Policy Brief
Health Insurance in Ghana and Tanzania: Increasing Access and Equity

Executive summary
The impact of health insurance was assessed using household surveys, patient exit surveys and in-depth interviews in Ghana and Tanzania. Health insurance provides financial protection and increases utilisation of formal health care, especially hospital services. Membership does not have larger effect on treatment seeking among the least wealthy compared to the wealthiest. Membership contributions is not unaffordable in absolute terms, but forms part of a value for money assessment against the expected capacity of the system to deliver timely quality healthcare. Quality of care did not differ much by insurance status, but adherence to standard guidelines was generally low. Number of workdays lost to illness was lower among insured, and they were more likely to adopt healthy behavior. In Tanzania, more CHF than NHIF households reported risk factors for healthcare utilisation and less wealth, suggesting a need for risk equalization to increase equity. The majority supported redistribution across the funds and favored a partial subsidy.

Introduction
This Policy Brief presents some main results of a joint research project “Health Insurance in Ghana and Tanzania: Increasing Access and Equity” by researchers from Institute of Development Studies, Muhimbili University of Health and Allied Sciences, Tanzania, Institute of Social, Statistical and Economics Research, University of Ghana, Ghana, and Department of Public Health, Aarhus University, Denmark, undertaken over the period 2010 to 2014.

Background
Many developing countries introduced health insurance – in order to improve access to care, provide financial protection of the sick/poor, mobilise resources for service improvement, and ultimately contribute to improved population health. In many countries health insurance is a strategy for achieving Universal Health Coverage. Until recently, only limited research had been performed on such issues as affordability of insurance to households, differential quality of health services by insurance status in resource constrained settings, and impact of health insurance on healthy behavior and health. These issues are, however, important for increasing coverage.

In both Ghana and Tanzania, risk pooling through community insurance schemes was initiated in the mid90s. The National Health Insurance Fund (NHIF) in Tanzania and the National Health Insurance Scheme (NHIS) in Ghana was introduced by act in 1999 and 2003 with the aim of increasing access to health care and improving the quality of basic health care services for all citizens, especially the poor and vulnerable. Implementation started a few years later. In Ghana, district insurance schemes formed part of the NHIS, whereas in Tanzania the Community Health Funds (CHF) continued to exist in parallel with the NHIF. However, in 2011 out-of-pocket health expenditure in both countries still exceeded 30% of total health expenditures; only 34% of the population in Ghana and less than 20% in Tanzania were active members of an insurance scheme.

This project aimed to study the impact of health insurance on access to quality health care,

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financial risk protection and affordability as well as improvements in health in Tanzania and Ghana. Furthermore, the aim was to explore the potential of risk equalisation between insurance schemes as a means to increase access to health services in Tanzania.

**Approach and methodology**
Workshops held in Tanzania and Ghana including collaborating partners, potential PhD students and selected key stakeholders, e.g. MOH and other researchers first helped narrow focus areas of interest in the national context. The project collected data through household surveys and patient exit interviews in health facilities. In Ghana, a representative household survey was conducted in three districts, including 2418 households (11089 individuals). In Tanzania, multistage sampling was used to select 695 households (3290 individuals). Patient exit surveys, comprising 523 malaria patients in Ghana and 446 patients in Tanzania, were undertaken in randomly selected health facilities. Furthermore, 52 in-depth interviews with key informants, including members, non-members and health facility managers and district coordinators, were undertaken. Data included socio-economic and demographic factors, health, health seeking behavior, treatment received, quality of care, perceptions and attitudes to insurance and insurance status.

**Key results**

*Determinants of insurance membership*
In Ghana, about 64% of the study population had ever registered with the NHIS but only 39% of the study population were active members. About 28% of the households were fully insured while 26% were partially insured and the remaining 46% uninsured. Disenrolment is a similar problem in Tanzania. Household size and composition, educational status of members and their health status significantly influence household insurance status. Other significant factors include sex and marital status of the household head, higher wealth status, proximity to higher level health facility and district of residence. In-depth interviews in Tanzania further pointed to the importance of household power relations, understanding of the concept of insurance and perceived quality of care.

*Low enrolment - Is affordability the problem?*
Lack of affordability is often given much attention as a main barrier for access to health insurance as well as healthcare. Our research shows that in Ghana and Tanzania, membership contributions cannot be claimed unaffordable in an absolute sense, but that expected membership contribution as part of a value for money assessment is weighted against expected need for healthcare and the expected benefit from healthcare, i.e. the capacity of the system to deliver timely care of reasonable quality. In Ghana, the NHIS contributions was reported to be a barrier to enrolment but its burden on household resources was less than 5% of total household food expenditure. Based on the normative definition of affordability, 66% of the uninsured and 71% of the partially insured households could afford to insure all their members. In-depth interviews in Tanzania point in the same direction.

*Do quality of care differ by insurance status?*
When only part of the population is covered by health insurance, there is a risk that membership may divert resources and result in differential treatment in terms of timeliness and quality of healthcare, especially in very resource constrained settings depending on the incentive structures and the professionalism of the providers. Low coverage of health insurance
could thus lead to increased inequity in benefit incidence. In both countries, some anecdotal evidence suggested that members were given preference; other that non-members paying directly were given preference. Adherence to standard treatment guidelines in malaria patients were generally low and constrained by lack of supplies, but no significant difference was found between members and non-members, although non-members tended to be tested more often. Similarly few differences were found in patient satisfaction.

**Does health insurance membership contribute to financial protection and better health?**

Few studies have investigated the impact of insurance on health and health behaviour. The NHIS has a significant effect in reducing out-of-pocket and catastrophic health expenditures and has significant positive effects on access to formal healthcare and utilisation of outpatient and inpatient services. A stronger effect was expected among the poor, as the wealthier was already expected to have better access, but this hypothesis was rejected. There was no significant effect on self-assessed health status, but the number of workdays lost due to illness was lower for those insured compared to the uninsured when controlling for background factors, including expected differences in health. The insured were more likely to engage in healthy behaviour and had low consumption of alcohol and tobacco.

**Is there a potential for risk equalization?**

Having multiple insurance schemes serving different population groups may compromise equity due to an unequal distribution of high risk members among the schemes, differential revenue raising capacity and benefit packages offered by the various schemes and a variation in access to health care. This occurs when the funds exist without mechanisms in place to promote income and risk cross-subsidisation across the funds. It is therefore of interest to examine the potential of risk equalisation for addressing the effects of risk pool fragmentation in Tanzania as well as the acceptance of risk equalisation by the public. It is often assumed that risk equalization is not acceptable. Our research shows that a higher proportion of CHF households reported identified risk factors for health care utilisation and was less wealthy compared to NHIF households, so that there is a need for risk equalization. The majority of the surveyed population expressed support for redistribution, but the level of support and willingness to contribute to its achievement are influenced by the perceived benefits, amount of subsidy considered and trust in scheme management.

**Conclusions**

Health insurance has positive effects on access to and use of healthcare, health behaviour and workdays lost. Although health insurance contributes to financial protection of the insured catastrophic health expenditure is not eliminated. The realization of the full potential of health insurance requires focus on increasing population coverage and retention of active membership. The benefit of insurance cannot be separated from the functionality of the health system. Perceived quality of care is important for decisions regarding membership. Members tend to seek care of higher level of quality, but once at the health facility there are few differences in quality of care received. The price of insuring all household members imposes a minimal economic burden on most household, - not an access barrier of significance. Innovative approaches are needed to make health insurance more attractive to low-risk populations.

Reducing fragmentation in risk pooling arrangements is important for the
achievement of equitable access and financial protection for all regardless of insurance affiliation. Risk equalisation between CHFs and NHIF in Tanzania is both needed and largely accepted, but depends on perceived benefits, size of subsidy, quality of healthcare and trust in scheme management.

**Recommendations**

Ministries of Health should increase focus on strengthening the health care system and improve quality of care as this is essential for increased enrolment and retention of members. Affordability is not the major problem, but rather the perceived lack of value for money. Exemptions to ensure financial protection for vulnerable groups must be continued and support for transport considered to increase access.

Health insurance agencies and service providers should work jointly to improve administrative processes for members in health facilities to reduce waiting times and increase patient satisfaction. This will increase attractiveness of membership.

In Tanzania, a comprehensive health insurance system linking the various insurance schemes should be created through introduction of risk equalisation mechanism, which partly redistributes between insurance schemes. Establishment of a trusted management would be essential.

**Further reading**


Chomi, EN; Mujinja, PGM; Enemark, U; Hansen, KS; Kiwara, AD. Health care seeking behaviour and utilisation in a multiple health insurance system: does insurance affiliation matter? Int J Equity Health, 2014 Mar 19; 13(1).

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**Contact**

Further information is available from Prof. AD Kiwara, Institute of Development Studies, MUHAS; Director FA Asante, ISSER, University of Ghana; Associate Professor Ulrika Enemark, Department of Public Health, Aarhus University, Denmark.

Ulrika Enemark ue@ph.au.dk.