THE ROLE OF THE PRIVATE HEALTH INSURANCE IN THE HEALTH CARE MARKET IN TANZANIA

By

Vishnu Cynwell Mahamba

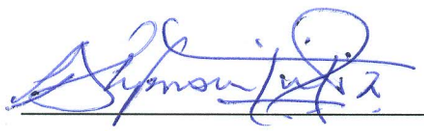
A Dissertation submitted in Partial Fulfillment of the Requirement for the Degree of Master of Health Policy and Management of the Muhimbili University of Health and Allied Sciences

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CERTIFICATION

The undersigned certifies that he has read and hereby recommends for acceptance a dissertation entitled: **The role of the Private Health Insurance in the health care market in Tanzania**, in partial fulfillment of the requirements for the degree of Master of Art in Health Policy and Management of the Muhimbili University of Health and Allied Sciences.



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Date: 20th November, 2009

DECLARATION AND COPYRIGHT

I, **Vishnu Cynwell Mahamba,** 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.

Signature _____

Date 9.11.2009

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DEDICATION

This work is dedicated to my beloved wife Josephine Nyonyi Mahamba for her patience and bearing with a busy husband.

ABSTRACT

Health care financing remains a critical challenge in most developing countries. With an increasing role in financing health care around the world, private health insurance (PHI) has received increased attention particularly where other alternatives of health financing mechanisms have not efficiently accommodated people who could afford private health expenditure. However evidence shows that without efficient regulations, PHI market operates on profit basis through adverse selection, risk selection and moral hazard leading to escalating cost of care, hence jeopardizing the goal of universal access of health care services. This study examined the characteristics, strategies and regulations controlling the PHI market in Tanzania. Furthermore, it examined the consumers' insight on PHI market in Tanzania. A cross sectional analytical study was conducted using both qualitative and quantitative approaches. It was conducted between March and May 2009 and involved a total of six PHI companies which operated on profit basis and were all registered by the Insurance Supervisory Department, Ministry of Finance. A total of 152 consumers were involved of whom 55.26% were aged between 30-39 years old. Majority of the consumers (60.5%) did not know their benefit packages and medical examination was not taken upon enrolment. Apart from high administrative costs, risk and adverse selections were found to be some of the characteristics of the PHI companies. Being insured influenced excessive utilization of health care services hence elements of moral hazard. There was no strict and specific regulation governing the activities of PHI companies which calls for the amendment of the Insurance act of 1996 or formulation of the Health Insurance act. Further studies are therefore needed in order to explore more on the characteristics and strategies of the PHI market in Tanzania. The studies would help in providing information on how to contain such characteristics and hence improve the accessibility of health care in Tanzania.

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LIST OF ABBREVIATIONS

AAR	Africa Air Rescue
CRDB	Cooperative Rural Development Bank
CT	Computed Tomography
GATS	General Agreement of Trade in Service
GTZ	Gesellschaft fur Technische Zusammenarbeit
HMO	Health Maintenance Organization
LMIC	Low- and –Middle income countries
MRI	Magnetic Resonance Imaging
NHIF	National Health Insurance Fund
OECD	Organization for Economic Co-operation and Development
OOP	Out of pocket
PI	Principal Investigator
PHI	Private Health Insurance
RA	Research Assistant
SPSS	Social Science Statistical Package
URT	United Republic of Tanzania
WHO	World Health Organization

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background

Health care financing remains a critical challenge in most low-and middle-income countries. Many governments in developing countries, faced with an increasingly hostile economic environment, demand for extension of health services and increasing pressure on government budgets, are seeking ways of financing health care system so as to increase health care access to the population (Lee and Mills, 1985). Despite various efforts to improve the health situation in the developing world, many countries are still far from achieving universal health coverage (Drechsler and Jutting, 2005); these countries rarely have institutional capacity to finance government-based health care services which in turn results into health costs to be borne by the patients. As a consequence, a sizeable proportion of total health care expenditures are paid out of pocket (OOP) by their population. It is estimated that out of pocket payments account for one third of total expenditure in two thirds of all low-income countries (WHO, 2004).

Low-income families suffer more when they get sick due to direct costs of illness and indirect costs resulting from the lost labor (loss of productive capital). The situation has become more prevalent with an introduction of cost sharing mechanisms in many developing countries e.g. user fees and co-payments (Drechsler and Jutting, 2005). This calls for health financing reforms so as to move away from excessive reliance on out-of-pocket payment as a source of health financing. One option of financing health care services is health insurance which can be in the form of public or private.

Private health insurance also known as voluntary health insurance means that the financial resources are channeled directly to the risk-pooling institution with no or relatively little involvement of the government (Drechsler and Jutting, 2005). Health service delivery in Tanzania has been largely a responsibility of the government. After the independence in 1961, Tanzania gave a high priority to education and health predominantly provided by the government. The government put more emphasis in primary health care and health services were free for all at the point of use. Private practice in health sector was discouraged and ultimately prohibited by law in 1977; and the practice of medicine and dentistry was prohibited as a commercial service (United Republic of Tanzania, 1994; Kumaranayake *et al*, 2000).

However in the mid-1980's Tanzania faced major economic crisis coupled with a fall in the value of exports which led the government to embark on economic liberalization policy (United Republic of Tanzania, 1994). As a consequence, health care expenditure fell, reserves of foreign exchange were reduced and structural adjustment programs deliberately cut back on allocation to the social sector. In an effort to tackle the problem, major health sector reforms were made in 1993 that affected the management, financing, and organization of services. User fees were introduced, services became decentralized, and the ban on private sector in health care delivery was lifted. New policies were developed that looked favorably on the role of the private sector. Following this change, private health sector activity increased dramatically and its importance was further recognized with an amendment of the law (United Republic of Tanzania, 1994).

In broader context of the health sector reforms, the increased private sector activity complemented the government role of health care service provision (Kumaranayake, Lake, Mujinja, Hongoro and Mpembeni, 2000). The rapid increase in private health sector activity favored the growth of private health insurance markets and was further

supported by the General Agreement on Trade in Services (GATS), which calls for opening markets in the service sectors in developing countries (Sekhri and Savedoff, 2005).

There are two types of Private health insurances, non-profit and for-profit private health insurance. Unless mentioned explicitly, in this dissertation work, the term PHI is used to mean the for-profit market. In Tanzania, the PHI market is growing tremendously despite being in its infancy stage. However since the introduction of the PHI market in Tanzania, there had not been an efficient regulatory framework to regulate the PHI market and this pose a threat in provision of health care services particularly in the cost of care.

It is envisaged that unregulated PHI market may lead to moral hazard, adverse selection and risk selection and if these are not well managed, may lead to increased or escalation of cost of care. There have been no studies done to examine the characteristics of the PHI market in Tanzania and how the unregulated PHI market affects the provision of health care services. Therefore, this study tries to fill this gap by exploring the effect of unregulated PHI market in provision of health care services with regard to cost of care in Tanzania.

1.2 Statement of problem

Private Health Insurance (PHI) plays a large and increasing role in financing health care around the world. In recent years, most developing countries have encouraged a rapid growth in the size of private health sector, in particular, private health insurance markets (Drechsler and Jutting, 2005). Being one of the health financing mechanisms, PHI has received increased attention particularly in developing countries where other alternatives of health financing mechanisms have not efficiently accommodated people who could afford private health expenditure (Sekhri and Savedoff, 2005). With

deliberate policies promoting private health sector, Tanzania has not been spared in this dramatic growth of private health insurance (PHI) markets.

Al-Khatib (2007) argues that there are several characteristics of private health insurance market that are applied to both developed and developing countries. These include moral hazard, adverse selection, risk selection (cream skimming) by insurers and supplier induced demand of health care services (Al-Khatib, 2007). However these characteristics have been criticized for escalation of costs in almost all countries that have introduced PHI schemes and have not well managed these insurance markets characteristics hence resulting in market failure. Tanzania cannot be spared from these problems of market failure in insurance if the market is not well intervened. The intervention of insurance market is meant to protect the consumers from the adverse effects or outcomes of characteristics of insurance market therefore protecting public health objectives of equity, affordability and access to health care services (Feldman, Escribano and Pellise, 1998).

The impact of insurance market failure in Tanzania would be exaggerated due to lack of regulation which would lead to escalation of costs and increased inequalities and ultimate insignificant contribution to universal access of health care. The PHI market in Tanzania is still in its infancy. Evidence from other countries show that if the PHI market is to meet public health care objectives, (enhance the efficiency of health care provision while providing fair and comprehensive cover), it has to be regulated. With the unregulated health insurance market, a number of problems have been indicated in the provision of health care services especially in distribution of services, price setting of premiums and quality of health care services (Kumaranayake et al, 2000; Al-Khatib, 2007).

Also experience has shown that unregulated or poorly designed private health insurance systems has led to many PHI market operate on business and profit basis (Sekhri and Savedoff, 2005), targeting mostly those well-off, good health individuals

leaving the poor suffering more. This has been attributed to lack or poor enforcement of regulation of PHI markets hence jeopardizing the goal of universal access of health care services in developing countries.

Tanzania has a relatively weak regulatory framework in the private health sector, which, as it is in many developing countries, mainly focusing on entry in the market, quality and standard setting rather than the regulations in the context of quantity, price and distribution of health care services (Kumaranayake et al, 2000; Kumaranayake, 1998).

In Tanzania, there have been an increasing number of PHI companies with no government intervention on regulating the market. Although basic legislation such as registration and licensing requirements for PHI companies exists for the entry in the health insurance market (Kumaranayake et al, 2000), there is dearth of information on the characteristics and strategies of the PHI markets and how they operate in Tanzania. Due to lack of proper and efficient health insurance regulatory framework and since the companies start operating before the focused regulations are in place (Kumaranayake et al, 2000; Sekhri and Savedoff, 2005), it is hypothesized that PHI companies are contributing to escalating the costs of care. Since they are built on the business profit motive, one would argue that, they may not have plans for containing costs of care to their clients although they may have plans to control costs on their side.

Furthermore, it is speculated that un-regulated PHI market in Tanzania leads to adverse selection, moral hazard and risk selection, consequently resulting in escalation of costs thereby hindering the provision of health care services. Therefore this study responded to some questions such as ' What is the structure and strategies of PHI market in Tanzania', 'What are the characteristics of the PHI market in Tanzania', 'To what extent these characteristics are problems in health care service provision in Tanzania'. In view of increasing role and expansion of PHI market, the answers of

these questions would help to understand the characteristics of the PHI market in Tanzania and thereafter providing useful information and contribution to future health care policy design, planning and formulation of effective regulations.

1.3 Rationale of Study

The study examined the structure and strategies of PHI market in Tanzania and explored the regulations and control that govern the functioning of the PHI market activities. Furthermore it examined consumers' views regarding benefit packages and premiums charges by PHIs in the health care market in Tanzania. This study is an attempt to generate knowledge on the role of PHIs in the health care markets, which is rare in Tanzania. The information generated by this study could also be used by potential clients before joining any of the schemes provided by PHI companies. Furthermore, the results of this study can be used by other stakeholders, ministries and other policy and decision makers in designing effective regulatory measures in the PHI market so as to meet public goal of universal, risk sharing and equitable access of health care services and hence improve the well being of the public.

1.4 Definition of Operational Terms

Universal access of health care	is defined as a 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.
Managed care	is a system of financing and delivering health care to health insured enrollees organized around managed care techniques and delivery systems intended to reduce cost of providing health benefits.

Adverse selection	It refers to a situation where an individual's demand for insurance is positively correlated with the individual's risk of loss and the insurer is unable to allow for this relationship in the price of insurance; this may be because of private information known only to the individual (information asymmetry).
Risk selection	Also known as "Cream Skimming" happens when unusually low-cost people select an insurance plan and an insurer knows more about consumers' expected costs than the consumers themselves and uses marketing or plan design to enroll a healthier-than-usual population (or encouraging unhealthy people to leave the plan).
Moral hazard	Refers to the prospect that a party insulated from risk may behave differently from the way it would behave if it were fully exposed to the risk. It arises when the behavior of the insured person changes in a way that raises costs for the insurer, since the insured person no longer bears the full costs of that behavior, hence that person has an added incentive to ask for pricier and more elaborate medical service—which would otherwise not be necessary.
Client	Refers to a person or group of people using the services of a professional person or organization. In this study, a client is referred to as the corporate company (employer) which is in contract with a PHI Company to provide health insurance to its employees.

Consumer	Refers to a person who uses goods and services i.e. the end user. In this study, consumers are employees of the corporate companies and non-governmental organizations who are insured by the PHI Companies.

1.5 Research questions were:

- What is the structure and strategies of PHI market in Tanzania?
- What are the characteristics of the PHI market in Tanzania?
- Does the existence of PHI market improve access to health care services in Tanzania?
- What is the effectiveness of the existing regulatory framework governing the activities of PHI markets in Tanzania?

1.6 Objectives of the study

The aim of this study is to assess the characteristics, strategies and structure of unregulated PHI market in Tanzania and consumers' perception on PHI market in Tanzania.

1.6.1 Broad Objective

To assess the role of Private Health Insurance in health care market in Tanzania.

1.6.2 Specific Objectives

- To determine the structure of Private Health Insurance companies in Dar es Salaam.
- To determine the strategies of the Private Health Insurance companies in Dar es Salaam.
- To explore the consumers' insight on Private Health Insurance market in Dar es Salaam.
- To examine regulations that governs the activities of the private health insurance market.

CHAPTER TWO

2.0 Review of Literature

2.1 Health Insurance and Structure of Private Health Insurance schemes

Insurance provides the means by which risks or uncertain events are shared between many people; in other words, it involves provision of protection against a possible eventuality (Lee and Mills, 1985). It entails paying premiums to an insurance company, which compensates any insured victim of the event, for any financial loss resulting from the event. Being one of the health financing mechanisms, health insurance can be financed and organized in a number of different ways; and generally its basic function is to provide access to care with financial risk protection (Sekhri and Savedoff, 2006). Depending on the financing agent, health insurance can either be funded publicly or funded on private basis by direct payment.

In public insurance schemes, the funds are obtained from taxes, either general or social security taxes. Whereas, PHI is provided through the direct payment of premiums to insurers (Wonderling, 2007); both of these types of insurance perform functions of a health financing mechanism: collecting funds, pooling funds and purchase services. Private health insurance also known as voluntary health insurance, rests upon a private contract between the insurance institution and its consumer, which sets the level of an insurance premium in exchange for a given benefit coverage (Drechsler and Jutting, 2005).

A review of insurance arrangements reveals a spectrum of classification based on whether the enrolment is mandatory or voluntary; whether risk is shared or not; whether management of scheme is commercial for profit, private non-profit or public/quasi-public (Sekhri and Savedoff, 2005; Al-Khatib, 2007; Wonderling, 2007).

Private or voluntary health insurance can serve a number of functions. Mossialos and Thomson (2004) identify three forms: Private Health Insurance which substitutes for mandatory insurance; PHI which provides complementary coverage for services excluded or not fully covered by such insurance; and PHI which provides supplementary coverage for faster access and increased consumer choice (Mossialos and Thomson, 2004). Mandatory insurance can be used as a policy tool, to encourage (or require) richer population groups to purchase their own health care coverage (Drechsler and Jutting, 2005). The supplementary coverage can happen by default, as in many Latin American countries where richer households are not satisfied with the statutory scheme and choose to purchase PHI in addition (Holst, Laaser and Hohmann, 2004). Complementary and supplementary coverage, on the other hand, close gaps of other forms of health care financing; the former providing cover for services excluded or not fully covered otherwise, the latter providing cover for faster access, better quality, and higher consumer choice (Mossialos and Thomson, 2004).

PHI can reduce the degree of equity of the health system as a whole by removing richer groups from pooling arrangements, as in Chile (Holst, Laaser and Hohmann, 2004), and by accentuating differences in the amount and quality of care available to different population groups (Al-Khatib, 2007).

Supplementary insurance can be a valuable tool to extend coverage to otherwise excluded individuals as shown by experiences from Ghana, where PHI may well be suited for low income groups when the respective schemes are adjusted to local conditions (Okello and Feeley, 2004).

Moreover, supplementary insurance is frequently designed to cover additional or superior treatment, which obviously restricts its outreach to a relatively small group of people; who are willing and able to pay for such services.

In addition to the above, experience from other countries show that PHI schemes are based on the principles of managed care (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007) which provide comprehensive health care for a fixed periodic per-capita payment. In this case, the private health insurance market is primarily influenced by health maintenance organizations (HMOs) (Drechsler and Jutting, 2007), a prominent feature in the US PHI market. HMOs provide (or arrange and pay for) comprehensive health care for a fixed periodic per-capita, which is paid by the consumer. HMO is a coordinated delivery system that combines both financing and delivery of health care services for consumers. However in HMO, consumer choice of service is limited because health services are often provided through the organization's own group practice, contracted health care providers, or both. In HMO, providers act as gatekeepers and have financial incentive to constrain access to more expensive care such as specialists care or inpatient stay (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007). Although there is no limit in amount of health care a consumer can use, adverse selection and moral hazard remain the main challenge with HMOs, this is observed in a number of countries (Drechsler and Jutting, 2007).

2.2 Economics and Importance of Health Insurance

The demand for health care services depends on several variables including being a member in health insurance scheme (Al-Khatib, 2007): having health insurance is one of the factors that influence seeking medical care. In microeconomics contexts, the economic theory of demand of health care services identifies the disposable income of an individual or a household, as one of the most important factors, that influences the consumption of health care. Moreover, the theory of insurance demand predicts that the risk averse household will voluntarily purchase insurance if it can be offered to them at a premium whose excess over expected expenses is smaller than the risk premium they would be willing to pay (Pauly, Blavin and Meghan, 2008). Therefore, the implication of a PHI market is most likely to emerge when three conditions hold:

(1) there is a risk of out of pocket payments which are high relative to households' income; (2) insurance companies can offer premiums to different households that are close to the different households' expected value of out of pocket health care spending; and (3) loadings for administrative costs and profits are moderate (Wonderling, 2007; Pauly, Blavin and Meghan, 2008). Therefore, these three conditions help in estimating how many people would be willing to pay for the health insurance above the expected value of benefits of the premiums.

Private health insurance offers a potential alternative to insure against the cost of illness and of lately, this has also been highly considered by policy makers around the world as an alternative (best) financing mechanism. It is argued that private health insurance cannot be ignored, instead can be harnessed to serve the public interest if governments implement effective regulations and rules (Drechsler and Jutting, 2005). Given the nature of health as a partially public good, private health insurance therefore, requires an efficient institutional and regulatory framework to prevent market failure (Sekhri and Savedoff, 2006). In developing countries like Tanzania, having poor or lacking the regulatory framework, this has led the PHI market to failure whereby the coverage has been mostly to those who are well of or are employed in large private companies.

2.3 Characteristics of Private Health Insurance Market

In economic context, the word 'market' is used to describe any situation where people who demand a good or service come into contact with the suppliers of that good or service (Wonderling, 2007). A prefect market is characterized by several entities of which include the consumer getting what they want, if they are willing and able to pay, and the supplier cannot exploit the consumers because the profits are evaporated in the price war. Among the assumptions of efficient operation of free market are perfect information of the good or service to all participants, no monopoly of the market and perfect competition in the market (Wonderling, 2007).

Consequently a market does not work well if characterized by imperfections and asymmetry of information, which leads to a market for health not being regarded as a typical market and therefore it has to be subjected to regulation within the health sector (Kumaranayake *et al*, 2000; Wonderling, 2007). Asymmetry of information about health risks and costs has led to processes of adverse and risk selections to be the most indentified characteristics in the PHI markets. Due to adverse selection, insurers have less information about an individual's health status than the individual her/himself. This means that, insurance companies use client's medical history (obtained after filling out a comprehensive medical history form) to screen out those whose pre-existing medical conditions pose too great a risk for the risk pool. In general, those who present large financial burdens are denied coverage or charged high premiums to compensations (Al-Khatib, 2007). In voluntary markets, this would result in healthier individual not buying health coverage because the cost will be higher than the potential benefits. For the private health insurers to protect themselves from this unknown risk, they would tend to set insurance premiums higher. However, sicker individuals will still choose to buy insurance resulting in a higher than expected average level of risk in the insurance pool. In order to combat this problem, adverse selection can be reduced by restricting consumer choice by offering only one insurance plan for a group or by mandating that everyone buy a given plan. However, this reduces consumer choice and flexibility when different people prefer different plans. It can also can be reduced by letting insurers set more accurate premiums by giving them more information or lifting restrictions on how premiums are set. However, this makes chronically-ill and high-risk people pay higher premiums (Wonderling, 2007). This adverse selection therefore, results in increasing the cost of care, and to some extent, reducing the beneficiaries of the insurance- for those who would find the premium higher than their expected average cost of care.

Another characteristic of PHI is moral hazard which exists when neither the consumer nor the provider of health care has an incentive to be cost-conscious (Wonderling,

2007). Moral hazard is referred to as to as the increasing use of services when the marginal costs for these services decreases through the effect of risk pooling. The consumer faced with free or low cost health care at the point of consumption has little or no financial incentive to restrain demands on the service. Likewise the providers have no financial incentives to moderate such demands. Moral hazard can increase and stimulate an excessive use of health care which will increase the costs of health care services (Al-Khatib, 2007).

Market response to combat moral hazard is the introduction of cost-sharing and co-payment schemes so as to provide some financial burden on the consumer so as to reduce unnecessary use of health care (Wonderling, 2007). However in developing countries where people's income is low, this can have a significant impact on health care provision. Depending on the amount of charges for health care, people may be excluded from consumption as a result of lack of ability to pay in this cost-sharing concept.

Risk selection, also known as cream skimming, is another characteristic of PHI market, which occurs when insurers try to counter adverse selection or maximize profit, by discouraging sicker individuals from purchasing insurance or by finding ways to insure only lower-risk individuals (Al-Khatib, 2007; Wonderling, 2007). Whereas, adverse selection leads to rising premiums and a growing concentration of high-risk individuals in an ever-decreasing market, risk selection leaves those who are sickest, without adequate insurance, even when they are willing to pay for it (Feldman, Escribano and Pellise, 1998). In developing countries, cream skimming have adverse effects which are substantial as seen in chronically ill who might receive poor quality of care and poor service. It also result in a market segmentation whereby the high risks are left in plans with high premium contributions and the low risks self-select into plans with low premium contributions hence making the selection to be more profitable than improving efficiency (Ven, Beck, Vande Voorde, Wasem and Zmora,

2007). In general, the PHI market gains by selection, however for the society as a whole selection represent a welfare loss threatening quality of care, and efficiency.

Another characteristic of the PHI market is supplier induced demand can happen due to the asymmetry of information between the insurer and the provider of health care, and the provider of health care and the patient. As a result, the health care provider may endow with unnecessary and more expensive treatment, as they feel that the cost is not directly paid for by the patient but rather by the PHI institution. However, in another circumstances, the health care provider may switch the demand-inducing abilities from lower-income people to those more able to pay (Wonderling, 2007). Consequently supplier-induced demand decreases the affordability of health care coverage and dampens insurance demand. Insurers may use different provider payment mechanisms—such as capitation and case rates—to provide an incentive for health care providers to control costs. Nevertheless, experience shows that introducing such payments may affect the insurer's ability to attract clients or engage providers (Sekhri and Savedoff, 2006). These mechanisms may also encourage the provision of poor-quality care, requiring regulation of the PHI market so as to protect consumers through quality assurance regulations to avoid under-provision of care.

2.4 Strategies of Private Health Insurance markets

2.4.1 Enrollment, retaining and maintenance of consumers

In many developing countries, PHI is the only form of risk pooling mechanism available. It provides coverage to those who are employed mainly in the private sectors (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007). Experience has shown that PHI enrolment tends to be voluntary in nature; however this is not true in some countries. In developing countries like Uruguay and Colombia, the enrollment in PHI schemes is mandatory, and this has led to increased coverage in the population. Having a long history of regulated mandatory health insurance; Uruguay has managed

to cover more than 60% of the population (Drechsler and Jutting, 2005; Sekhri and Savedoff, 2006). However in developed countries like Switzerland and Australia, PHI is also mandatory whereas in Australia the high income earners are required to purchase private health insurance (Colombo and Tapay, 2003). Although the enrolment in PHI is mandatory in Switzerland, risk selection strategy is still evident in major insurers (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007) especially in the managed care setting.

In Australia, a country grouped with countries where PHI has a relatively significant financing role, recent reforms require those with personal incomes over US$30 000, or families making over US$60 000 annually to purchase private insurance. To encourage enrolment, Insurers are prohibited rating premiums on the basis of risk status, and open enrolment compels funds to accept all applicants with no discrimination. Another policy strategy introduced by Australian government to encourage enrolment is a 30% tax refund to those who purchase private insurance and an introduction to a life time community rating plan in which those who join after 30 years of age pay a premium over base rates for each year they remain uninsured; this eventually encourages people to enter earlier and stay in the risk pool (Colombo and Tapay, 2003). All of these have increased the PHI coverage from 30.1% to 45.7% in three years period (Frech and Hopkins, 2002; Colombo and Tapay, 2004).

Similarly, enrolment in the United States of America (USA), a country which relies on voluntary enrolment to PHI to provide coverage, mandates most of the PHI companies to provide community rating or do not permit premium that are fully risk-rated. Individual-market coverage is available in a variety of deductible levels and plan types, to allow people to select coverage that best meets their specific needs (Trautwein, 2002). Despite being heavily regulated, the PHI markets in developed countries including the USA still face problems of adverse selection and cream skimming in the insurance industry (Ven et al, 2007; Trautwein, 2002); as seen in

Belgium, German and Netherland where there is aggressive commercial campaigns, selective advertising, approaching employers and opening clinics in healthy regions (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007).

In addition, in the United States of America and many Latin American countries, have adopted PHI schemes that are based on the principles of managed care. In this respect, the PHI market is primarily influenced by health maintenance organizations (HMOs) (Al-Khatib, 2007; Drechsler and Jutting, 2007; Trautwein, 2002). As seen in the US PHI market, similar observations of the managed care activities have been noted in Switzerland whereby PHI companies have an option of to create HMOs (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007). However these HMOs are envisaged to be used as one of the methods used to retain customers in the PHI market by enhancing quality and cost-effectiveness of health care (Wonderling, 2007).

With exception of South Africa (coverage is 18% of the total population), Zimbabwe (coverage is 6 % of the total population) and Namibia, the PHI industry in the Sub Saharan Africa is still in its infancy; and its coverage is among people who are employed by companies (Soderlund and Hansl, 2000).

In countries where there is poor or lack of regulation of PHI industry, usually the market would tend to have strategies (adverse selection, cream skimming and moral hazard) which are of profit in nature. This is even observed in countries with regulation like the USA, Australia and Switzerland. Nevertheless, these strategies were evident in a study done in South Africa which examined the pattern of PHI coverage in respect of regulation. It was found that the country initially had regulations of PHI whereby health insurers were required by law to community rate their premiums during enrolment, and were not allowed excluding the high risk people from cover. This improved equity and efficiency in private health care (Soderlund and Hansl, 2000). However, when regulations were removed, the insurers risk rated the premiums to enrollees with higher premiums, and excluded high risk individuals. This

necessitated the government to re-regulate the insurance industry so as to improve coverage of health care services (Soderlund and Hansl, 2000; Pauly et al, 2006). Nevertheless, this study was done in a country with a history of more than 100 years in private insurance market, yet the results show significance and relevancy of regulating the market right from the process of enrollment of customers. Similar observations apply to countries with diversified PHI markets like Lebanon and Jordan, where lack of effective control mechanisms have contributed to cost and premium escalation in the PHI market (Al-Khatib, 2007).

PHI started recently in Tanzania, and we could not find literature on the strategies of enrolment, retaining and maintaining customers of PHI market in Tanzania. Anecdotal evidences shows that most of the PHI clients are employees of large and medium companies; the formal sector of government employees have a mandatory risk pooling mechanism under the National Health Insurance Fund (NHIF) (Hussein, 2005). However, experience from other countries from the literature, one would argue that, coupled with lack of regulation, the PHI market in Tanzania may be operating with the same strategies as in other countries which lack strong regulatory framework. It has been observed that some PHI companies in Tanzania have introduced managed care concept in the form of HMO although their role in universal access to health care is still unknown.

2.5 Role of government regulation

The experience shows that without government intervention, PHI markets will not efficiently match supply to demand (Lee and Mills, 1985). The reason for government intervention in PHI is based on market failures specific to health insurance and the public's interest in preserving the health of its citizens. Regulations must correct for systemic risks and instability, and protect consumers from unscrupulous insurers (Sekhri and Savedoff, 2005). Without efficient and effective regulatory instruments and control mechanisms, it becomes difficult to prevent cream skimming, cost and

premium escalation thus putting equity strategies in jeopardy (Kumaranayake *et al*, 2000; Sekhri and Savedoff, 2006; Hongoro and Kumaranayake, 2000).

Recent increase in activity of PHI market in developing countries has been attributed to several factors including liberalization of markets, increased international trade in the insurance industry, and growing dissatisfaction with public health care (Drechsler and Jutting, 2005). Without effective regulation of the PHI markets, this development poses threats and opportunities to health care system in developing countries hence jeopardizing the intentions of universal access of health care services. If PHI market is carefully managed and adapted to local needs and preferences, it can be a valuable tool to complement existing health-financing options (Drechsler and Jutting, 2005). However the regulations need to be formulated and be in place earlier enough in the process of marketing as it becomes difficult or even impossible to be implemented once the insurance industry is well established (Kumaranayake, Lake, Mujinja, Hongoro and Mpembeni, 2000).

The regulations of PHI market by the government vary largely between regions and countries. The regulation requirements depend on the development stage of the country, the size of the PHI industry and government's institutional capacity in implementing the regulation (Kumaranayake, Lake, Mujinja, Hongoro and Mpembeni, 2000). The aim of regulation has been on protecting consumers from insurer insolvency so as to ensure access to health care services. Health Insurance studies in the developed countries have shown that in order to have a well-established private health insurance markets, the government should routinely intervene in the market, to protect consumers and promote public health objectives of equity, affordability and access to health services (Sekhri and Savedoff, 2006). Review of literature reveals 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).

Experience from the European Union countries shows that there was a formation of a directive which required the governments to abolish existing product and price controls, the directive accorded primacy to the financial approach to regulation, rendering the material model redundant and, in some cases, illegal. Second, it required governments to liberalize markets for private health insurance, opening them to competition at national, and European Union levels. Third, it prevented governments from discriminating among insurers on the basis of legal status (Thomson and Mossialos, 2000). These changes have introduced tighter solvency control and in turn improved access and coverage to health care services.

Similar effects of the government intervention has been noted in Australia, where private health insurance plays a prominent role in the health care system, and in private hospital 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). Besides financial solvency requirements, Australia thus tightly regulates premium rating and insurers' offering for all private insurers, which reveals a desire to maintain broad participation in the PHI market across different risk cohorts.

However, in contrast to other countries with recent growth of PHI market, PHI is still in its infancy stage in developing countries as many of them have entered the market as part of general reform process toward market based economic systems (Drechsler and Jutting, 2005). PHI has failed to become a significant channel of health care financing due to lack of public regulation as well as missing oversight of the companies' solvency. This has been the case for many developing countries (Sekhri and Savedoff, 2005; Al-Khatib, 2007), whereby the lack of regulation, have let the PHI industry to operate on profit basis.

Studies done in Latin America on PHI markets revealed that the government intervention on improving market performance increased the health care coverage in countries like Uruguay and Chile. 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).

Elsewhere in the world, the effect of lack of regulation of PHI market is evident in developing countries where the PHI industry is relatively a new phenomenon. Studies and observation done in Jordan and Lebanon, showed lack policy harmonization and institutional accountability between ministry which is responsible for PHI regulation and the Ministry of Health (Drechsler and Jutting, 2005; Al-Khatib, 2007). Coupled with lack of effective control mechanisms, these have contributed to the cost and premium escalation in the health care sector in these countries, thus many people failing to buy premiums. Although PHI is relatively a new phenomenon and is already diversified in these countries (Al-Khatib, 2007), it is being envisaged that better mechanisms and regulations could decrease uncertainty among the population about crucial coverage and consequently improve the market outcomes.

In the study to analyze the trend in risk pooling in South Africa, Soderlund and Hansl 2000, found that lack of regulation led to adverse selection and escalation of costs of premiums in PHI market. This had an observable impact on the sick and elderly whereby they lost cover of insurance (Soderlund and Hansl, 2000). However re-regulation of PHI market in South Africa has shown to have improved the situation on equity and coverage of health care services. With the exclusion of South Africa, most of the Sub Saharan countries do not have regulatory framework governing PHI activities. Nevertheless, they do have regulations which govern legislation and standard setting of private health sector (Kumaranayake et al, 2000; Hongoro and Kumaranayake, 2000), not for the insurance industry *per se*. This is the same case as

in Tanzania whereby there is no regulatory framework governing the PHI market rather than the legislation required before the entry in the market. In addition to this, the private health insurance activities in Tanzania is regulated by the Ministry of Finance and Planning under the Office of Commissioner of Insurance; regulation mainly through legislation aiming at controlling the entry in the PHI market. However it has been observed that the PHI companies are not being regulated on the quantity of the services, price or even distribution of health care services.

In general, regulating the PHI market is required in order to improve the access to health care services. It has been noted that, with lack of regulation, the PHI can have strategies resulting into adverse selection, cream skimming and moral hazard, which in turn can jeopardize the goal of universal access of health care.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Area of study

The study was conducted in Dar es Salaam Region, Tanzania. Dar es Salaam has three municipalities; Ilala, Temeke and Kinondoni. According to the 2002 population census, Dar es Salaam had 2,497,940 populations with an annual growth of 4.39% (United Republic of Tanzania, 2004). The projected population for the three municipalities of Dar es Salaam as per the end of 2008 was therefore 3,232,476. Dar es Salaam was chosen because most of private health insurance companies have their headquarters in this city. This city attracts private insurance due to the fact that it is the major commercial and industrial centre in the country; coupled with other business activities and more likely to have companies and individuals who would enrol for private health insurance.

3.2 Design of the Study

This was an analytical cross-sectional study that was conducted between March and May 2009. Both qualitative and quantitative approaches were employed. A qualitative data collection was utilized so as to give more insight and understanding on the characteristics, structure and strategies of the PHI market (with regard to escalation of cost of health care) in the provision of health care services in Tanzania. On the other hand, a quantitative approach was used to establish the insight of consumers of health care services financed by PHI companies in Dar es Salaam.

3.3 Study Population

Two different study populations were involved in the study. The first study population included the private health insurance companies in Dar es Salaam. According to the Insurance Supervisory Department (which is under the Ministry of Finance), there are 18 insurance companies registered in Tanzania. Of these, 7 insurance companies provide health insurance; and these are AAR Insurance Tanzania Ltd, Prosperity Life care Insurance, Strategis Insurance, Reliance Insurance Co. Ltd, Phoenix Assurance, Heritage Insurance Company Ltd and Jubilee Insurance company Ltd. However, AAR, Strategis and Prosperity life care Insurance are registered as specialists in health insurance while for the rest, health insurance remains as a product or one of their business activities. Reliance Insurance Co. Ltd is registered to provide health insurance however it has not yet started to provide health insurance services.

Another study population included consumers of the PHI companies. These were mainly employees in companies and organizations which are insured by the PHI companies and all self insured individuals.

3.4 Sample size and sampling procedures

3.4.1 PHI companies

Since the companies involved in private health insurance market in Tanzania were very few, there were no strict criteria for the sample size; this is due to the fact that the sample size in qualitative research is unlikely to be known with certainty at the start of the research. The target was to interview all private health insurance companies involved in the health insurance market in Tanzania.

3.4.1a Inclusion criteria

The study included only companies that were providing health insurance. Selection of PHI companies was done on convenient basis. This implies that all companies that

provide private health insurance in Tanzania were involved in the study. However, purposive sampling method which focuses on selection of particular individuals from the target group of a study, was employed to get at least one key informant to be interviewed from each of PHI company in Tanzania. The purposeful sampling was employed to find out information-rich cases which would be used to deeply explore the intended issues. In this study, for each PHI company, at least one executive director, managing directors or chief executive officers, were involved so as to find out information from the management perspective.

3.4.1b Exclusion criteria

National Health Insurance Fund (NHIF), National Insurance Company (NIC) and Zanzibar Insurance Company (ZIC) were excluded in this study. Although ZIC has a branch in Dar es Salaam, its headquarters are in Zanzibar; for logistical reasons the location consequently led to its exclusion. NHIF was excluded due to the fact that it covers government employees. However NHIF members were used for pre-testing the research tool.

3.4.2 Consumers

All employees of the corporate companies and organizations which are insured by the PHI companies were included in this study. However, all individuals who are not employed but enrolled in the insurance scheme were included in the study as well.

3.4.2a Inclusion criteria

A complete list of companies and organizations covered by PHI was obtained from each PHI company. Then from these companies and organizations, consumers were selected on the convenient basis. This means that all individuals present at the workplace/department during data collection were interviewed. The goal was to have

interviews of at least 150 consumers. All interviews were done at the consumers' workplace.

3.4.2b Exclusion criteria

Individuals, who were enrolled in private health insurance companies but at the time of data collection were not residing in Dar es Salaam, were excluded.

Also individuals, who were enrolled as dependants to the primary enrollees, were excluded from this study due to the fact that some of them were children who could not be able to respond to technical questions.

3.5 Recruitment and training of research assistants

Two people with background in social or health sciences and with good communication skills were recruited as research assistants (RA) after being interviewed for the task. Prior to the actual fieldwork, research assistants were trained for one day and given orientation on the overall scope of the study. The orientation contents comprised of study objectives, familiarization of research tools and how to administer tools. RA's were also introduced to research ethics and administrative issues such as work plan and other logistics.

The principal investigator (PI) was involved in collecting qualitative data and supervised research assistants and coordinated day to day activities. In order to secure verification and ensure quality and consistency of data collected from the field, the principal investigator and the research assistants checked all the questionnaires to ensure there was no missing information.

3.6 Data collection techniques and Instruments

The study used both quantitative and qualitative methods in data collection (*see appendices VI and VI*). Qualitative interviews were used as a principal approach for

data collection through in-depth interview using semi-structured questionnaire which were free to probe and explore within predetermined areas of inquiry. Interview guides with a list of questions was used by interviewer to interview the participants. For all in- depth interviews, tape recording was done so as to capture information more authentically.

For both tools, questions were initially written in English; thereafter they were translated into Kiswahili language (*appendices V and VII*) so as to ensure the questions are clear and easily understood to the respondents. However, to increase validity of the responses in qualitative interviews, an English version was used for those individuals who were more conversant with English than Swahili. The instruments were peer-reviewed for content validity and revised before data collection commenced.

The qualitative tool, which was grouped in three sections, was designed to collect information. These sections were: the structure, strategies of the PHI companies and regulatory framework governing the PHI market in Tanzania.

3.6.1 Structure of the company

This included brief description of the private health insurance company, its benefits packages in terms of different types and benefits; reimbursement mechanisms and its administrative costs.

3.6.2 Strategies of the companies

This section involved questions on strategies employed to attract clients and consumers, carry out risk selection, and counteract moral hazard effect for consumers. In this study, these strategies involved filling the membership forms during enrollment, target population on recruitment, the use of selected /special health facilities or use of HMOs and consumers' freedom in choosing health facilities.

Through these strategies, the PHI companies' activities can be thought of practicing adverse selection and risk selection to their consumers.

3.6.3 Role of regulations of PHI market

Regulation is meant to protect consumers and increase cover of insurance. In this study, regulation was examined on premium priding, benefit packages, profits, provision of services and recruiting customers.

The quantitative tool was designed to collect information which was grouped in three sections: socio demographic information of consumers, health insurance profile and their knowledge and insight on PHI market.

3.6.4 Socio demographic information

This section generated socio demographic information of consumers; variables included were age, sex, marital status, education level, main occupation, individuals' rank in employment, number of people living in the household and how many depend on the consumer for health care costs.

3.6.5 Health Insurance profile

This section generated information on the membership status of the consumer, his/her spouse, the name of the insurance company covering the consumer and coverage of dependants.

3.6.6 Consumers' insight on PHI market

This section included identification of how one enrolls in the PHI company, identification of owns' benefit package, consumer involvement in choosing the benefit package, taking medical examination before enrollment, freedom of choosing health facilities and comparison of consumers' behavior and attitude before and after the cover with health insurance. Moral hazard by consumers was determined by questions

on request for extra services, presence of limitation on services, limit of bills, presence of cost sharing or copayments and frequency of seeking health care after being insured.

3.7 Pre- testing

Pre-testing of the instrument was conducted by the principal investigator and research assistants and it was done to test the clarity of questions. Later on, modification of the instruments was done to ensure that they bring the desired outcome for the study. This activity was carried out to 15 National Health Insurance Fund members.

3.8 Data management and procedures

Qualitative data collection and verification were done by the Principal Investigator (PI). The risk in recording wrong responses (in qualitative data collection) on account of having misunderstood responses was minimized by reviewing the tape recorded interview during transcription.

Qualitative data analysis involves organizing, categorizing and coding of data in order to search for patterns and how concepts influence each other, discovering what is important and what is to be learned. Qualitative data in this study was analyzed using Tech's method of analysis (Tesch, 1990:84-94) whereby all transcription were read carefully and rich information sorted out, unnecessary one discarded. Thereafter identification of patterns, categories and themes were used to organize the raw data in order to bring the meaning of vast information collected.

Quantitative data collected was checked during and after data collection and coded. The questionnaires were given serial numbers before data entry. Data was then entered and analyzed using Social Science Statistical Package (SPSS) software. Frequency distribution tables and figures were run followed by cross tabulation and analysis of different variables.

3.9 Study Variables

Both closed and opened ended questions were asked. The responses were post coded numerical, ordinal or nominal at the end of data collection.

Independent variables

1. Weakness/Lack of governments' regulatory framework
2. Level of employment
3. Enrollment period
4. Income
5. Knowledge on the cost of premium
6. Being insured
7. Taking medical examination

Dependent variables

1. Benefit package choosing
2. Benefit package knowledge
3. Benefit package grouping
4. Affordability of buying a premium
5. Happy with the benefit package
6. Health care provider treatment
7. Health care provider attitude
8. Availability of medication
9. Time in waiting for services
10. Spending more time with provider
11. Freedom of choosing health facility

3.10 Ethical Considerations

To adhere to ethical issues, a research ethical clearance (*appendix VIII*) was sought and obtained from Muhimbili University of Health and Allied Sciences (MUHAS) Research and Publication Ethical Committee after processing it through the School of Public Health and Social Sciences. Furthermore a letter for research permit (*appendix I*) from the Commissioner of Insurance, Ministry of Finance was sought before the study commenced. A letter of introduction (*appendix IX*) to the PHI companies involved in the study was obtained from the Commissioner, Insurance Supervisory Department Ministry of Finance.

Furthermore, written informed consent (*appendix III*) was sought and obtained from individuals before they took part in the study. Specifically, interviewees were informed about the aim and objectives of the study and that their participation was voluntary. Only those who consented were interviewed, and were free to withdraw from the study at any point in time. It was clearly clarified that the information to be provided whether orally or in writing would be for research purposes and would therefore be strictly anonymous and dealt with confidentially.

3.11 Limitation of the study

1. Some directors of the PHI companies were not cooperative to contribute freely since they did not feel free to disclose information regarding their company's activities for instance who are clients covered by them and financial issues of the company. However the PI ensured confidentiality to those who had queries on the issues asked and an introductory letter from the Commissioner of Insurance Supervisory Department explained and emphasized more on the study implication and its aim and benefits.

2. There may be information bias, since most of the workers had no much time to respond to the questions asked. These were workers in private companies who were afraid of spending more time with the interviewer. It may be that most of them gave strategic information so that they could be left to leave for their workplaces.

3. The results of the study cannot be generalized to all places in Tanzania, since respondents were purposively selected.

4. Some respondents faced difficulties with some terminologies during interview as they were not conversant with Kiswahili. This was minimized by use of English language to clarify and rectify the difficulty issues faced.

CHAPTER FOUR

4.0 RESULTS

This chapter presents the results obtained from analysis of both qualitative and quantitative data. A total of six PHI companies were involved in the study in qualitative data collection. The information collected was systematically categorized into three main themes followed by sub-themes. The first theme was structure of the company accompanied with sub-themes of brief description of the companies, types of benefit packages and administration costs. The second theme was strategies of private health insurance companies. Sub-themes included recruitment and enrollment of clients/consumers, medical examination upon enrollment, retaining and maintaining consumers, reimbursement mechanisms, selection of health facilities and lastly courtesy of providers towards consumers. The last section on the qualitative information is on regulation and control of private health insurance market. However the quantitative information of consumers' insight on private health insurance market is incorporated in the qualitative information.

4.1 Structure of the company and socio-economic characteristics of consumers

4. 1.1Brief description of companies and the consumers

All the companies visited reported that their business were for-profit. They started private health insurance operations in Tanzania between 2002 and 2007, after being licensed by the Insurance Supervisory Department of the Ministry of Finance of United Republic of Tanzania. Three of the companies are registered as specialists in health insurance. This means they are not involved in any other insurance business but health insurance. A respondent from Prosperity Life Insurance Company confirmed by saying:

'As a company, we insure clients on their health, same as motor or any other policy where insurance is against risks, accidents,..... So we insure human beings against diseases.'

For the other three companies, health insurance is one of their products as they are involved in other insurance business like motor and fire insurances.

One company (AAR) reported to have started its health insurance business in 2007; although it had been providing health care services as a Health Management Organization (HMO) since 1999. Of recent, the health insurance business has also been found to be lucrative. A respondent from AAR acknowledged by saying:

'....later on it was discovered that it could not fit in within Insurance act. So in September 2007, the AAR registered an insurance company primarily to deal with medical insurance.'

Also it was found that some of the companies are operating in more than one country. They also operate in countries like Kenya, Uganda and Rwanda.

We found that there are two types of clients of the PHI companies. The first group comprises those individuals who obtain health insurance to cover themselves on individual basis. The second group comprises corporate companies like Vodacom, Tigo, Zain, GTZ, British Airways, banks like Citibank, CRDB, Standard Chartered etc. Non-governmental organizations and embassies are included in this group as well. The coverage was based on the employers wish as a respondent at AAR confirmed that:

'These are mainly employers who wish to obtain the services of medical insurance for their employees.'

The study found that most of the PHI consumers are employees of corporate companies. A total of 152 consumers were interviewed and their socio demographic characteristics are summarized in Table 1. Most of the interviewed consumers were aged between 30 and 39

years old. About 98% of all respondents possessed formal employment status, mostly employed by private companies and non- government organizations. The majority of individuals interviewed (76.3%) had completed post-tertiary education; and 68.4% of all respondents were married.

Table 1: Socio demographic profile of consumers by sex (%)

Characteristics		Sex		
		Male N=82	Female N= 72	Total N= 154
Age groups	20-29	53.3%	46.7%	19.74%
	30-39	46.4%	53.6%	55.26%
	40-49	69.6%	30.4%	15.13%
	50-59	73.3%	26.7%	9.87%
Occupation	Formal employment	54.4%	45.6%	98%
	Self employed	0%	100%	1.3%
	Others	100%	0%	0.7%
Education level	Completed Primary school	75%	25%	2.7%
	Completed O-level	50%	50%	10.5%
	Completed A-level	37.5%	62.5%	10.5%
	Completed Post-tertiary Education	56%	44%	76.3%
Marital status	Married	54.8%	45.2%	68.4%
	Single	25(59.5%)	45.2%	27.7%
	Widowed	0(0%)	100%	2.6%
	Separated/divorced	0(0%)	100%	1.3%

The study revealed that about 51% of all consumers had had an episode of illness in the last four weeks prior to this interview. Majority of these (83.1%) visited hospitals; the rest visited other health facilities like dispensary and health centers.

4. 1.2 Types of benefit package/premiums

It was found that there are different benefit packages provided by these PHI companies. Some of the companies cover for inpatient services only while others have different categories of

services ranging from covering outpatient and inpatient to international cover. Two of the companies studied provide inpatient cover only, and the outpatient costs are paid by the customer. Commenting on this kind of benefit package, an interviewee from Phoenix Assurance said:

> *'We do not sell outpatient policy because in our opinion out-patient insurance is a bad insurance; insurance having feature of uncertainty, if you are sure that you are not going to get sick, then no need of insurance. In our opinion, out-patient is of some degree of certainty, everybody has to go for outpatient; some has to go daily, once a week or once a year.'*

We also found that there are different names for the benefit packages provided which are different between companies. For instance from AAR, the benefit package are known as Gold preferred, Silver prestige, Bronze Elite; Strategis has several ones known as Premier, Flexi plus, Flexi, Prime plan- 10, prime plan-10 plus, Prime plan5; Prosperity Life Insurance has two of them known as Prestige comprehensive and status comprehensive. This in turn makes the companies to have different prices for different premiums and as the premium gets higher, an individual gets more health care services with non-elective treatment in some of the countries abroad.

The study also found that in some instances, depending on one's budget, a client could negotiate with a PHI company to have a product which would suit the needs and service of its employees i.e. a tailor-made product. This was confirmed by a respondent from AAR who reported that:

> *'However we have employees group schemes (tailor made) whereby an employer who has a huge population (like the cement company), we design a product which suits the needs of the employer and is affordable to the company.'*

4.1.2a Consumers' knowledge on the benefit packages

Assessment of consumers on the knowledge of their benefit packages revealed that majority of respondents (60.5%) did not know their benefit packages (Table 2) regardless of their duration of enrollment.

Table 2: Period of enrollment of consumers and their knowledge on benefit packages (%)

Enrollment period	Benefit Package knowledge			P value
	Know	Don't know	**Total**	
	N= 60	N= 92	**N= 152**	
Less than a year	29.51%	70.49%	**100%**	0.116
Between one and five years	45.68%	54.32%	**100%**	
More than 5 years	50%	50%	**100%**	
Total	**39.47%**	**60.53%**	**100%**	

It was also found that majority of the consumers (90.8%) did not choose the benefit package on their own; of these who did not choose on their own most of them (82%) , the benefit package was chosen by the employer (Tables 3 and Figure 1).

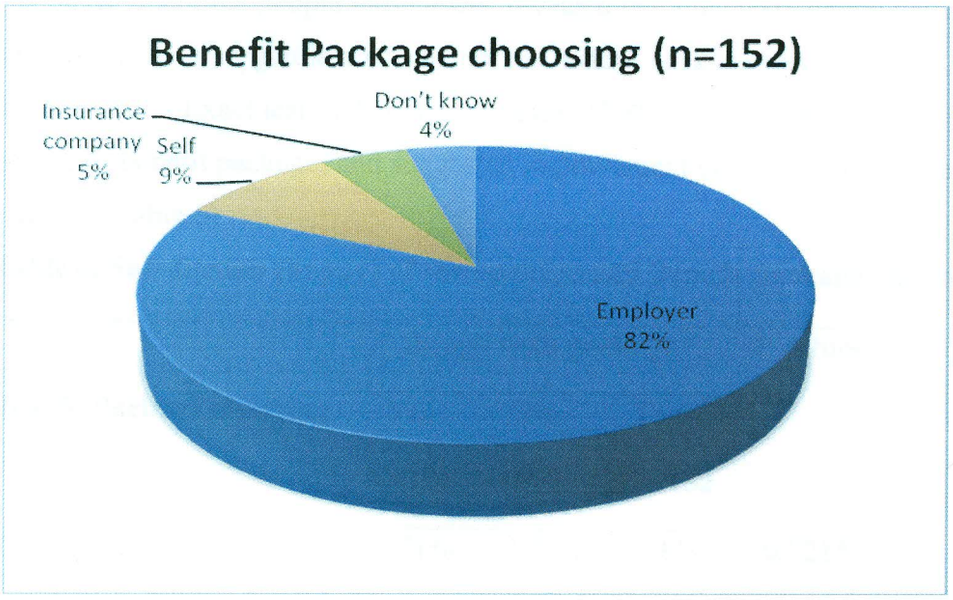


Figure 1: Benefit package choosing for consumers

Data in table 3 shows that majority of consumers from all levels of employment did not choose their benefit packages. The data show that level of employment of the consumer did not have any significant effect in choosing the benefit package (p=0.946).

Table 3: Consumers' level of employment and benefit package choosing (%)

Level of employment	Benefit package choosing			P value
	Yes N= 14	No N= 138	Total N=152	
Managerial	10%	90%	**19.73%**	**0.946***
Supervisory	7.89%	92.11%	**25%**	
Normal staff	9.52%	90.48%	**55.27%**	

Key:

* Fisher's Exact test was used to calculate p-value since more than 20% of cells had an expected count less than 5.

About 88.2% of the people interviewed revealed that they were happy with their benefit package (Table 4) regardless of whether the benefit package was chosen by themselves or for them (Fisher's Exact test, p=0.721). However, 17.8% of those interviewed, were not happy with their benefit package; and suggested improvement or addition of services so as to be satisfied (Table 5).

Table 4: Satisfaction (happy) of the package and Benefit package choosing

Benefit Package choosing	Happy with package			P values
	Yes	No	Total	
	N=125	N= 27	N= 152	
Yes	85.71%	14.27%	9.21%	0.721*
No	81.88%	18.12%	90.79%	
Total	**88.24%**	**17.76%**	**100%**	

Key:

* Fisher's Exact test was used to calculate p-value since more than 20% of cells had an expected count less than 5.

Table 5: Suggestions from consumers who were not happy with benefit package

Suggestion (n=22)	%
There should not be limitations on services e.g. Dental, Optical, chronic diseases etc	**66.7**
There should not be limitations on age to be covered and on the number of dependants	**18.5**
Dependants should have the same benefit package as the principal beneficiary	**7.4**
There should be enough information before enrollment and hence freedom to choose owns' premium	**7.4**
Total	**100**

The study also found that majority of the consumers (61.18 %%) had a knowledge on the cost of the benefit packages (Table 6); the rest did not know the cost of their benefit packages. However, the table below shows that knowledge on the cost of premium does not significantly affect affordability of buying a premium (Chi square test, p=0.828).

Table 6: Consumers' level of employment, income, knowledge on the cost and affordability of buying a premium (%)

	Affordability of buying a premium			
Employment level	**Yes N= 22**	**No N=130**	**Total N=152**	**P-value**
Managerial	26.67%	73.33%	19.73%	
Supervisory	5.26%	94.74%	25%	**0.045**
Normal staff	14.29%	85.71%	55.27%	
Consumers' income				
Less than 1 million Tshs	17.07%	82.93%	27%	**0.58**
More than 1 million Tshs.	13.51%	86.49%	73%	
Knowledge on the cost of Premium				
Know	13.98%	86.02%	61.18%	**0.828**
Don't know	15.25%	84.75%	38.82%	

The data in table 6 shows that employees in managerial levels and some in lower cadres could afford to pay the premium on their own. The level of employment significantly affected affordability of buying a premium (Chi square test, p=0.045). However, the same table shows that few people from both higher and lower income groups could afford buying the premium. Majority of the consumers from both high and low income groups could not afford buying the

premium. Therefore consumers' income did not significantly affect the affordability in buying a premium (Chi square test, p=0.58).

4.1.2b Benefit package limits

This study found that depending on the kind of benefit package, there are limits on the quantity of services provided. These packages have their own limits, for instance one interviewee from Prosperity Life Insurance company responded by saying:

> *'For in-patient services, the higher limit is Tshs 10 Million per beneficiary per year with service limits in dental surgery and 1 CT scan and MRI scan per year. Its coverage is in Tanzania only. For out-patient services, the higher limit is 4,000,000 Tshs per beneficiary per year and with 14 visits per beneficiary per year and clients are limited to 2 eye tests per year.'*

Figure 2 shows results from the consumer interviews and it indicates that majority of the consumers (47%) reported that they were not aware of the limit imposed on services in their benefit package. Furthermore, the table shows that 45% of consumers did not know whether there is limit in number of services they can receive.

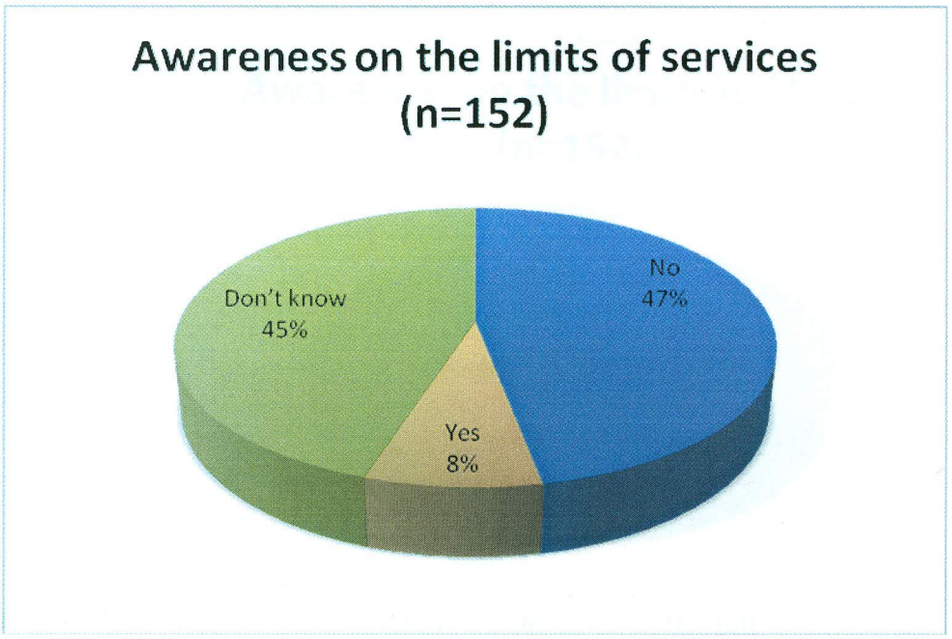


Figure 2: Awareness of consumers on the limits of services

Furthermore, Figure 3 summarizes the awareness of consumers on the limit of amount that the company could be billed by the health care providers. About 45% of the consumers did not know if there was a limit on billing amount when the insurance company pays for the service rendered. Only 20% of the consumers were aware that there is a limit on the amount to be paid for the service rendered. The remaining 35% of the consumers, reported that there was no limits on the bill.

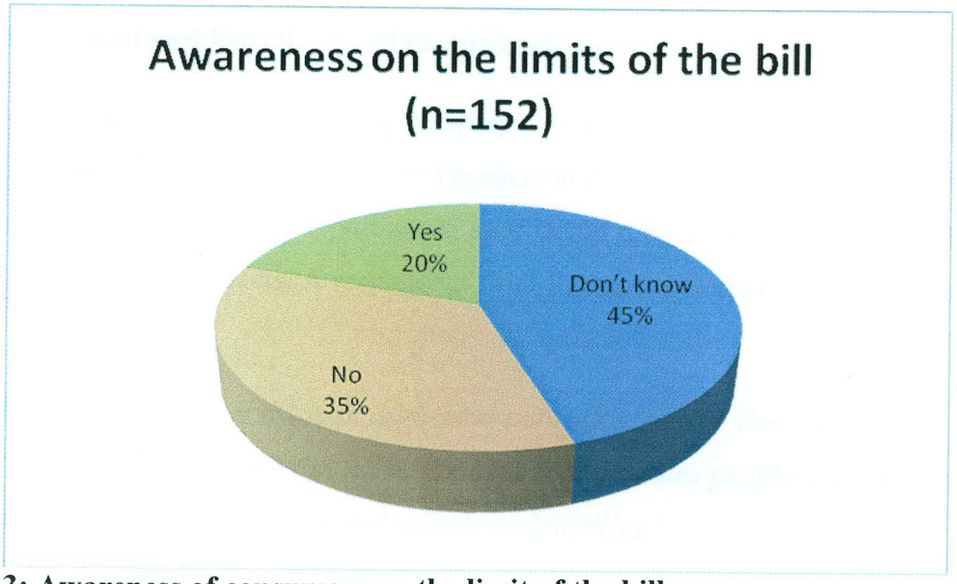


Figure 3: Awareness of consumers on the limit of the bill

4. 1.3: Company's administrative costs

All respondents reported that the administration costs were higher compared to other types of insurance business. It was revealed that most of the costs incurred by these companies are through paying the clients' bills; in some companies this was estimated to be 65% of the total price of the premium. Respondents reported that the administrative costs are estimated between 15-30% of the price of the premium. High costs of administration were reported to be caused by the labor intensity nature of the industry. A respondent from Jubilee Insurance Company reported that:

> *'Health insurance business requires hiring people (doctors and nurses) who can often go through the billing documents. Therefore the costs are high, higher than normal.'*

However most of the respondents reported that administrative costs regarded as normal were of less than 15% of the price of the premium.

4.2 Strategies of Private Health Insurance companies

4.2.1 Recruitment and Enrollment of clients/consumers

All the companies involved in the study, employ marketing strategies to recruit customers. Apart from using their own staff, they used brokers and agencies as well to recruit customers. It was learnt that the marketing departments, approaches the prospective clients and do presentations on their products. A respondent from Strategis Insurance Company confirmed that:

> *'Recruitment is done through the broker network but more than 50% of our business, it is done through our sales team. We have specific sales people who deal with corporate; others deal with individuals and families.'*

Brokers and agencies are given commissions as an incentive, whenever they recruit a costumer. One of the companies gives commission to its marketing department whenever they recruit costumers as well.

The results from consumer interviews as summarized in Figure 4 revealed that the majority of consumers (51%), considered enrollment as compulsory while 5% considered enrollment among the benefits of the employment.

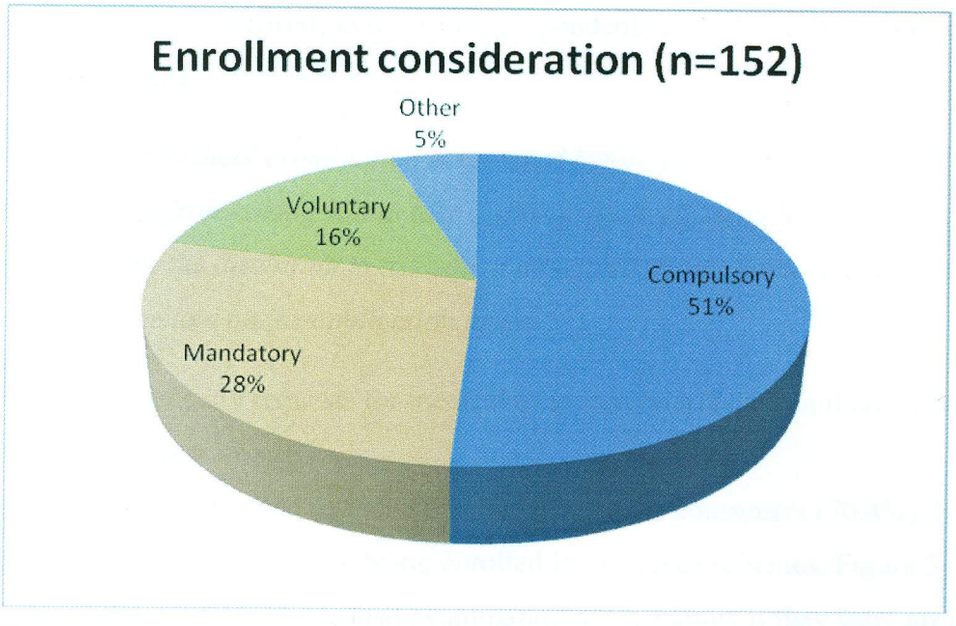


Figure 4: Consumers' consideration on their enrollment status

Upon enrollment, the recruited has to fill in some application forms, before the coverage commences. There are two types of forms; the first one is for individuals and the second is for corporate members. In these forms, one is required to provide personal details and history of chronic illnesses. Filling the forms depends entirely on the faithfulness of the consumers as a respondent from AAR Insurance Company pointed out:

> *'If you complete the forms in good faith, then if you are really sick, there is somewhere you will say yes. If you say yes then I will say either you go for medical checkup, or I will exclude the condition from coverage or I will check if you will have to pay extra because you are not a normal person'.*

In all companies the maximum age for enrollment was found to be between 55-60 years. Any pre-existing condition was not being covered in the package unless an extra fee was paid.

4.2.2 Medical examination upon enrollment

The study found that no medical examination is done to consumers during enrollment. However in certain circumstances, one might be asked to take medical examination before the

membership is approved, as one of the respondents from AAR insurance company acknowledged:

> *'No medical examination is required before enrollment .....But that does not exclude AAR from asking you to take it if it suspects anything in the process of recruitment. I have the discretion to ask you at any given point of time to comply with the request; it is written on the application forms.'*

Only one company requests for medical examination to be taken if an individual to be covered is above 50 year of age.

Consumers interviewed revealed that majority of the consumers (70.4%) did not take any medical examination before being enrolled in insurance schemes. Figure 5 shows that about 57% of those who took medical examination did not know if they were grouped for the benefit package based on the medical checkup.

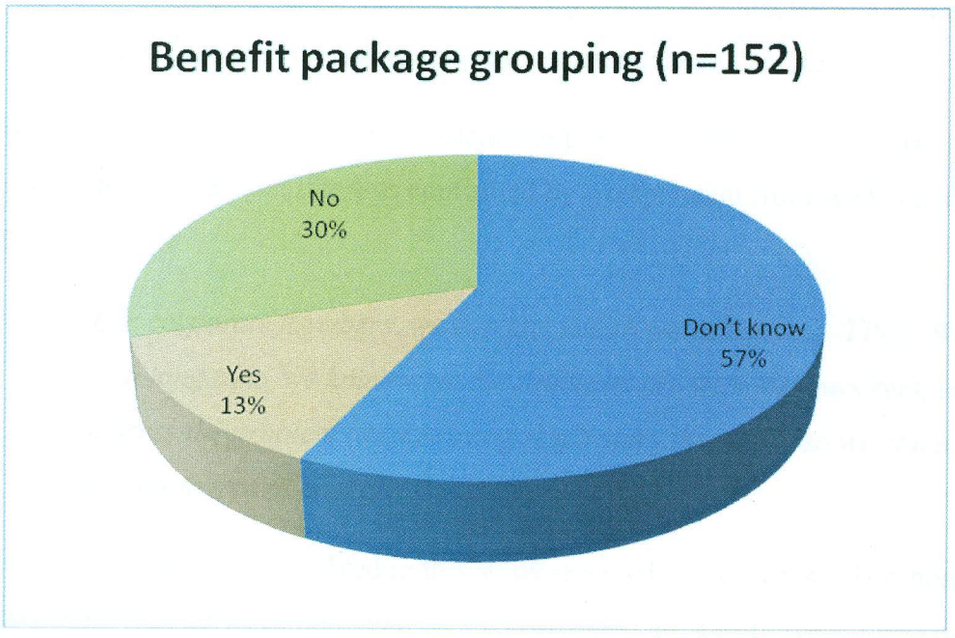


Figure 5: Consumers' knowledge in benefit package grouping

4.2.3 Retaining and maintaining of clients

Good customer service and relationship were reported as the main strategy to maintaining clients. Good customer service included visits to clients and obtaining their feedback on services provided. This phenomenon was emphasized by all PHI companies involved. A respondent from Jubilee Insurance Company confirmed this:

> *'We do visit our clients to evaluate their satisfaction of our services, to find out where to improve more.'*

Another interviewee from Strategis Insurance also confirmed by saying:

> *'We have a retention team which focuses mainly on corporate and business people. This team visits clients 60 days before renewal of contract to find out what are their needs, problems and inform them if there will be new pricing of our premiums.'*

Beside good customer service and relations, all companies reported to have provided their telephone contacts to their consumers and they could be contacted at anytime by their consumers in case they have difficulties in accessing health services.

Another strategy involved in good relationship with customers was provision of free health education to customers; this was confirmed by a respondent from AAR Insurance Company by saying:

> *'For corporate members, we conduct health workshops e.g. TPCC Wazo being with us for a long time, we know what the problems are with their workers, we will go and address the problem (dust causing respiratory diseases), so we conduct health education free of charge.'*

Two of the companies involved in this study reported that they visit their hospitalized consumers regularly accompanied by a consolation card and flowers. One company has a policy of following up on their consumers after discharge from the hospital. Another company

makes management revisits to all hospitalized customers as the respondent from Jubilee Insurance Company reported:

> *'Reviewing the case management enable us to control services which have increased payment and also this helps in following up on the quality of service provided. Before hospitalization of the client, the service provider has to seek permission from our offices for authorization of the admission with tentative cost and probable length of hospitalization.'*

An additional strategy in maintaining and retaining consumers was revealed to be good relationship with service providers especially paying the bill on time.

4.2.4 Reimbursement mechanisms to health care providers

Reimbursement is made to those health care providers who are contracted by a particular Private Health Insurance Company. Most of the reimbursement is done after the consumer has received the services, and the payment is done within 30 days after receiving invoices from the health provider; and the claim is valid for 90 days.

It was found that services are being provided after the consumers have presented their membership cards to the service provider. The membership card is used for identification and normally it shows which plan or benefits one is entitled to.

Once the consumer has been attended, an invoice is sent to the PHI Company for reimbursement. Most of the PHI Companies have medical teams which go through the invoices, together with medical history, to validate the claim before the decision to pay or not to pay is made. This procedure helps in revealing mal-practice, as one of the interviewee commended:

> *'It is through that process where you dictate things like poly-pharmacy, not following standard treatment guidelines, or the pricing has been inflated. If the claim/bill is payable, a cheque is written to the respective facility. If there are poly-pharmacy*

cases, the invoice of the treatment provided, is rejected. Therefore in the course of invoice payment, explanations are given accordingly.'

Nevertheless, two of the companies studied, have a system for payment approval (pre-authorization) for anything that seems to be expensive and/or for inpatient admission. A respondent from Jubilee Insurance Company confirmed this by saying:

'We normally contact the doctor who is admitting the patient so that decision on to pay or not to pay is granted.'

Only one PHI Company has a strategy of reimbursing some of its contracted health care providers on credit. In this case, the health facility is given certain amount of money e.g. Tshs. 20 Million in advance, and when a customer gets service and the charges are deducted from the balance accordingly.

4.2.5 Reimbursement mechanisms to beneficiaries

Reimbursement to beneficiaries is done if a beneficiary gets health care service from a non-contracted health care facility, since the customer cannot use the membership card and uses his/her own means of which should be refunded by his/her health insurer. It was reported that claims are accompanied with brief valid medical history before reimbursement was effected. The reimbursement was reported to be done within 14 working days.

The consumers' interviews (Figure 6) revealed that about 24% of all interviewed consumers had paid money when getting health care services. For those who had paid, the main reason for paying was that the health facility visited was not on the contracted list of health care providers.

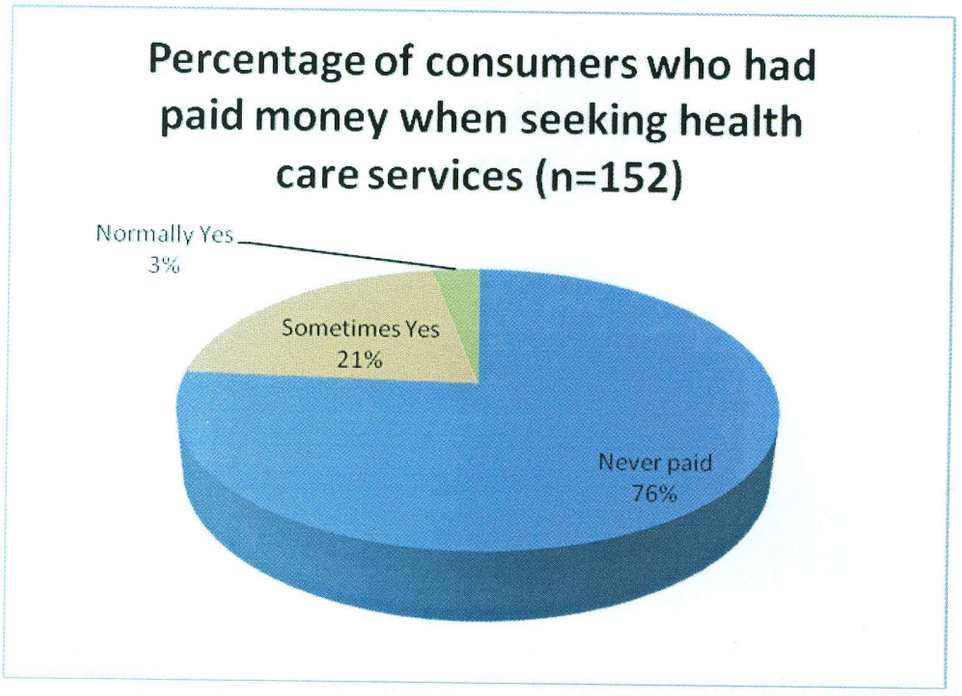


Figure 6: Percentage of consumers who had paid money when seeking health care services

Figure 7 shows that majority of the consumers (61%) have never paid any amount of money for their dependants to receive health care services. Table 7 shows reasons of consumers who had paid money for their dependants (17%) when receiving health care services; the main reason being service required was not covered in the benefit package.

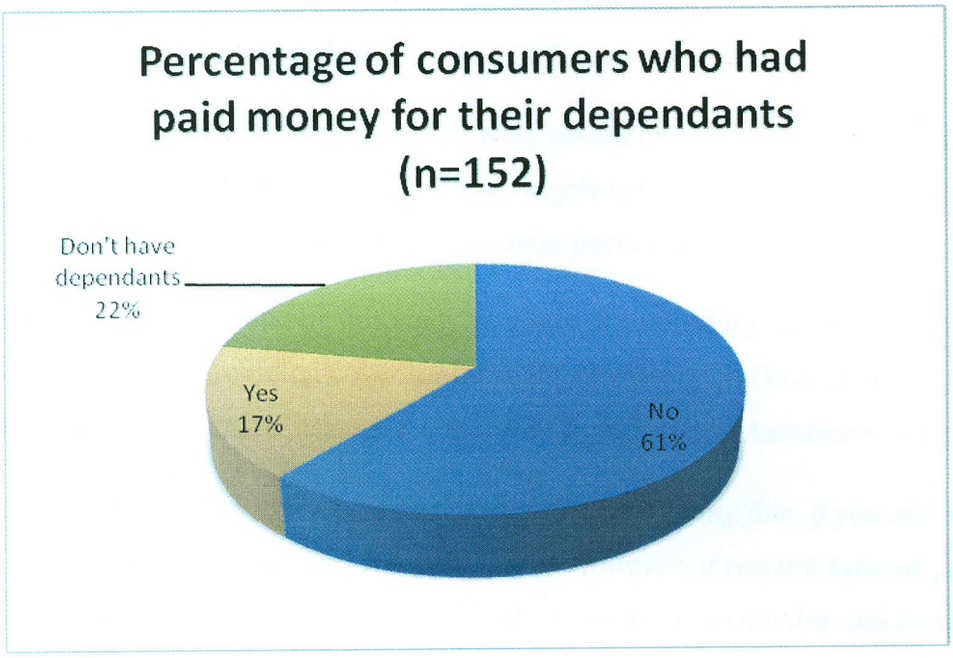


Figure 7: Percentage of consumers who paid money for their dependants

Table 7: Reasons for paying for dependants when receiving health care services as reported by interviewed consumers

Explanation (n=26):	%
Service required was not covered in the benefit package	53.85
The health facility visited was not in the list of health care providers contracted	19.22
Cost-sharing on the service provided	15.4
Was recently enrolled, so had no ID card yet	11.53
Total	**100**

Despite the reimbursement system to non-contracted facilities in some companies, one company which is a HMO is not encouraging its customers to use non-contracted health facilities. And recently it has introduced a regulation whereby all consumers have to use its own facilities first, if the customer requires further treatment then he/she is being given a

referral note to go to other contracted health care facility. This is done to control costs as it was reported by a respondent from the HMO who confirmed:

> *'..... Given the cost of medications, we are remodeling to have a filter for some facilities. Some of the consultant hospitals have a tendency of using consultants rather than General Practitioners and these pushes up the cost.'*

Another strategy found by this study as a way of controlling and reducing cost to the PHI companies was providing cover for inpatient services only. On emphasizing that outpatient insurance attract moral hazard, a respondent from Phoenix Assurance Company confirmed:

> *'For instance, if you have a viral infection causing flue, if you are not insured, may be you will get panadol and get rid of it. However, if you are insured, you go to Aga Khan, he charges you Tshs. 50,000, he writes you vitamins and somewhere there is panadol and you also get better in 3 days. So if you are insured, you will be paying money unnecessarily. Therefore, you can manage the outpatient services yourself and the insurer takes the inpatient bills.'*

However, one company admitted that it does not reimburse its consumers once they seek health care services from non-contracted health care facilities. Since they believe that the contracted facilities are capable of managing their consumers. A respondent from Phoenix Assurance Company confirmed this:

> *'We believe most of health facilities (and important ones) are contracted with us.'*

The study found that about 19.7% of all the interviewed consumers, their choice of health facility were determined by the health insurance company (Table 6). The majority of the respondents (78.9%) were free to choose a health facility when seeking health care services. About 51% of consumers reported to have an episode of illness in the last four weeks prior to this interview. It was also reported that the majority of consumers, who had an episode of illness four weeks prior to the interview, made their own choice (92.2%) in choosing where to

get health care services. Conversely about 7.8% of consumers who reported to have had an episode of illness, the choice of visiting a certain health facility were made by the insurance company. Moreover, a total of 20.8% of all consumers who had visited health facility in their last illness episode, requested extra services. Figure 8 presents type of extra services requested by consumers who had an illness episode in the last four weeks before the interview. From Figure 8, half of those consumers (50%), who requested extra services during the last episode of illness, requested extra medications.

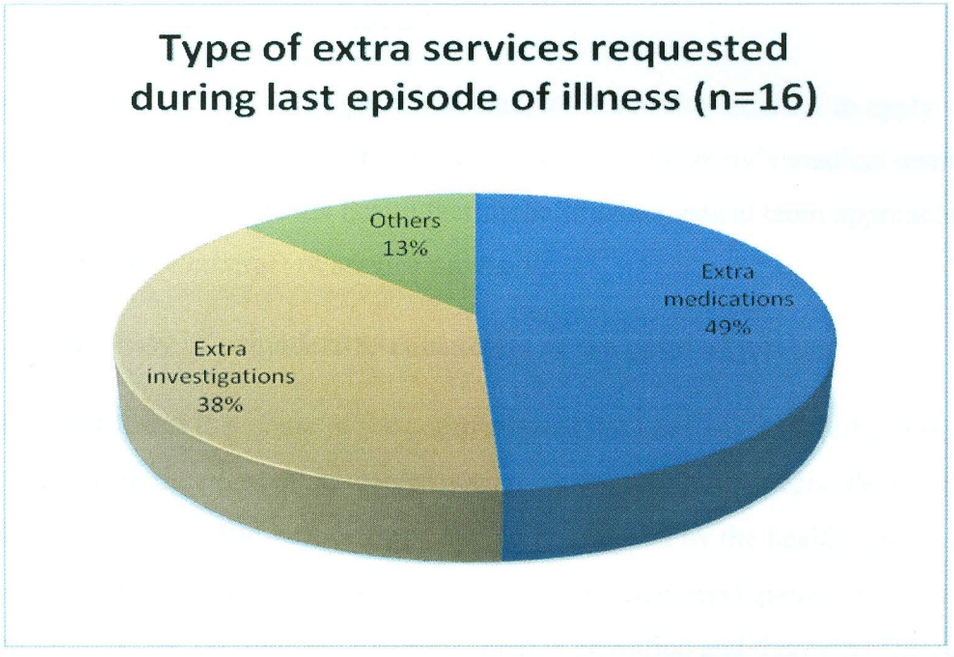


Figure 8: Type of extra services requested on the last consumers' episode of illness

4.2.6 Selection of facilities that provide health care to consumers

The study found that most of the companies have contracted health facilities in several regions in the country. Almost all companies had contracted all hospital and some health centers in Dar es Salaam. A respondent from Phoenix Assurance Company confirmed:

'The coverage of health facilities is tremendous; all big hospitals in Dar es Salaam are included (contracted). It is unlikely a person will require services from hospitals which are not in the list.'

Selection of health care facilities depends on the location, type and quality of services rendered. A respondent from Strategis Insurance Company emphasized the importance of factors used to select facilities:

'Location is very important for instance you might have one place in the remote area that you can use, quality then might not be an issue but we have to use it as we do not have an option in the area.'

Furthermore, one of the companies studied, invites health facilities to apply for provision of health services to its consumers. In this context, the company's medical team goes through the application and inspects the health facility before the medical team approaches the health facility to make contract of service provision.

4.2.7 Courtesy of providers to consumers at the point of service

The study found that some of the companies do not have any unique handling of their consumers at the point of service provision while some have special desks or window where their consumers report before they are seen or attended by the health care provider. This means that their consumers do not join other (non-members) queue while seeking care. At the special desk, the consumers' status and plan is identified and thereafter the consumer is allocated to the respective consultation room. The proper handling of consumers is used to retain consumers as it was argued by the respondent from Jubilee Insurance Company:

'This person makes sure every step of the client is dealt with quickly. We assist clients in getting services in a quick way, whereby a person goes to our desk with his/her card and is attended accordingly.'

Furthermore, results from the consumers' interviews revealed that 17.76% of all consumers reported to seek health care more frequently compared to when they were not insured. From Table 8, majority of those who admitted to seek health care frequently after being insured (55.56%) reported that health care providers were treating them better and paid more attention compared to when they were not insured. There was a significant difference as far as health care providers' treatment and attention is concerned, in relation to whether you are insured or not (Chi square test, p= 0.016).

The results show that majority (59.26%) of those who confirmed to seek frequently health care service after being insured, reported that health care providers' attitude towards them was much better compared when they were uninsured (Table 8). Being insured, had a significant effect on health care providers' attitude to consumers (Chi square test, p=0.008).

Majority who reported to have increased the frequency of seeking health care services after being insured (74.07%), reported that availability of medication had significantly become easier than before (Chi square test, p=0.002) (Table 8).

Table 8 also shows that majority of the consumers who had increased the health care seeking behavior after being insured (51.85%) reported that they were not wasting time in waiting for services significantly compared to when they were not insured (Chi square test, p=0.004).

Table 8: Consumers' frequency of seeking health care compared when insured or not insured

Frequency of seeking health care compared when insured and not insured	Health care provider treatment has improved			
	Yes N (%)	**No N (%)**	**Total N (%)**	**P value**
Yes	15 (55.56%)	12 (44.44%)	27(17.76%)	
No	39 (31.20%)	86 (68.80%)	125(82.24%)	**0.016**
Total	**54(35.53%)**	**98 (64.47%)**	**152 (100%)**	
	Health care providers' attitude is much better			
Yes	16 (59.26%)	11 (40.74%)	27(17.76%)	
No	40 (32%)	85 (68%)	125(82.24%)	**0.008**
Total	**56(36.84%)**	**96 (63.15%)**	**152 (100%)**	
	Availability of medication is easier			
Yes	20 (74.07%)	7 (25.93%)	27(17.76%)	
No	51 (40.8%)	74 (59.2%)	125(82.24%)	**0.002**
Total	**71(46.71%)**	**81 (53.29%)**	**152 (100%)**	
	No wasting time in waiting for services			
Yes	14 (51.85%)	13 (48.15%)	27(17.76%)	
No	30 (24%)	95 (76%)	125(82.24%)	**0.004**
Total	**44(28.95%)**	**108 (71%)**	**152 (100%)**	
	Spending more time with the doctor than before			
Yes	11 (40.74%)	16 (59.26%)	27(17.76%)	
No	31 (24.8%)	94 (75.2%)	125(82.24%)	**0.093**
Total	**42(27.63%)**	**110(72.37%)**	**152 (100%)**	
	More free to choose where to get health care services			
Yes	23 (85.19%)	4 (14.81%)	27(17.76%)	
No	55 (44%)	70 (56%)	125(82.24%)	**0.000***
Total	**78(51.32%)**	**74 (48.68%)**	**152 (100%)**	

Key:

*Fisher's Exact test was used to calculate p-value since more than 20% of cells had an expected count less than 5.

Majority of consumers whose health care seeking behavior was not changed after being insured (75.2%), reported that time spent with the doctor had not changed significantly, compared to whether you are insured or not (Chi square test, p=0.093).
Majority of the consumers who increased the health care seeking behavior after being insured (85.19%), agreed that they are more free to choose where to get health care service compared to when they were not insured. And the difference was strongly significant (Fisher's Exact test, p=0.000).

Table 9 shows that majority of consumers (81.3%) who admitted to be seeking health care frequently after being insured did not request extra service during their last episode of illness. About 78.7% of consumers, who denied increases frequency of seeking health care after being insured, also did not request extra service on their last episode of illness. Being insured did not have a significant effect on request for extra services (Fisher' Exact test, p=0.821).

Table 9: Consumers' comparison of time when insured and not insured with request of services on the last episode of illness

Comparing the time when uninsured and insured	Requested service			P value
	Yes N (%)	No N (%)	Total N (%)	
Yes	3 (18.8%)	13 (81.3)	16(20.78%)	
No	13 (21.3%)	48 (78.7%)	61(79.22%)	**0.821***
Total	**16 (20.8%)**	**61 (72.2%)**	**77 (100%)**	

Key:

*Fisher's Exact test was used to calculate p-value since more than 20% of cells had an expected count less than 5.

4.3 Regulation and control of Private Health Insurance market

All companies reported that their businesses are governed by the Insurance Supervisory Department (ISD) hence regulated by the Insurance Act of 1996. The Insurance Supervisory

Department is under the Ministry of Finance. The registration process was reported to follow the laid down procedures as clearly elaborated by a respondent from AAR Insurance Company:

> *'You need to be registered as an insurance company doing health insurance business. The approval is given by the commissioner of ISD who has power to authorize for those services.'*

This study has also revealed that there are no regulations guiding setting of prices for different premiums as a respondent from Jubilee Insurance Company confirmed:

> *'On prices, there is no unique premium. You go to any insurer and all these have different prices. It's a competition in which each insurer has own prices.'*

Furthermore the PHI Companies are required to provide quarterly details and keep ISD informed for all products and send copies of different policies as well.

In addition, it was found that the PHI Companies have internal regulations as well; as reported by a respondent from AAR Insurance Company:

> *'We have internal regulations (enrollment policy) e.g. membership recruitment policy which has all standard terms and conditions and explains everything on cover provided, paying premium and how to make a claim. This policy document is given to the consumer once his/her application is accepted.'*

This chapter has presented results on the characteristics of the PHI companies and their different strategies in recruiting, maintaining and retaining their consumers and clients. Generally, all companies visited for qualitative interviews, were involved in health insurance business either as the sole business (registered as specialist in health insurance) or as one of their business products. The results revealed several strategies to attract and retain consumers. However, the study found that besides requirement for registration and the Insurance Act of 1996, there was no strict regulation which governs the PHI market activities.

CHAPTER FIVE

5.0 DISCUSSION

5.1 Strategies employed on enrollment and recruitment

This study explored the characteristics, strategies and the role of regulation and control of Private Health Insurance companies market (PHI) in Tanzania. It has also explored the consumers' perception on the role of Private Health Insurance market in Tanzania.

Findings of this study reveal that all companies involved in the provision of private health insurance business in Tanzania operate on for-profit basis, as found by Sekhri and Savedoff (2005) who found that many PHI companies in poorly regulated systems, in developing countries, were operating on profit basis. The flourishing of these companies in Tanzania is facilitated by weak and unregulated health insurance market, as well as the infancy of the private health insurance market.

The PHI companies are strategically engaging private firms, embassies and NGOs that have bigger workforce. Employees working in private firms or NGO's and the likes, comparatively earn higher salaries/wages than those working in the public sector. Furthermore, most of people employed in the private sector are young (WHO, 2004), the fact which was obvious in this study as the majority of the consumers enrolled (75%) were less than 39 years of age. In this study, the PHI companies targeted young individuals, higher income earners and those well off so as to make profit; leaving those who cannot afford or unhealthy individuals to be a public's burden. Nevertheless, individuals employed in the public sector are covered by the National Health Insurance fund (NHIF); however this fund caters for only employed individuals, it does not cater for unemployed people and the rest of the community.

The strategy of PHI companies targeting young individuals and high income earners was observed by Drechsler and Jutting (2007) who found that in developing countries, PHI was

mostly reserved for high income and healthy individuals, who are believed to be capable of buying premiums; and large private firms who can pay insurance for their employees. Most of the literature found indicate that enrolling in PHI companies is on voluntary basis hence open enrollment (Ven et al, 2007; Al-Khatib, 2007; Sekhri and Savedoff, 2005). Conversely, as observed in this study, clients of PHI companies who were employers, were enrolled on voluntary basis hence consumers enrolled on group basis. There were no consumers who were enrolled on individual basis due to the method used in getting consumers from the PHI companies. Some companies even denied providing addresses of their clients.

Enrolling consumers on group basis is seen as a cost saving strategy for the PHI company as risks of consumers are pooled in a group. Although there was an indication that people could enroll voluntarily in the PHI market on individual basis, still very few could afford buying the premiums. However, it is cogitated that if premiums are adjusted according to local settings and policies put in place, people could be able to afford buying premiums on individual basis. Experience of enrollement in Latin America has showed that based on mandatory basis, PHI market has resulted in increased health insurance coverage rather than targeting certain groups of people (Sekrhi and Savedoff, 2006). Therefore, there must be an emphasis on how people should enroll in PHI companies so that access to health care services is improved.

5.2 Adverse selection in PHI market

Upon enrolment in any insurance plan, the consumer is supposed to fill the forms declaring among other things, age and any history of chronic or pre-existing condition. Consumer's information is usually used to screen those with chronic and pre-existing conditions and in most cases they are denied coverage or their premium increased (Al-Khatib, 2007). In this study, it was learnt that majority of the consumers were enrolled after filling membership forms and were grouped in the insurance schemes without taking medical examinations. This means that the PHI companies relied on the information given by the consumers when filling the enrolment forms. In this context, the consumer has an incentive to lie that he/she does not have any chronic or pre-existing condition; so that condition is being covered without an extra

fee and excluded in coverage. The insurer then provides the cover without having genuine health status information of the consumer. This results into an insurer getting less information on consumer's health status hence information asymmetry which then might lead to adverse selection by the insurer.

One way of getting more information on the consumer's health status is taking pre-medical examination. This would have been a good strategy to find out those who provide wrong information so as the insurance cover to be granted. Conversely, in our study some PHI companies reported to have a mandate of examining a consumer at any moment. On the contrary, this mandate has never been used to any consumer by these PHI companies, possibly due to insurance being offered on a group basis. Another reason of not taking pre-medical examination would be reducing costs in examining every consumer who is to be enrolled in the scheme. In this study, offering group insurance is seen as one way of combating the effects of adverse selection but on the other hand, it is used as a way of reducing costs in taking medical examination as well.

5.3 Risk selection in PHI market

Voluntary enrollment to PHI companies has been shown to be an ineffective tool which has an incentive to facilitate consumer selection hence cream skimming. Cream skimming or risk selection can lead to sick individuals or individuals with chronic illness to be left out in PHI coverage as the target is for health individuals. This may lead to shifting the cost burden to mostly public health systems (Ven *et al*, 2003; Bertranou, 1999). Our study found that any person aged more than 55 years could not be enrolled in the scheme. It is obvious that at this age, someone is prone to chronic illnesses like hypertension and diabetes and is considered high risk individual compared to a young and healthy person who is considered low risk person.

In this study, the presence chronic or pre-existing conditions before enrollment were found not to be covered in the benefit package. Including these conditions would mean increasing

costs of managing and treating these conditions, of which were present even before commencement of coverage (Sekrhi and Savedoff, 2006). Excluding high risk people or charging them with an extra fee was found to be another strategy in containing the cost of health care services by PHI companies. By targeting low risk individuals, the PHI would be ignoring the overall goal of universal access of health care, a social aspect of health protection. In this manner, the insurance company gains by this kind of selection but as for the society, the whole selection procedure produces no gain. Soderlund and Hansl (2000) found that, with regulations on including high risk individuals during enrollment, PHI companies improved equity and efficiency in health care service. Therefore in order to attain the goal of universal access of health services, PHI should be mandated not to risk rate premiums.

5.4 Moral Hazard and service limits in PHI market

In most cases, there are strategies that are implemented by the PHI companies to combat moral hazard. In this study, some companies did not provide outpatient cover; the consumers had to pay out of their pocket for outpatient services or had to pay for their dependants. Literature show that insured individuals have a tendency to use health care services uncontrollably, especially the outpatient services (as the inpatient service costs are inevitable) (Pauly et al, 2006; Al-Khatib, 2007). In this study, few consumers admitted that being insured has made them seek health care frequently compared to when they were uninsured. Although the number was small, it showed that there is some degree of moral hazard employed by consumers.

Furthermore, consumers who reported to have had visited a hospital, requested for extra services to prescribed by the provider. Extra service would therefore mean increase in costs for the PHI Company. Therefore there are strategies employed so as to reduce these costs incurred and these include eliminating outpatient services in the benefit package and having limits to some services. However despite of service utilization limits imposed, majority of the consumers were happy with their benefit packages although few were dissatisfied due to the limits imposed.

The limits are imposed on those services which are costly for instance dental and optical services. This may have emanated from a belief or evidence from developed countries that insured individuals tend to utilize dental and optical services for cosmetic purposes. From the health insurance point of view, this would escalate the costs for these services unnecessarily. Our study found that being insured did not have a pronounced effect on frequency of unnecessary utilization of health services although few consumers reported to have changed their health care seeking behavior after being insured. This implies that further studies are needed to compare the effect of being insured in establishing the existence and magnitude of moral hazard in the health insurance market.

In addition, this study found that consumers have to make a co payment if certain limit of health services consumption is exceeded. Such a strategy has some negative implications in health care of consumers due to the fact that if the consumer fails to pay for the excess, he/she might be denied care, constraining the intended goal of universal access to health care.

Furthermore, the study found more strategies that are employed to control costs for inpatient services as well. This is done through seeking payment approval before admission (for more expensive services) and doing case revisit for hospitalized consumers. However in the case of life threatening situation like emergency, the admission is effected and approval sought later. In addition, some companies checks medical notes of the hospitalized consumer and establish whether the treatment and medication given are correct and genuine.

The poly-pharmacy behavior is controlled through auditing the invoices which if not controlled may result in overbilling the invoice of which could increase the cost on the insurer. This is the reflection of the PHI companies' dedication to providing and monitoring quality of services as well minimizing the quantity provided.

5.5 Benefit Packages in PHI companies

This study found that different companies offer different packages with dissimilar benefits. Furthermore, we found that there are products which are designed by the employer (company or organization) so as to suit the needs of that particular employer and it is affordable. These tailor made products have limited services in their packages; yet in this study, majority of the consumers did not know their benefit packages.

Furthermore, majority of consumers admitted that their benefit packages were chosen by their employers hence consumers did not have freedom in choosing the type of package they would prefer. In addition, there was limited information on the benefits of the packages that were given before enrollment. Hence, consumers are allocated to a package without being informed on the benefits embedded in a particular package.

Therefore one would argue that the PHI market in Tanzania is not competitive due to presence of different benefit packages and many consumers were not well informed on the benefit package.

5.6 Role of HMO in the PHI market

In order to contain costs, PHI companies introduce managed care in the form of Health Management Organization (HMO) (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007; Feldman, Escribano and Pellise, 1998; Trautwein, 2002) which provides comprehensive health care to consumers. In this study only one PHI company reported to operate as a HMO, and has four health facilities in Dar es Salaam. It was found that their consumers were not allowed to consult specialists from other health facilities unless referred by HMOs' health care providers.

Drechsler and Jutting (2007) argue that with HMOs, the consumer has limited choice of health services and limited choice of providers. However the important question is on the quality of service provided by the HMO's health facilities as experience has shown that

consumers fear of being insufficiently treated. Furthermore, HMOs are believed to have adverse selection and risk selection through selection of healthier members, which can jeopardize the quality of care rendered (Drechsler and Jutting, 2007). Conversely, literature shows that HMOs are more involved in patients care and preventive care than other forms of insurance (Ven, Beck, Vande Voorde, Wasem and Zmora, 2007). On the other side, HMOs are believed to have adverse selection and risk selection which can jeopardize the quality of care (Drechsler and Jutting, 2007). Nevertheless, managed care through HMO is still a new phenomenon in Tanzania; there is therefore a need of more studies to be done to assess the extent of adverse and risk selection among HMOs.

5.7 Administrative costs in PHI companies

Administrative costs are important aspects of private insurance market. In this study, high administrative costs were reported to be a problem due to nature of the industry, labor intensity whereby most of the activities are done manually. The administrative costs incurred by the PHI companies were reported to include salaries for employees, printing of forms, development and production of brochures and advertisements. Conversely, Ezra Klein (2009) argues that administrative costs are one of the most confusing issues in health care setting whereby there is lack of proper description of what is meant by these costs; according to him, these costs reflects all functional costs including commission, premium taxes and he argue that the administrative costs are not easy to measure. The literature show that the administrative costs in PHI companies are between 25-30% of cost of premium (Klein, 2009; Sakowski, Kahn, Kronick, Newman and Luft, 2009). In this study we found that the administrative costs could be as high as 30% of the total cost of the premium. Despite the fact that administrative costs helps in ferreting out fraud in health services provided, it can be used by the PHI companies as a pretext for escalating the cost of premium in order to maximize profit.

The labor intensity which is believe to escalate administrative costs can be reduced by introducing automation of the current systems in PHI companies eventually increase

efficiency. One way of automation which can be used as a cost containment strategy, is the introduction of an electronic case-based payment known as Diagnosis-related group (DRG) system, whereby hospital cases are classified and categorized and priced (WHO, 2004). In DRG system, each case is assigned the appropriate diagnostic and procedural category on the basis of costs likely to be incurred with the hospital admission hence it is used as a base for determining the level of prospective payment by the client. Despite being common in developed countries, this system has been introduced and has worked well in low income countries as well (Wonderling, 2007). With advantages of being transparent, efficient and being able to predict future financial payout, PHI companies in Tanzania can benefit reducing their manual work consequently reducing their administrative costs.

5.8 Role of regulation of PHI market in Tanzania

Regulating and controlling PHI market is part and parcel in making sure the goal of universal access of health care is achieved. The literature shows that there are many problems related to introduction of PHI companies in many countries (Sekhri and Savedoff, 2006; Drechsler and Jutting, 2005). For a developing country like Tanzania where there is insufficient regulatory framework for the PHI market, one would expect the market to behave with imperfections due to adverse selection, moral hazard and risk selection. This study found that PHI activities and other insurance business in Tanzania were regulated and controlled by the Insurance Supervisory Department (ISD) of the Ministry of Finance with the guidance of the Insurance Act of 1996. However besides regulations on registration and legislation of the PHI companies, no other strict regulations governing PHI market in particular exist. This could be probably due to by the time the Insurance Act was formulated in 1996, PHI activities had not started.

Lack of strict regulation gives opportunity for PHI market failure, as it excludes or discriminates high risk consumers and escalates costs of premiums. Soderlund and Hansl (2000) in their study of the effects of regulation PHI market found that the period without the regulation, the schemes risk rated individuals and excluded high risk individuals and hence

affecting equity and efficiency in accessing health care. With re-regulation under a specific act, the PHI market in South Africa was found to be improving the inequity in accessing health care.

In order for the PHI market to be integrated in any health system, it should be properly controlled with strict and specific regulations in order to minimize the effect of market failure. Therefore, amendment the Insurance Act is required, so as to include specific regulations for PHI or having a specific act of health insurance business which will oversee every activity of PHI companies rather than the current act which deals with the insurance business in general.

CHAPTER SIX

6.0 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

Study findings indicate that all companies involved in private health insurance (PHI) provision in Tanzania are for profit companies. Strategically, the PHI companies target employees in private firms, embassies and NGO's who comparatively earn higher salaries/wages than those working in the public sector. Also the PHI companies target individuals who are young and health as observed in this study whereas the majority of consumers enrolled were less than 39 years of age. These strategies are meant to maximize the profit in insurance business.

The study also found that majority of consumers insured by the PHI companies do not know the benefits of their packages; and are not given much information with regard to benefit packages upon recruitment and enrollment. Hence consumers are allocated to a package without being informed on the benefits embedded in that particular package.

The study revealed that there is some degree of moral hazard in utilizing health care services when a consumer is insured. This was noted in some consumers who admitted seeking health care services frequently after being insured. Therefore being insured has an influence in the frequency of utilizing health care services, compared to when uninsured.

There is risk selection employed by the PHI companies. Consumers of older age (more than 55 years) and those with pre-existing and chronic illnesses are not covered during enrollment. Covering these individuals would mean escalating cost of care, hence high risk individuals are required to pay extra fee to the normal premium. Therefore, the risk selection of consumers practiced by PHI companies is aiming at reducing cost of care.

The study found that the administrative costs in PHI companies are high due to the nature of PHI business, to be labor intensive. This is due to the fact that most of the activities are done manually and the costs are incurred to pay salaries for the manpower and other consumables.

One way of providing comprehensive health care to PHI consumers is through the HMO's. The study revealed that only one PHI company operates as an HMO. If properly regulated, HMO's can be used to provide good quality of health care services to consumers.

It was found that there is lack of strict and specific regulations governing and controlling PHI companies' activities and this poses an opportunity for PHI market failure. The Insurance Act of 1996 which is set to govern the PHI market is outdated. When it was enacted, the PHI activities had not yet started, so it does not have any information on the PHI activities.

6.2 Recommendations

The study provides information on the strategies and characteristics and the role of the PHI companies in the health care market in Tanzania. It therefore recommends the following to the policymakers and stakeholders involved in the PHI business, research institutions and ministries.

Based on the findings of this study, the PHI companies should provide comprehensive information to consumers prior their enrollment, especially on benefit packages. This will help the consumer to know what are the benefits embedded in different packages. And also it will make the market to be competitive as consumers will be well informed on the benefits in those packages.

There should be specific and strict regulations that are required to regulate and monitor PHI companies so as to minimize the effects of market failure. The regulations should target to lessen the consequences of adverse selection, risk selection and moral hazard. The Ministries of Finance and Health can collaborate in formulating specific regulations which will govern

the PHI activities. This in turn would result in increasing coverage hence increase in the universal access to health care services without neglecting high risk individuals.

In order to govern and control the PHI activities in Tanzania, the Insurance Act of 1996 should be amended so as to include PHI issues. On the other hand, the Insurance Supervisory Department, (which is under the Ministry of Finance) should look into a possibility of formulating a new Health Insurance Act which will specifically deal with PHI and other health insurance activities.

Further researches are needed in order to explore more on the characteristics of the PHI market in Tanzania and the extent of moral hazard, risk selection and administrative costs. The study would help in providing information on how to contain such characteristics and hence improve the accessibility of health care in Tanzania.

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