THE UNITED REPUBLIC OF TANZANIA
MINISTRY OF HEALTH AND SOCIAL SERVICES

REPORT ON MEDICINES COVERAGE AND
HEALTH INSURANCE PROGRAMS SURVEY
IN TANZANIA

2008
Acknowledgements/Disclaimer

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# TABLE OF CONTENTS

1.0 INTRODUCTION ................................................................................. 6
  1.1 Background .......................................................................................... 6
  1.2 Objective ................................................................................................. 8

2.0 METHODOLOGY .................................................................................... 9
  2.1 Area of Study .......................................................................................... 9
  2.2 Study Design ........................................................................................... 9
  2.3 Sample and Sample Size ......................................................................... 9
  2.4 Data Collection Methods ......................................................................... 9
  2.5 Data analysis Plan .................................................................................... 9

3.0 RESULTS .............................................................................................. 10
  3.1 Insurance Program and Membership ......................................................... 10
  3.4 Description of Medicines Benefit ............................................................... 15
  3.5 Access to Medicines Benefit ..................................................................... 16
  3.6 Medicine Covered .................................................................................... 17
  3.7 Medicine benefit Review ......................................................................... 18
  3.8 Excluded medicines list .......................................................................... 19
  3.9 Medicines inclusion criteria ..................................................................... 20
  3.10 Restrictions on the Covered medicines ................................................... 21
  3.11 Cost Sharing ............................................................................................ 21
  3.12 Perceived Problems with the Medicine Benefit ....................................... 21
  3.13 Availability of Data in Health Insurance Programs .................................... 22
  3.14 Barriers in Data Monitoring .................................................................... 25

4.0 DISCUSSION ......................................................................................... 27
  4.1 Insurance program and membership ....................................................... 27
4.2 Medicines Benefit

4.3 Treatment facilities

4.4 Medicines covered

4.5 Perceived problems

4.6 Data availability in the Schemes

4.7 Barriers in data monitoring

5.0 CONCLUSION

6.0 References
ACKNOWLEDGEMENTS

Many African and transitional countries are currently establishing or expanding health insurance programs. Many of these programs successfully collect revenues and enrol beneficiaries, but they struggle to devise optimal benefit packages and frequently provide inadequate medicines coverage. Health insurance programs also have routine enrolment and claims data that enable them to monitor medicines utilization and cost, increase transparency, maintain efficiency, and design policies to increase quality of care and promote equity. They often however lack the capacity, tools, and networks to use existing data for evidence-based medicines policy decision making. The collection of medicine insurance coverage of several African countries including Tanzania was a pre-requisite to a training of policy makers, and analysts in health insurance programs as well as WHO Essential Medicines, National Professional Officers (NPO) in the different countries which took place in Ghana from the 16 to 25/11/08 to build their capacities in insurance information systems and how to generate evidence for medicines policy decision making.

The Ministry of Health and Social Welfare (MOHSW) therefore wishes to express its sincere gratitude to the European Union through which the World Health Organization (WHO) was able to provide technical as well as financial support to enable the collection of the information in this report as well as the attendance of participants from Tanzania to the Ghana meeting.

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Ms Rose Marwa from the Tanzania Health Insurance Fund did a great job of collecting the required information and preparing this report. She also attended the workshop in Ghana. Special thanks are therefore accorded to her for the good work she did.

Last but not least, the constructive contribution from Ms. Rose Shija (NPO EDM/WHO – Tanzania) for her helpful technical advice during the development of this document is hereby acknowledged.
**EXECUTIVE SUMMARY**

This report describes a survey carried out in Tanzania to collect information on medicines coverage and health insurance programs in the country. The information was collected using a pre-designed survey forms and through insurance programs documents.

60% of insurance schemes in Tanzania are privately owned but covers only small proportion of the general population in the urban areas who can afford. The National Health Insurance Scheme for public servants covers more than 5% of the total population and its beneficiaries are equally distributed in urban, peri urban and rural areas. Major source of income for insurance programs in Tanzania is members contributions.

Insurance programs in Tanzania have very comprehensive benefit packages whereby medicines are full covered in both inpatient and outpatient services. Medicines covered mostly have to be in generic and has to be approved by the Tanzania Food and Drug Authority (TFDA).

40% of the Insurance programs have a written medicines formulary of which contains all medicines in the National Essential Medicine List (NEMLT) and few other more which are frequently prescribed especially in Referral Hospitals.

Lack of regulatory marker authority in medicines and medical services prices is one of the threats facing insurance programs in Tanzania.

In conclusion, Health Insurance is still a new concept in Tanzania but much has been done with regards to medicines coverage to its beneficiaries. The major challenges facing the health insurance companies in the country are: Uncontrollable rise in medical expenses especially medicines due to lack of price regulatory authority in country for medical care; Increase cases of chronic illnesses like diabetes, heart diseases and cancer and fraudulent practices by health services providers.

Medicines are covered by insurance but medicines availability in the treatment facilities is another question which need to be addressed.

Lastly Data keeping and proper utilization of the stored data for future development of the Insurance programs is something which needs to be strengthened in our health insurance programs.
1.0 Introduction

1.1 Background
Thirty years after independence the government was the major provider of health services in Tanzania. The government chose to be the sole provider of social services under the socialist ideology. Following the Arusha Declaration (1967), private individuals and firms were restricted to own investments in production of goods or provision of services (Teskey and Hooper 1999). Private health services providers were actually banned in 1977 under the Private Hospitals (Regulation) Act. The practice of medicine as a commercial service was also prohibited under this act\(^1\).

Tanzanian economy experienced a serious deterioration in 1970s and early 1980s. Before 1970, the rate of economic growth was at 4.5 per cent but from the mid 1970s the rate decreased to 2.5 per cent (Shitundu and Luvanda, 2000). The inflation rate reached a historically high figure of 36 per cent in 1984 (Bureau of Statistics, 1989). According to Maliyamkono and Bagachwa (1990) the economic crisis was mainly caused by decline in the terms of trade balance, rise in oil prices, rise in food prices, the war with Uganda, droughts of 1973-74 and 1981-82 and the break of East African Community in 1977.

Decreasing economic stability caused failure of the government to meet its obligations to provide social services to the citizens (Mallya, 2005). The government later in early 1980s decided to introduce a series of Structural Adjustment Programs (SAPs). One of the SAPs features was to cut government expenditure on social services (Enos, 1995).

The Structural Adjustment policy of reducing government expenditures on social service sectors like health created a lot of problems. Statistics show that aggregate central government expenditures on health fell by 9 percent in real terms between 1980 and 1987. The development budget for urban areas, as a percentage of the total development budget, began to decline in 1978-79 when it was only 1.62 percent; the situation worsened in 1986-87, when it was just 0.31 percent (Kulaba 1989: 234).

Per capita spending on health declined by more than a third between 1980 and 1986. (Afro-Aid 1991; World Bank 1995). According to the total financial requirements of the Priority Social Action Program of 1989/90 to 1991/92, the percentage of the unfunded gap in health was 42.9,

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\(^1\) www.tanzania.go.tz as retrieved on 1 Sep 2008
67.4 and 63.5 for 1989/90, 1990/91 and 1991/92, respectively. The government's ability to maintain, expand or improve the health care system declined tremendously, leading to serious deterioration of health services.

In 1990’s there were health sector reforms which were started to improve the quality of health care services. Through these reforms cost sharing for health services was introduced. Cost sharing includes drug revolving fund, out of pocket payment, community health fund in the rural areas and health insurance for employed people. Therefore in early 2000 health insurance schemes started to operate in the country both private and public insurance schemes.

The current situation on the medicine sector shows that procurement and distribution for public sector is managed by the Medical Stores Department (MSD). But again the policy of cost sharing still exists. Private sector is also procuring and distributing medicine in the country.

1.2 RATIONALE

Medicines in Tanzania and in other parts of the world have variable and often high prices. In this case they are unaffordable for large part of communities and a major burden on government budgets. The high burden of paying for essential medicines falls disproportionately on poor households in developing countries, resulting in preventable mortality and morbidity. Long term sustainable financing strategies are needed to extend access to medicines and health insurance coverage for medicines offers a significant potential to reduce disease burden and poverty in developing countries through its high purchasing power they can improve access to medicines at affordable prices and monitor rational prescribing habits by clinicians.

Currently many developing countries are either trying to establish health insurance schemes or expands coverage in its existing health insurance programs. Therefore this survey is trying to see the existing insurance programs in Tanzania in the view of beneficiaries enrolment and revenue collections, benefit packages offered by different programs and how comprehensive is the medicines coverage. Further more this study is trying to see the types of data collected by insurance programs and how the collected data is used in improving the quality of services to its beneficiaries and sustainability of the programs

The findings from this study will assist the World Health Organisation on advising member countries and insurance programs how they can streghthen capacity for medicines policy so that healthcare organizations and insurance schemes can improve medicines access and use.
1.3 OBJECTIVE

1.3.1 Broad Objective

Main objective of the survey is to collect information on medicines coverage and health insurance programs in Tanzania.

1.3.2 Specific Objectives

- To investigate health insurance schemes available in the Country
- To determine the corporate status of the scheme (private or public)
- To determine sources of income, membership coverage and contributions collections for different schemes
- To determine type of benefit packages offered by different insurance schemes
- To determine how medicine benefit is covered by different insurance schemes
- To determine types of data kept by different insurance programs
2.0 METHODOLOGY

2.1 Area of Study
The survey was carried out in Dar Es Salaam where the majority of health insurance program offices are found.

2.2 Study Design
The survey was carried out using the MedIC health Insurance pre-designed survey forms.

2.3 Sample and Sample Size
All the identified Health Insurance Programs were visited. These were:

- National Health insurance Fund
- National Social Security Fund
- AAR health services
- Prosperity Africa
- Momentum
- Tanzania Private Hospitals Consotorium Services
- Ministry of Health for Community Health Fund

2.4 Data Collection Methods
Primary and secondary data were collected. Primary data was collected using the MedIC pre-designed survey form/questionnaires. Secondary data was collected through relevant documents from insurance programs and Ministry of Health & Social Welfare. Unfortunately the survey forms were filled and returned by only five insurance programs. Out of the five one did not want to include their identity but the information collected was used in the data analysis.

2.5 Data analysis Plan
Data was analyzed manually, through computer package (SPSS) and through tables and charts.
3.0 RESULTS
The results are discussed basing on the survey form questions as presented below

3.1 Insurance Program and Membership
The question regarding the corporate status of the health insurance program in Tanzania, 60% of the respondents observed that health insurance are operated under private while 20% each belongs parastatal and public. (See table 1 below)

Table 1: What is the corporate status of the insurance program

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>1</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Parastatal</td>
<td>1</td>
<td>20.0</td>
<td>20.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Private</td>
<td>3</td>
<td>60.0</td>
<td>60.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Table 2 and chart 1 below, shows that health insurance program is almost voluntary for all members by 60% while 40% reported to be compulsory for all members. This is advocated with government policy for public servants (Public and Parastatal) it is a must to have a health insurance.

Table 2: How is membership in this health insurance program constituted?

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compulsory for all members</td>
<td>2</td>
<td>40.0</td>
<td>40.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Voluntary for all members</td>
<td>3</td>
<td>60.0</td>
<td>60.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
The health insurance program in Tanzania currently is not only insuring specific groups of private sector employee but also groups from informal sectors, pensioners, specific communities, children who are under 12 years, unemployed and anyone who can afford to pay for the contribution arranged by the specific health insurance.

Regarding the distribution of members in health insurance program, the respondents observed that 80% of health insurance programs are working and distributed mostly in urban area while 20% are found in both urban and rural areas.

**Table 3: What is the regional distribution of members**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mostly urban</td>
<td>4</td>
<td>80.0</td>
<td>80.0</td>
<td>80.0</td>
</tr>
<tr>
<td>Both urban and rural, about equally</td>
<td>1</td>
<td>20.0</td>
<td>20.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>
According to table 4 below it shows that most of the health insurance programs have their sources of revenue. The analysis shows that contribution scored 40% as a source of revenue, followed by revenue from sales, interest on investment and research grants and contracts which account to 20% each. Further analysis observed that employers contributed the most compared to the registered employees and individual members who paid contribution. (See table 5a and 5b below)

**Table 4: What are sources of revenue**

<table>
<thead>
<tr>
<th>Source</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contributions</td>
<td>4</td>
<td>40.0</td>
<td>40.0</td>
<td>40.0</td>
</tr>
<tr>
<td>Revenue from sales</td>
<td>1</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Interest on investment</td>
<td>1</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td>Research grant and contract</td>
<td>1</td>
<td>20.0</td>
<td>20.0</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
Table 5a: Who pays contributions

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employers</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 5b who pays contributions

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employees registered with an employer</td>
<td>3</td>
<td>60.0</td>
<td>75.0</td>
<td>75.0</td>
</tr>
<tr>
<td>Individually paying members</td>
<td>1</td>
<td>20.0</td>
<td>25.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>80.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

3.2 Benefit Packages

With regards to services covered by the insurance schemes, analysis showed that all health insurance are providing primary care for outpatient visits, preventive services (for example cancer screening and purchase of mosquito nets), specialist services for outpatient visits, laboratory services, diagnostic services, hospital inpatient care (boarding, lodging and medical treatment), emergency room care, maternity care, inpatient medicines and outpatient medicine. Others are dental, optical services and eyes care services for all members.

3.3 Medicines Benefit

With regards to medicines benefits, most of the respondents provided it to both inpatient and outpatient by 100% since it is part of the insurance program from the beginning. See table 6ai, 6aii, 6bi and 6bii.
Table 6ai: Does your health insurance program provide medicines benefit

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, an Inpatient medicines benefit</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 6aii: If yes was inpatient medicine benefit always part of the benefit package or was added later

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of the insurance program from the beginning</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 6bi: Does your health insurance program provide medicines benefit

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, an Outpatient medicines benefit</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table 6bii: If yes was Outpatient medicine benefit always part of the benefit package

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of the insurance program from the beginning</td>
<td>5</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The respondents were asked to establish which are the main criteria used to establish the medicines benefit package. Table 7 below shows that, medical need or importance scored 40% while 20% each are dominated by Stakeholder (e.g., medical societies, industry) preferences and cost-effectiveness.
### Table 7: Which were the main criteria used to establish the medicines benefit package as it is

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical need or importance</td>
<td>2</td>
<td>40.0</td>
</tr>
<tr>
<td>Stakeholder (e.g., medical societies, industry) preferences</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td>Cost-effectiveness</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td>No responses</td>
<td>1</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

### 3.4 Description of Medicines Benefit

The study wanted to reveal out if there are any written description concerning medicines package, most of the respondent on table 8 and chart 3 comments that there are no any written description on medical package by 60% while 40% observed to have some written description of the medical package.

Further analysis reveals that, most of the written descriptions of the medicines benefit package are distributed at the hospitals and pharmacies only.

### Table 8: Is there a written description of the medicines benefit package

<table>
<thead>
<tr>
<th>Description</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>40.0</td>
<td>40.0</td>
<td>40.0</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>60.0</td>
<td>60.0</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>5</strong></td>
<td><strong>100.0</strong></td>
<td><strong>100.0</strong></td>
<td></td>
</tr>
</tbody>
</table>
3.5 Access to Medicines Benefit

The general issue concerning the access of medicines benefit to health insurance program in Tanzania, medicines are almost accessible to all members by 80% regardless whether the patient gets inpatient or outpatient medicines benefits as it is indicated in the table 9a and 9b below.

Table 9a: Who has access to medicines benefits- Inpatient medicines benefit

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>All members</td>
<td>4</td>
<td>80.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing information</td>
<td>1</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 9b: Who has access to medicines benefits- Outpatient medicines benefit

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>All members</td>
<td>4</td>
<td>80.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing information</td>
<td>1</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The respondents were asked to identify the place where members could obtain the covered medicines. The analysis shows that public facilities are the most places which cover medicines, followed by private retail pharmacies, then pharmacies in NGO/mission facilities. Others are pharmacies in other type of clinics (for example employer based clinic and pharmacies run by the health insurance system.

3.6 Medicine Covered

The survey aimed at finding out if there is any written list of medicines covered under the medicines benefit (formulary). The analysis shows that, 40% agreed and specified that all medicines are in the NEMLT and its formulary indicated to be containing 555 items including medical supplies while other 40% disagreed even though 10% of the respondent had nothing to comment. (See table 10a, 10b and 10c below)

In short it can be said that all insurance schemes covers the medicines benefit as part and parcel of the scheme but majority do not have a specific formulary for medicines coverage but they pay to what has been issued to its beneficiary and be claimed by the service provider.

Table 10a: Is there any written list of medicines covered under the medicines benefit (formulary)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>40.0</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>40.0</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing information</td>
<td>1</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.7 Medicine benefit Review

The question regarding how frequently are lists of covered medicines are updated, the findings on chart 4 shows that most of the medicines are updated on yearly 20% while other 20% indicated to be more frequently than once a year and the remaining 60% have not able to comment on it.

Chart 4: How frequently are lists of covered medicines updated
3.8 Excluded medicines list

Concerning the written list of medicines excluded from coverage under the medicines benefit (negative list), the majority of the people interviewed disagreed by 60% as there is no any written list of medicines while 20% agreed to have a list of medicine excluded from coverage under the medicines benefit. On other hand, 20% had no any information. (See table 11)

Table 11: Is there a written list of medicines excluded from coverage under the medicines benefit (negative list?)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>1</td>
<td>20.0</td>
<td>25.0</td>
<td>25.0</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
<td>60.0</td>
<td>75.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing Information</td>
<td>1</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.9 Medicines inclusion criteria

With regards to criteria most used to decide which medicines are covered by the benefit. Table 12 revealed that medicines must be approved by the country regulatory authority by 80% in the first option while in the second option shows that Medicines must be listed on the insurance formulary and others Medicines must be listed on an essential medicines list (NEMLT).

Table 12a: which criteria are used to decide which medicines are covered by the benefit

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines must be approved by the country regulatory authority</td>
<td>4</td>
<td>80.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing Information</td>
<td>1</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 12b: Which criteria are used to decide which medicines are covered by the benefit

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines must be listed on the insurance formulary</td>
<td>1</td>
<td>20.0</td>
<td>50.0</td>
<td>50.0</td>
</tr>
<tr>
<td>Medicines must be listed on an essential medicines list (NEML)</td>
<td>1</td>
<td>20.0</td>
<td>50.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Missing information</td>
<td>3</td>
<td>60.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.10 Restrictions on the Covered medicines

The analysis regarding the restrictions applied to coverage of inpatient and outpatient medicines, the available data shows that medicines must be prescribed by generic or international nonproprietary name, medicines must be dispensed as generics when generics are available, medicines must be approved by the insurance before they are dispensed (prior authorization), for some medicines, only limited quantities are covered, medicines are covered up to a maximum cost (based on cost of medicines only), medicines are covered up to a maximum cost (based on cost of entire hospitalization or visit) are all applied to both to in and outpatient medicines by over 80 percent.

3.11 Cost Sharing

In this study the result shows that there is no any type of cost sharing which exists for medicines benefit in both inpatient and outpatient services.

Furthermore the result shows that there is no cost sharing for civil servants, poor, dependants, children, pensioners, surviving dependents, unemployed and chronically ill.

3.12 Perceived Problems with the Medicine Benefit

The perceived problem with the medicines benefit in health insurance program revealed that 50% of providers have a minor problem about administrative issues in medicines benefit and limited benefit. More than 80% revealed that there is no problem about limited medicines benefits and administrative issues. Not only has that, but also more than 40% of the result showed that there is minor problem in delaying in reimbursement and fraud (i.e. some hospitals claims for services not provided).

Consider chart 5 below which shows perceived different problem with medicines benefits. From the figure the data revealed that there are no serious problem with medical benefits in different complain rather than the small percent which appeared in fraud where some hospitals claims for services which is not provided. Otherwise there is a minor problem reported on members complaining about delay in reimbursement,
providers complain about limited medicines benefit and members complain about administrative issues.

**Chart 5: Shows the perceived problems with the Medicines Benefit in the health insurance program**

3.13 Availability of Data in Health Insurance Programs

More than 75% of the collected answer reveals that in health insurance the data for Enrollee demographic, Pharmacy claims, Hospitalization claims and Outpatient visit data are available. Moreover most of the reported data are available in claims form except procedure codes which are not used. Furthermore the data for medicines, medical/surgical (including dental, ophthalmology, orthopedic supplies and devices,
hospitalizations, outpatient visits and procedures are available on the amount of money paid by insurance program.

Consider the following chart which shows the routinely collected data and computerized.

**Chart 6: Shows data which are routinely collected**

Not only that but also the analysis shows that the insurance program administrator receive some reports quarterly such as cost of medical services, cost of medicines and appropriateness of medical services. The report such as utilization of medical services and utilization of medicines and appropriateness of medicines use are received monthly. Consider the following column chart which shows how frequently the insurance program administrators receive the different types of data.
Chart 7: which shows how frequently the insurance program administrators receive the different types of data

From the graph above it reveals that most of the reports are received quarterly and monthly. On the other hand some of the reports mentioned above are available to individual or institutional providers as shown by the chart 8 below. This imply that most of the report of appropriateness of medicines use and medical services are available to individual or institution but the report for utilization of medicines, utilization of medical services, cost of medicines and cost of medical services are available and some are not available.
3.14 Barriers in Data Monitoring

As much as Insurance programs collect data but still there are some barriers such as lack of policy makers, Lack of standard data and lack of computer system is counted in monitoring as depicted in the chart 9 below.
From the above figure it shows that lack of policy maker interest is the big barriers in using available data for monitoring than other barriers. Moreover most of the interviewers that were asked about what are the most important questions that insurance program officials would like to answer about medicines policy or coverage issues for example how are newer drugs used and what are we spending on those? They have different opinion such as: - How can we best control our medicine prices, Standard pricing of medicines, incompatible rise in medicines prices is a big problem and challenge to our services, We are covering new ant cancer medicines (monoclonal antibodies) but they are too expensive and cancer cases are on the rise, Use of generic names should be encouraged and there should be a standard treatment protocols.
4.0 DISCUSSION

4.1 Insurance program and membership
Around 60% of Health Insurance Programs in Tanzania are privately owned whereby family members premiums are paid for individually. This means only few people can afford to register with these type of insurance and this can be proven by seing that majority of its members comes from big private companies which are mostly found in urban areas.

Unlike private insurance schemes public health insurance scheme only the principle member contributes and he/she can have up to 5 dependants who are full covered without additional payments. But membership for public scheme is compulsory where individual contributions are directly deducted from their monthly salaries.

4.2 Medicines Benefit
Access to quality medicine is one of the biggest challenges facing people in many developing countries like Tanzania. Fortunately all insurance programs in the country covers medicines costs for all its members in both inpatient and outpatient services. From this survey it was learnt that the major criteria used to establish the medicines package was medical needs.

With regards to written formulary for medicines covered only 40% of the programs has written description of medicines covered while the remaining 60% pays for medicines as claimed by services providers.

4.3 Treatment facilities
Only 20% of health insurance programs has their own treatment facilities for its enrollee and the remaining 80% accredit health facilities registered with the Ministry of Health which includes government health facilities, faith based and non governmental organizations and the privately owned treatment facilities, where insurance beneficiaries are expected to receive treatment services including medicines; unfortunately medicines
availability in treatment facilities especially government owned is still a problem therefore health insurance schemes has accredited privately owned pharmacies including Accredited Drug Dispensing Outlets (ADDOs in rural areas) to issue medicines to its beneficiaries through a special pharmacy claim form.

There is no any kind of cost sharing in medicines package for insurance schemes

**4.4 Medicines covered**

The health insurance programs with medicines formulary covers all medicines in the NEMLT with some few additional for medicines which are most frequently asked for especially in the referral hospitals and are not in the NEMLT. The insurance formulary has 555 items while the NEMLT has 538 items.

Medicines covered are generic formulations with exception of few cases where generic formulations are not available, innovator brands are used.

For health insurance schemes without its own written formulary they pay for what is submitted in the claim forms for both brand and generic formulations. But there are very few innovator products in Tanzania market (*medicines survey*)

All the medicines covered under the insurance programs must be approved by Tanzania Food and Drug Authority (TFDA) to ensure quality, efficacy and safety of the products used by insurance beneficiaries.

**4.5 Perceived problems**

With perceived problems with medicines benefit there were no major problems except fraudulent tendencies of some service providers. Fraud can collapse insurance programs if are not well controlled. Insurance programs in Tanzania are still new and have tried to have a very comprehensive benefit packages; computerization of benefit administrations is not yet full fledged therefore the fraudulent practices could be even higher than it is perceived now.
4.6 Data availability in the Schemes

Insurance schemes in Tanzania collect and computerize important data like beneficiaries demographic data, inpatient and outpatient services, investigations done, medicines and medical supplies issued. These data are important especially in actuarial evaluations and determination of the benefits to be offered and future development of the scheme. Medical services costs and medicines costs reports are submitted frequently to insurance program administrators.

With all these good data collected if are not well used to monitor utilization of medicines, increase the quality of services offered and to increase efficiency the programs can easily collapse.

4.7 Barriers in data monitoring

Lack of policy marker interest is the major barrier to data monitoring in insurance schemes because in Tanzania medical services including medicines are under free market where everybody puts prices as they please without control. This situation makes insurance programs to pay for the same service/medicine from different treatment facilities of the same category with different prices. Currently medicines price volatility and use brand and generic names are the biggest challenge facing insurance programs in Tanzania.

Lack of full fledged computerized system in insurance program is another barrier to data monitoring as most of the important information are recorded manually by services providers and later on captured in the computer by the insurance program. This system of data transfer can loose/miss some important information and fraudulent practices by service providers can be high and go un noticed

All these barriers are dangerous for the development of insurance programs and it is an issue which needs to be addressed.
5.0 CONCLUSION
Health Insurance is still a new concept in Tanzania but much has been done with regards to medicines coverage to its beneficiaries. The major challenges facing the health insurance companies in the country are: Uncontrollable rise in medical expenses especially medicines due to lack of price regulatory authority in country for medical care; Increase cases of chronic illnesses like diabetes, heart diseases and cancer and fraudulent practices by health services providers.

Medicines are covered by insurance but medicines availability in the treatment facilities is another question which need to be addressed.

Lastly Data keeping and proper utilization of the stored data for future development of the Insurance programs is something which needs to be strengthened in our health insurance programs.
6.0 **RECOMMENDATIONS**

- Health Insurance schemes to be assisted in developing and monitor evidence based medicines policies

- Health Insurance Schemes to be assisted in type of data to be collected and stored and how they can used these datas in improving quality of services offered and ensuring sustainability of the schemes basing on Tanzania environment
7.0 References


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