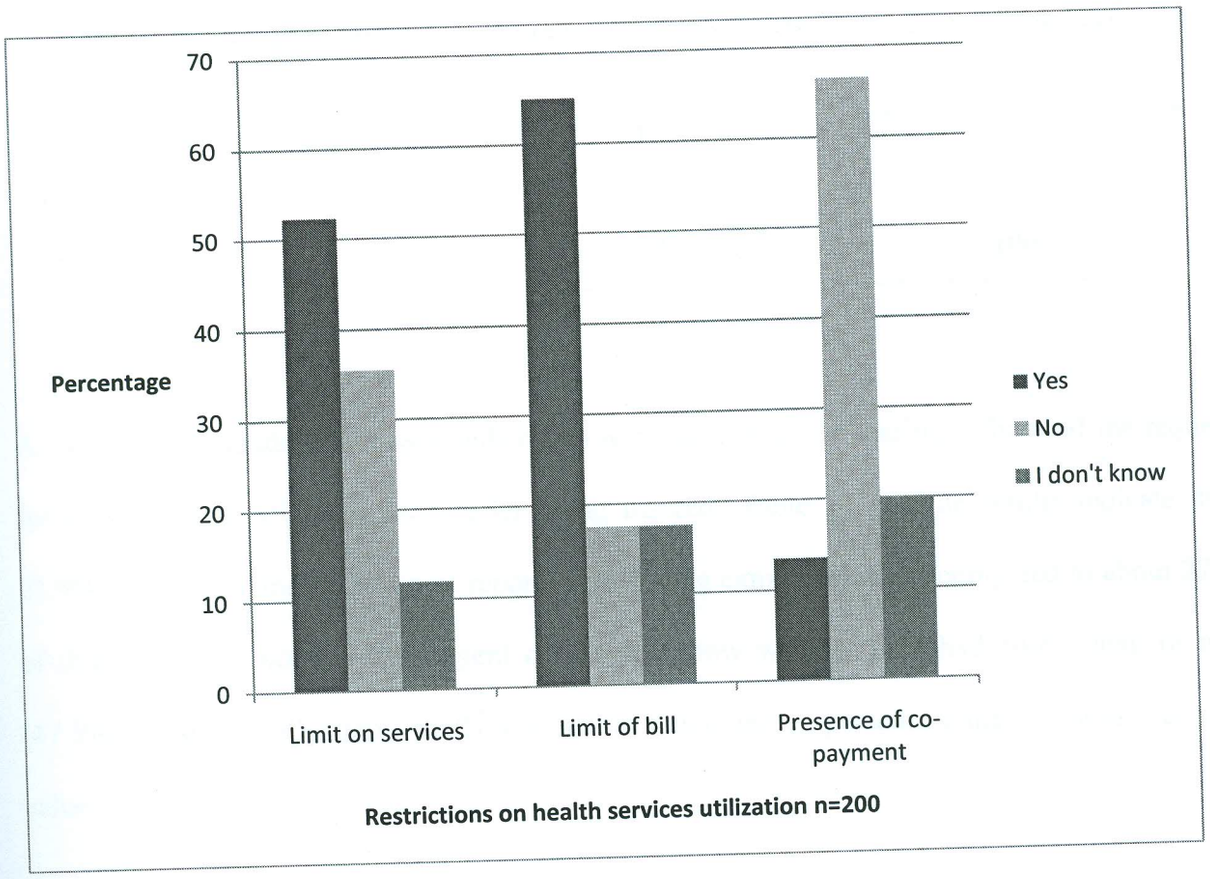


Figure 4: Beneficiaries responses regarding types of restrictions instituted by PHI companies on health services utilization

Of those beneficiaries who reported having co-payment/cost sharing arrangements, 15 (55.6%) reported that they were required to pay less than Tsh 20,000 per visit as co-payment while the rest reported having to pay more than Tsh 20,000 (Table 13).

Table 13: Distribution of beneficiaries with co-payment responses on amount they have to pay per visit

Amount paid per visit	Number of respondents	Percentage (%)
Less than 20,000	15	55.6
More than 20,000	12	44.4
Total	**27**	**100**

An attempt was made to assess whether having co-payment/cost sharing influenced the request for extra medicines/investigations after being insured (Table 14). The results indicate that 25.9% of those having co-payment reported requesting extra services as compared to about 27% of those who did not have co-payent or did not know whether they had co-payment or not (47.5%). A statistically significantly association was found on perfoming the Chi Square test (p value = 0.04).

Table 14: Beneficiaries with/without co-payment and their behaviour in requesting extra medicines and investigations after being insured

	Requested extra medicines/investigations			P-value
Have co-payment or cost sharing	Yes n (%)	No n (%)	Total n	
Yes	7 (25.9)	20 (74.1)	27	
No	36 (27.1)	97 (72.9)	133	**0.041**
Don't know	19 (47.5)	21 (52.5)	40	
Total	62	138	200	

CHAPTER FIVE

DISCUSSION

5.1 Regulation and control of the PHI market – The approach used, legislation (tools) and autonomy of the regulatory authority

Regulation is often seen as a possible solution to addressing the many problems which take place in the private production, financing and delivery of health services. To attain the public health goal of universal access to healthcare, regulatory approaches that are preferred are those that can mobilize resources for healthcare, promote financial risk protection, protect consumers and reduce inequities (Roberts, 2004).

In this study we found that the existing regulation of the PHI market in Tanzania is done by direct state regulation which is one of the modes of regulation available in health services regulation as found by Nigenda et al, (1997). It was also found that an autonomous authority, Tanzania Insurance Regulatory Authority (TIRA) was established in accordance with the Insurance Act of 2009 to oversee all the insurance business in Tanzania including private health insurance. Domestic regulations are the main regulatory style followed by other African countries like Nigeria (Daniels 2008) which have also created regulatory authorities/agencies to superintend all insurance businesses. Conversely, experience from developed countries with an advanced PHI market has shown that to be effective the private health insurance market requires a regulatory mechanism separate from other insurance business. In Australia for instance, the private health insurance market has its own regulatory body known as the Private Health Insurance Advisory Council (PHIAC) which superintends the PHI market and the results are increased coverage and access to healthcare (Colombo and Tapay, 2003)

The objective of forming an autonomous organization could be to improve performance and reduce interference which have been noted to be some of the elements required in assuring good governance and regulation that creates institutional independence from political interference (Sekhri and Savedoff, 2006). Thus the establishment of TIRA may have been in response to the previous regulatory body, (the Insurance Supervisory Department-ISD which was a department of the Ministry of Finance) not being independent to make its own decisions and be able to enforce regulations.

Findings of this study also indicate that although the PHI market has been operating for almost ten (10) years now and a revision of the 1996 Insurance Act has been done recently with the introduction of the 2009 Insurance Act, the new act does not include any regulatory issues specific to private health insurance or even health insurance in general. This may be because the size of the PHI industry is not as big as that of the general insurance or the government does not have sufficient ability to implement private health insurance regulation. Similarly Kumaranayake et al, (2000) found that the size of the market and government institutional capacity were some of the issues that the type of regulations depends on. This could imply that in order for adequate regulation to be put in place there must be sufficient growth of the PHI market and/or improvement of the governments' institutional capacity. Nevertheless, in order for regulations to be effective, they need to be established either before a market is introduced or as early as possible after introduction as it may become difficult to implement once it is well established (Kumaranayake et al 2000; Kumaranayake, 1998) thus the delay in instituting specific regulations for private health insurance could become a problem in future.

5.2 Effectiveness of the existing PHI regulatory framework

Effectiveness of regulation in the PHI market is the extent to which regulations are able to hinder the adverse outcomes of the market activities. The effectiveness also depends on the aspects being regulated, the tools used to regulate, frequency of regulation, institutional capacity of the regulatory authority and adherence to the regulations (Kumaranayake et al, 2000). In this study, adverse outcomes of regulations like risk selection, adverse selection and moral hazard were found to be present thus questioning the effectiveness of the regulations.

The aspects being regulated are important to be recognized as affecting regulation. The regulatory framework in Tanzania does not distinguish issues that are regulated in health and other insurance market and apart from market entry and finance issues (including capital, reserves and solvency); the regulatory authority leaves the PHI market to operate as a free market. This kind of regulatory mechanism has been explored in the literature. Skipper Jr. and Klein, (1999) explored the approaches used in direct state regulation and argued that this kind of approach emphasizes competitive markets with minimal intrusion with respect to market forces and insurers' decisions while Zweifel and Pauly (2004) ranked this kind of regulation as low intensity and called it 'formal oversight of private health insurance' where the issues considered are sufficient capital invested, reserves, actuarial know-how and provision of information showing that conditions for market entry are still satisfied. However, this approach may not be appropriate for private health insurance because it does not address the issues of coverage, benefit packages, premiums and provider payments which are also important to govern in the health insurance market. Studies have shown that countries with significant PHI markets generally regulate PHI markets more heavily (Colombo and Tapay, 2003).

Effective regulation requires sufficient resources. The regulatory authority in this study had insufficient resources to regulate the PHI market, in terms of funds, number of staff and expertise. This was indicated by the low frequency of inspections of PHI companies being done and the lack of skills of the inspectors as reported by the PHI companies who had been inspected. The reason for this could be the high costs involved in regulation and the unavailability of staff with the technical expertise and experience in the PHI market who can be employed. This suggests that the regulations might be ineffective. Other studies have also found that for lower and middle income countries because of the lack of sufficient resources, regulation fails to achieve its objectives and becomes ineffective (Kumaranayake, 1998) and in Chile, the weak regulatory capacity allowed private insurers to deny coverage to high-risk individuals (Holst, Laaser and Hohmann, 2004).

While adherence to the existing regulations was found to be good, in this study it was also reported that there are no regulations for enrollment, premiums, benefit packages or provider payment mechanisms in the PHI market. The absence of regulations targeting these factors can also lead to the regulations being ineffective and increasing the insurance adverse effects of risk selection, adverse selection and moral hazard and eventually reducing access to healthcare.

5.3 Outcomes of regulation on enrollment of beneficiaries

Regulations that have been found to mitigate adverse selection and risk selection include requiring mandatory purchase of coverage, requiring insurers to accept all applicants (including guaranteed renewal), limiting exclusions and waiting periods and implementing risk-equalization schemes (Sekhri and Savedoff, 2006). In this study, we found that there were no regulations regarding coverage. The results showed that purchase of coverage was voluntary; no groups of

individuals were mandated by law to have private health insurance. Also, insurers were not required to accept applicants even if the applicants were able to pay premiums. Individuals presenting with chronic conditions had these conditions excluded, were subjected to waiting periods or had their premiums raised thus making insurance inaccessible and unaffordable to those who need it most.

Health insurance in this country like in many other places uses a maximum age limit of 60 years for enrollees to be accepted, and in this study only those individuals who were part of a large group with few people older than this age were accepted as members while others were rejected. It is known that individuals of this age are more prone to chronic illnesses like diabetes mellitus and hypertension thus excluding them is one of the methods of avoiding high risk individuals. These restrictions on enrollment imply that the absence of regulations for enrollment of individuals could be propagating the behavior of risk selection in the PHI market in Tanzania and leaving those who are most in need of healthcare defenseless. Similarly, Soderlund and Hansl, (1999) found that in South Africa, during the period of deregulation relatively lower levels of cover were evident for the permanently disabled and elderly suggesting that risk selection with regard to the easily 'identifiable factors' such as age and disability were operating.

This study also found that there are mechanisms that PHI companies use to avoid adverse selection. Generally, they requested individuals to indicate any chronic condition they had on their application forms and conduct pre-enrollment medical examinations. Although the insurers themselves reported that they usually do not require enrollees to undergo medical check-ups unless there are special reasons, like having age of more than 50 years, interviews with the beneficiaries indicated that at least a third of them had been requested to undergo an

examination. No statistically significant association was found among those who had been requested to have a medical check-up and their age group indicating that a substantial number of younger individuals were also required to have a medical examination implying that there may be adverse selection in the PHI market and that is why the companies try to detect it. Other studies found that adverse selection causes ever increasing premiums because those who are at high risk have the incentive to lie regarding their health status if not requested to undergo medical examination, to avoid being charged higher premiums (Mahamba, 2009). This implies that due to the high health care costs that these individuals will cause, all individuals including the low risk ones, will have their premiums increased and thus be encouraged to drop out or not enroll at all.

5.4 Outcomes of regulation on healthcare services utilization by beneficiaries

Literature shows that insured individuals have a tendency to use health care services uncontrollably, especially the outpatient services (Pauly et al, 2006). This tendency usually leads to increased cost of claims and inevitably increased premiums. This study found evidence of the presence of an element of moral hazard. A few of the interviewed beneficiaries agreed that being insured has made them to request more medication or investigations than those prescribed to them compared to when uninsured. A small number also admitted to seeking treatment more frequently after being insured. Studies have found that having health insurance is one of several factors that influence seeking medical care, (Al Khatib, 2007) however this over use of services may also be explained by the fact that the study involved beneficiaries who were employees of organizations and that people, who are insured through their place of employment, are unlikely to be immediately aware of the cost of their insurance coverage and thus may have little

responsibility for that cost as also found by Jost (2008). On the other hand it may not be necessarily overuse, but being insured may have opened doors to people who previously sat back with illnesses instead of seeking treatment since they could not afford health care before insurance.

A statistically significant relationship was found between being female and requesting extra medicines/investigation and also seeking services more frequently implying that women are more prone to utilizing more services. This could be because during the pregnancy and delivery period, attendance of antenatal and postnatal clinics is done more attentively as they do not have to think of paying for the cost out of pocket.

PHI companies had strategies in place to diminish excessive use of services. These included restricting health facilities that the beneficiaries could use as primary providers, use of referral mechanisms and instituting co-payments, limits on services, limits of benefits or bills of beneficiaries. There was a statistically significant association found between requesting extra medicines/investigations and having co-payment where those who did not have co-payment requested extra services more. This implies that the co-payment restricts beneficiaries' behavior in requesting extra services by having them pay out of pocket. On the other hand, some studies show that co-payments may disproportionately reduce service utilization among the poor and discourage people from seeking preventive services that would avoid the subsequent need for costly curative care (Sekhri et al, 2005).

5.5 Beneficiaries involvement in regulation

Consumer protection is linked to the idea of "consumer rights" (that consumers have various rights as consumers), and to the formation of consumer organizations which help consumers make better choices in the marketplace. This study found that only about a fifth of all the beneficiaries had ever heard about the Tanzania Insurance Regulatory Authority or knew its name. Those who knew were mostly beneficiaries who were more educated or held higher positions of employment. This implies that those with low level of education and employment position who were more vulnerable did not know where to seek help when having complaints against their insurers. A study done by Mujinja et al, (2000) in Dar es Salaam had similar findings where very few consumers utilizing the private drug outlets knew of the regulatory authority or where to take their complaints when they were mistreated.

There were no consumer rights organizations found in the PHI market and also an absence of a law/act related to private health insurance beneficiaries' protection. This implies that level of consumer involvement in the regulation of the PHI market is very low in Tanzania despite the efforts reported by the authority for educating consumers. In other countries like India, Bhat (1996) found that the Consumers Protection Act (COPRA) publicized in 1986 was important to consumers to increase awareness and protect the interests of consumers through the establishment of consumer councils and has succeeded in defending the rights of consumers in the health sector.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

The findings of this study indicated that regulation of PHI business is done solely by the Tanzania Insurance Regulatory Authority since 2009. The Insurance Act of 2009 that is in use does not have any information on regulation of PHI activities like enrollment, premium setting, benefit packages or use of providers despite being enacted well after introduction of the PHI market. The issues that were mentioned as being regulated are mainly registration and finances. This lack of specific regulations for governing and controlling PHI companies' activities creates an opportunity for PHI market failure unless steps are taken to include regulations specific for health insurance.

Regulation was found to be done by off-site and on-site inspections. The lack of sufficient staff and little expertise caused the frequency of on-site inspections to be low and issues checked to be unsatisfactory, indicating insufficient capacity of the regulating authority. While adherence to the regulations was found to be high, the issues being regulated were not specific to health insurance activities thus suggesting that the lack of specificity could be making them ineffective in hindering the adverse outcomes of the PHI market.

There is risk selection practiced by the insurers and moral hazard by beneficiaries. A limit of 60 years for enrollment of individuals was imposed by all PHI companies, and those with chronic conditions either had the conditions excluded or had waiting periods instituted. Their objective was to reduce cost of care and maximize profit thus posing a threat to the attainment of public

health objectives of equity and universal access to healthcare. Moral hazard was noted among few beneficiaries who admitted to seeking care more frequently and requesting more investigations/medicines after being insured although those who had co-payments were found to request extra treatment less.

Very few of the beneficiaries had ever heard of the presence of the regulatory authority and most of those who had, were of high level of education and high positions of employment. Even less than those named it as the place where they would seek assistance to address complaints against their insurers indicating a lack of knowledge on the regulations by beneficiaries.

In view of the study findings, there appears to be a need for either amendment of the existing act or possibly formulation of a new health insurance act to increase the effectiveness of PHI regulations and increase beneficiaries' knowledge on PHI regulatory issues.

6.2 Recommendations

This study provides information on the existing regulatory framework governing the PHI market and its ability to avoid the unwanted outcomes of private health insurance including risk selection, adverse selection and moral hazard. In view of this, the following recommendations are made to the relevant stakeholders involved in the PHI market:

1. There should be amendment of the existing Insurance Act and regulations to include specific issues that pertain to the health insurance market. These should include issues that are specific to the PHI market like enrollment, premiums and benefit packages that will diminish the consequences of adverse selection, risk selection and moral hazard and in turn increase access to health care. The Ministry of Finance, Ministry of Health and

TIRA can work together with policymakers to amend the existing Act to incorporate these issues.

2. TIRA should increase the number of inspectors they have and distribute them widely in the country. The inspectors should be trained on issues that are relevant to PHI market regulation. This could be done by forming collaborations with other countries where the PHI market has specific regulations and is more advanced. This collaboration can involve exchange of information sending their inspectors to gain experience and see how other countries are regulating the PHI market.

3. Further studies are needed to explore more on how healthcare costs are affected by the PHI market and how the prices can be regulated. The studies would be useful in providing information on whether the PHI market influences the cost of care and suggest ways to contain costs ultimately increasing access to care.

REFERENCES

Al-Khatib, B. (2007) Can Health Insurance improve Health Care in Syria. Indiana School of Medicine.

Bhat, R. (1996) Regulation of the Private Health Sector in India. *International Journal of Health Planning and Management,* **11**: 253-274

Bertranou, F. M. (1999) Are market-oriented health insurance reforms possible in Latin America? The cases of Argentina, Chile and Colombia. *Health Policy,* **47**: 19-36.

Colombo, F., & Tapay, N. (2003) Private Health Insurance in Australia: A Case study. *OECD Health Working Papers,* **8** . OECD Publishing.

Colombo, F., & Tapay, N. (2004) Private Health Insurance in OECD Countires: The Benefits and Costs for individuals and Health System. *OECD Health Working Papers*, **15**. Paris: OECD Publishing.

Daniels, F. (2008) Insurance regulation in the African environment. Presentation by the Commissioner for Insurance, Nigeria. Nigeria Insurance Commission www.**african-insurance**.org/.../mr_fola_daniels_paper_eng.ppt accessed on 2nd Mar, 2010

Drechsler, D., & Jutting, J. (2007) Different Countries, Different Needs:The Role of Private Health Insurance in Developing Countries. *Journal of Health Politics, Policy and Law,* **32** (3): 497-534.

Drechsler, D., & Jutting, J. (2005) Private Health Insurance for the Poor in Developing Countries? *Policy Insight No.***11**. OECD.

Feldman, R., Escribano, C., & Pellise, L. (1998) The role of government in health Insurance markets with Adverse Selection, *Health Economics,* **7**: 659-670.

Frech, H., & Hopkins, S. (2002) *Why subsidise private health insurance?* Paper presented at the conference: Regulating private health insurance. Priorities for Australia and lessons from Abroad.

Holst, J., Laaser, U., & Hohmann, J. (2004) Chilean health insurance system: a source of inequity and selective social insecurity. *Journal of Public Health* , **12**: 271-282.

Hongoro, C., & Kumaranayake, L. (2000) Do they work?Regulating for-profit providers in Zimbabwe. *Health Policy and Planning,* **15** (4): 368-377.

Jost, T.S. (2009) The regulation of Private Health Insurance. *National Academy for Social Insurance Working papers*. Washington: Washington and Lee University.

Kumaranayake, L. (1998) Effective Regulation of Private Sector Health Service Providers. *Paper prepared for World Bank Mediterranean Development Forum* . London: London School of Hygiene and Tropical Medicine.

Kumaranayake, L., Lake, S., Mujinja, P., Hongoro, C., & Mpembeni, R. (2000) How do countries regulate the health sector? Evidence from Tanzania and Zimbabwe. *Health Policy and Planning* , **15** (4): 357-367.

Krysik, J., & Finn, J. (2007) *Research for Effective Social Work Practice*. New York: McGraw-Hill Companies

Kutzin J. (2001) A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy* 2001; 56(3):171-204.

Lee, K., & Mills, A. (1985) *The Economics of Health in Developing Countries.* Oxford: Oxford University Press.

Mahamba, V. (2009) The role of private health insurance in the health care market in Tanzania. A dissertation submitted for the completion of the Master of Health policy and management at Muhimbili University of Health and Allied Sciences.

Mossialos, E., & Thomson, S. (2004) Private Health Insurance and Access to Health Care in the European Union. *Newsletter of the European Observatory on Health System and Policies* , **6:** 1-4. Euro Observer.

Mujinja, P., Mpembeni, R. & Lake, S. (2000) Regulating private drug outlets in Dar es Salaam – perceptions of key stakeholders; in Soderlund, N., Mendoza-Arana, P. & Goudge, J. (eds) *The new public/private mix in health: exploring the changing landscape*. Alliance for Health policy and Systems Research, Geneva 2003.

Mujinja, P. (2008) Consumer Rights and Non-Governmental Action in Medicines Markets: Knowledge, Risk and Trust in Rural Tanzania. *IKD Working paper 39*. Available from: https://www.open.ac.uk/ikd/projects_lowcostdrugs.shtml accessed on 5th Mar 2010

Nigenda, G., Machado, M., & Arroyo, J. (1997) The impact of health care reform on the professional regulation of physicians in Latin America: in Soderlund, N., Mendoza-Arana, P. & Goudge, J (eds) *The new public/private mix in health: exploring the changing landscape*. Alliance for Health policy and Systems Research, Geneva 2003

Pauly, M., Blavin, F., & Meghan, S. (2008) Is there a market for voluntary health insurance in developing countries? *Working paper:National Bureau of Economic Research* . Cambridge.

Pauly, M., Zweifel, P., Scheffler, R., Preker, A., & Bassett, M. (2006) Private Health Insurance In Developing Countries. *Health Affairs,* **25** (2): 369-379.

Roberts M. J. (2004) Getting health reform right: a guide to improving performance and equity. Oxford; New York: Oxford University Press, 2004.

Sekhri, N., & Savedoff, W. (2006) Regulating private health insurance to serve the public interest: policy issues for developing countries. *International Journal of Health Planning and Management,* **21**: 357-392.

Sekhri, N., & Savedoff, W. (2005) Private Health Insurance: implications for developing countries. *Bulletin of World Health Organization,* **83**: 127-134.

Skipper, H. Jr. & Klein, R. (1999) Insurance Regulation in the Public Interest: The Path towards Solvent, Competitive Markets. Atlanta: Georgia. Center for Risk Management and Insurance Research, Georgia State University.

Soderlund, N., & Hansl, B. (1999) Health Insurance in South Africa: an empirical analysis of trends in risk pooling and efficiency following deregulation. *Health Policy and Planning,* **15** (4): 378-385.

Teerawattananon, Y., Tangcharoensathien, V., Tantivess, S. & Mills, A. (2003) Health sector regulation in Thailand: recent progress and the future agenda. *Health Policy* **63** (2003): 323-338

Thomson, S., & Mossialos, E. (2006). Regulating private health insurance in the European Union: the implications of single market legislation and competition policy. *Working Paper No.4* London: The London School of Economics and Political Science.

Trautwein, J. S. (2002) Options And Opportunities For Individuals And Families In The Private Health Insurance Market. *Health Affairs,* **6**: 387-390.

United Republic of Tanzania (2004) Dar es Salaam City Profile. Dar es Salaam.

United Republic of Tanzania (1994) *Proposals for Health Sector Reform.* Dar es Salaam: Ministry of Health.

United Republic of Tanzania (1996) *The Insurance Act.* United Republic of Tanzania.

United Republic of Tanzania (2009) *The Insurance Act*. United Republic of Tanzania

Ven, W. P., Beck, K., Vande Voorde, C., Wasem, J., & Zmora, I. (2007) Risk adjustment and risk selection in Europe: 6 years later. *Health Policy,* **83**: 162-179.

World Health Organization (2006). *World Health Report 2006: Working together for health.*

World Bank (1993). *World Development Report 1993: Investing in Health.* Washington, D.C.: World Bank.

Wonderling, D. (2007) *Introduction to Health Economics.* (N. Black, & R. Raine, Eds.) London: Open University Press.

Zweifel, P., & Pauly, M. (2004) Private Voluntary Health Insurance in Developing Countries: Market outcomes, regulations, and recommendations for policy. *Report submitted to the World Bank*

APPENDICES

Appendix 1: Regulatory Authority In-Depth Interview Guide - *English Version*

Assessment of effectiveness of regulation of private health insurance (PHI) and outcomes on enrollment/recruitment and healthcare utilization of beneficiaries in Dar es Salaam

A. How regulation is done, tools and frequency of supervision/inspection

1. Could you please explain how supervision/regulation of the PHI companies done? Probe on:
    - Who does it?
    - Whether there is a department/unit specific to PHI
    - Are there professional insurance conduct/ethics bodies?
    - Is there a schedule for on site inspections? If yes, is it to all PHI companies? What is inspected?
    - How many supervisors/inspectors are there for PHI?
    - What is the frequency of inspection? e.g how many times per year
    - Do PHI companies have to submit any reports to the RA for examination?
    - If yes, what is the content of the reports, how frequently do they need to be submitted?
    - Are there offices/agents of the authority in other parts of Tanzania that inspect/supervise the activities in their areas (decentralization)
2. Could you please explain what are the issues being regulated in the PHI market?
    - For example, market entry/registration, operation in the markets (solvency, claims payments, customer complaints), market exit
3. Which instruments are used to regulate the PHI market in terms of law and acts.

- Which law and act (and which year it was passed). Availability of supervisory guidelines that are used to regulate the PHI companies, are there guidelines specific to PHI's

4. Could you explain on the registration process and requirements for a PHI company to be able to operate in Tanzania.
    - Any special qualifications/skills for the management of the company?
    - Is there accreditation of PHI companies
    - Any financial requirements e.g capital, security deposits, reinsurance arrangements
5. Is the regulatory authority an independent/autonomous organization? Enquire on who has the final say in issues concerning PHI operations.
6. How are consumers involved in the supervision of PHI companies? Enquire on:
    - Presence of consumers organizations dealing with consumers' rights
    - Whether consumers are informed on their rights
    - Whether complaints are received from consumers and how are they handled
    - If yes, how are they informed/educated by the authority (e.g meetings, posters, fliers, radio/tv information bulletins)

B. Adherence of PHI companies to regulations

7. Should PHI companies fail to comply with the requirements set by the authority, what actions are taken? Probe on:
    - Whether there are penalties, what type of penalties (e.g suspensions, fines, court actions)
    - Duration of the penalties
    - How the penalties are enforced

- What are the costs of enforcement

C. Enrollment and recruitment strategies utilized by insurers and health care utilization of beneficiaries

8. Does the authority have rules regarding recruitment / enrollment of clients by PHI companies? Probe on:
    - Whether enrollment is voluntary/compulsory
    - Are premiums regulated? If yes, how?
    - Whether companies have to accept anyone who seeks insurance or can they refuse to enroll consumers
    - Whether some people are mandated to have PHI (e.g employers to pay for employees)
    - Whether any part of the enrollment process is supervised by the supervisory authority
9. Does the authority have rules regarding benefit packages? Probe on:
    - Whether there are basic services that each benefit package must have
    - Whether consumers are allowed/should be allowed choice of benefit packages

D. Capacity of the regulatory authority

10. Can you explain which resources are used in inspection/supervision of PHI companies?
    - Are the resources enough? E.g sufficient number of personnel, ability and skills of personnel, funds.
    - If not sufficient, what is the deficit? Eg % of personnel required vs those available, funds required vs received funds

11. Which challenges does the RA face in regulating PHI? What are the plans to address them. (eg. Any shortcomings in the law, guidelines, PHI's finding loopholes)
12. Are there any suggestions for improvement?

Thank you for your time and participation in the study.