HP+ HEALTH POLICY PLUS

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Mobilizing Domestic Financing for HIV through Health Insurance in Tanzania

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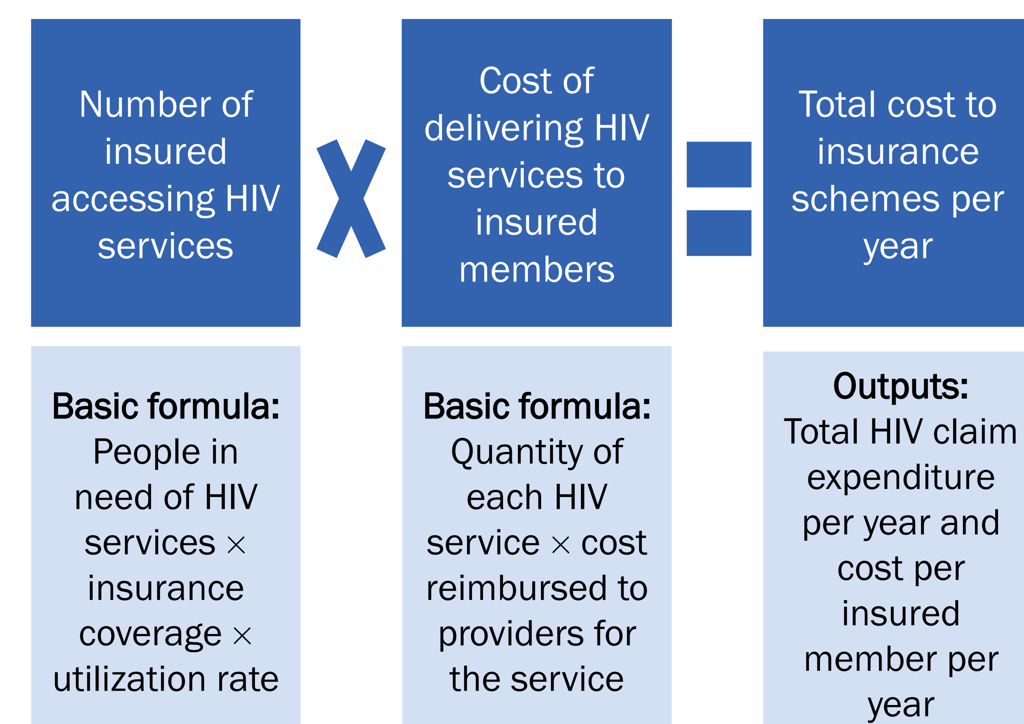
Background

In light of globally plateauing external resources for HIV, sustaining higher levels of coverage for HIV care and treatment will require implementing a combination of domestic financing options. Integrating HIV services into health insurance provides one option to sustainably increase domestic resources to fund the epidemic response through premium contributions and pooled funding. Levels of coverage for antiretroviral therapy (ART) in Tanzania are high, and the resources required to sustainably finance services at the facility level are taken entirely from the government tax-funded budget and supplied directly to facilities. Few resources are available to additionally fund HIV-related commodities.

Findings from an analysis of HIV integration into insurance can provide evidence on whether additional financing is required to cover expenditures for a package of HIV services within existing schemes in Tanzania. The analysis, conducted by the USAID- and PEPFAR-funded Health Policy Plus (HP+) project, focused on the long-term financial impact of including these services, considering underlying demographic and epidemiological attributes of the insured populations, potential utilization of HIV services, and costs of purchasing the services from providers.

Methods

Analytical Model Structure



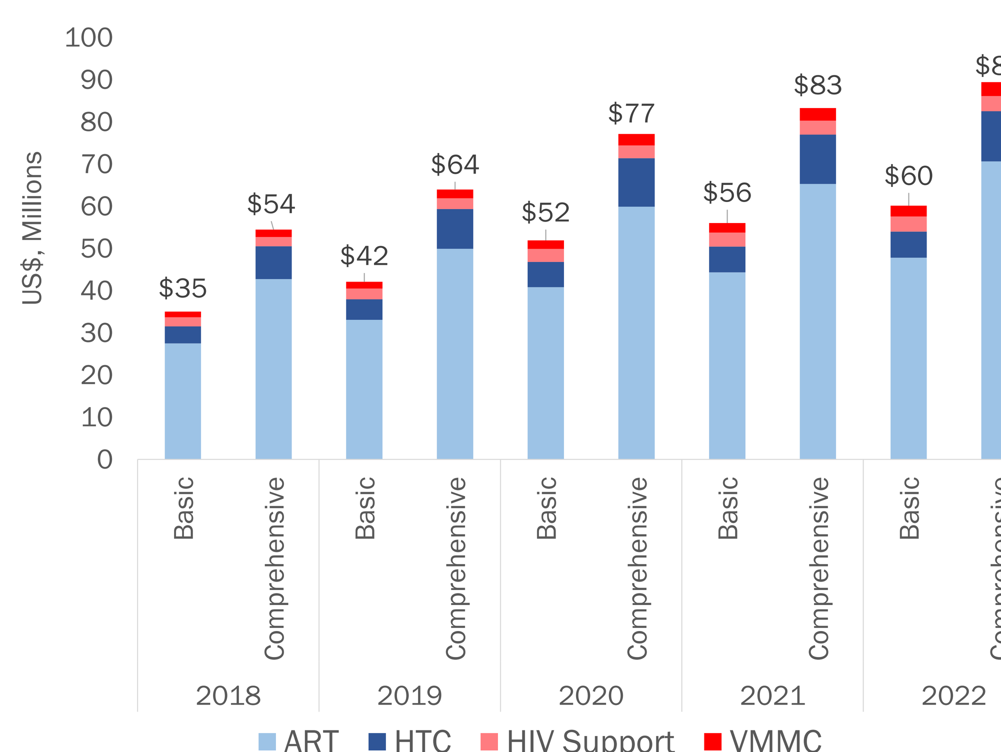
Methods (continued)

Enrollment

Enrollment growth rates, disaggregated by employment, were varied based on three scale-up scenarios. Under the "optimistic" scenario, enrollment was based on a previous actuarial analysis with the assumption of rapid scale-up of single national health insurance (SNHI). The "pessimistic" scenario was based on historic enrollment growth rates achieved by the National Health Insurance Fund (NHIF) and the Community Health Fund (CHF) as of FY 2016/17. The "realistic" scenario was based on midpoints calculated from the two other scenarios. Projected numbers of people living with HIV were sourced from the official National AIDS Control Programme's national Spectrum AIDS Impact Model 2017 for mainland Tanzania. Estimates for the number of people living with HIV enrolled in each of the insurance schemes in Tanzania were calculated using the latest Tanzania AIDS Indicator Survey that reported HIV prevalence rates by socioeconomic status.

HIV Service Packages and Unit Costs

HP+ relied on secondary data from existing programmatic sources as well as expert opinion to estimate the underlying unit costs for each of the HIV services to be considered for inclusion in the schemes.



Package	HIV Service	Cost Inputs	Commodity Inputs
HIV Standard Package	ART including diagnostics tests	Supplies; shared facility, equipment, and overhead costs	Antiretrovirals; laboratory diagnostics including viral load
HIV Standard Package	HIV testing and counseling (HTC)	Supplies; shared facility, equipment, and overhead costs	HIV test kits; confirmatory tests; EID
HIV Plus Package (includes standard services)	HIV support services (loss-to-follow-up tracking and peer support)	Phone credit, travel, and meeting venue costs; treatment literature; patient incentives	
HIV Plus Package (includes standard services)	Voluntary medical male circumcision (VMMC)	Shared facility, equipment, and overhead costs; training and planning	Consumables

Basic (no commodities) — Cost Inputs; Comprehensive (with commodities) — Commodity Inputs

Utilization

Utilization rates were estimated to be proportional coverage from achieving Tanzania's national targets for each of the proposed HIV services with the size of the total population in need.

Methods (continued)

Provider Payment Mechanism

HP+ recommends provider payments for HIV services to mirror the current structure under the existing schemes in Tanzania. The NHIF is all fee-for-service while the Improved Community Health Fund (iCHF) is capitation.

Premiums Collected

Assumptions on premiums were based on the previous actuarial analysis and the government of Tanzania's iCHF design document. Baseline annual premiums per beneficiary were estimated at US$118 for NHIF and US$8 for iCHF.

Results

Potential Enrollment of People Living with HIV

	2018	2019	2020	2021	2022
NHIF	95,832	105,926	120,075	131,102	143,066
iCHF	369,543	460,186	585,852	628,748	674,645
Total	465,375	566,112	705,927	759,850	817,710
% of people living with HIV	33%	40%	50%	54%	57%

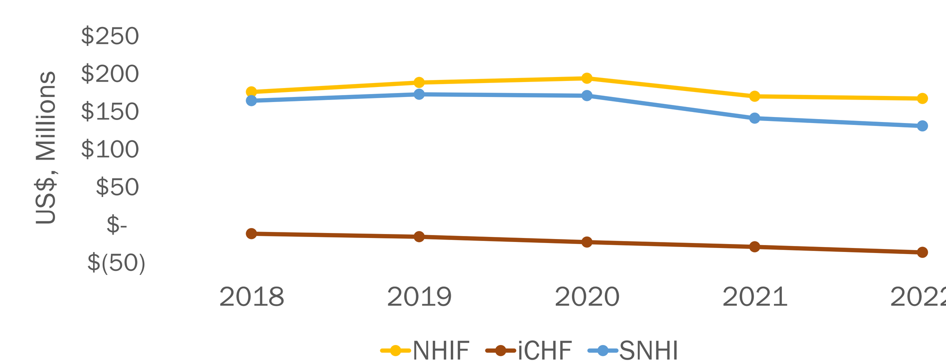
Baseline Incremental Costs to Schemes

US$, Millions (0–100); Basic / Comprehensive by year 2018–2022: 2018 $35 / $54; 2019 $42 / $64; 2020 $52 / $77; 2021 $56 / $83; 2022 $60 / $89

ART ■ HTC ■ HIV Support ■ VMMC

Results (continued)

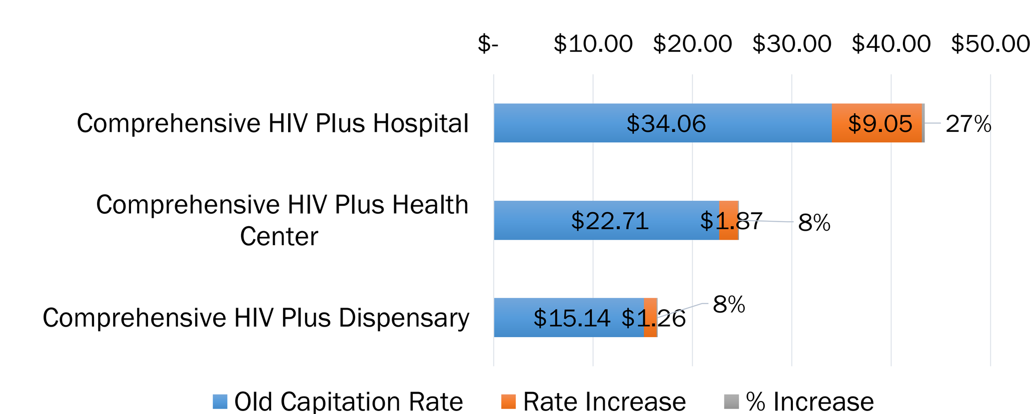
Scheme Surplus/Deficit after Integrating Comprehensive HIV Plus Package



Conclusions

Based on the modeling results from the recommended provider payment mechanism scenario, HIV integration appears manageable in the short- to medium-term under an SNHI without any increase to premium rates. Expenditure on HIV alone is estimated to be between five and nine percent of contribution income and these percentages decline over time. This scenario would require cross-subsidization from the NHIF surplus and reserves to cover iCHF deficits.

Adjustment to iCHF Capitation Rates



Premiums to Maintain Claims Ratios

Maintaining the baseline claims ratio in Year 1 for the NHIF would require an increase to the premium rate ranging from four to 16 percent, depending on HIV package selected, which is equivalent to a maximum increase of US$4 to US$19 per beneficiary. Similarly, the iCHF would require a maximum increase to the premium rate from 28 to 33 percent, which is an increase of about US$2 per beneficiary. If attrition of the claims ratio is acceptable, premiums could be increased at a reduced rate.

Health Insurance Reform Dialogue in Tanzania

Under the draft *Health Financing Strategy 2016–2020*, the Ministry of Health, Community Development, Gender, Elderly and Children (MOHCDGEC) proposed a single national health insurance (SNHI) scheme as a means to end fragmentation of health insurance coverage, increase resources for health, provide a minimum benefits package for all, and increase the efficiency of health spending. Seventy percent of the Tanzanian population is currently uninsured. SNHI legislation is expected to be considered in Parliament in September 2018–but even if passed, implementation is not likely to begin until 2019 or 2020. The interim plan is to have two concurrent schemes: the National Health Insurance Fund will cover the formal sector and enrollment will be made mandatory; meanwhile, an improved Community Health Fund, designed to cover rural and informal households, has been launched and will pool funds at the regional level. The prior implementation of the scheme, the Community Health Fund, had enrollment of over 2.1 households and pooled funds at the district level. The improved scheme is designed to be uniform across Tanzania in terms of contribution rates and provider payment mechanisms. Some enrollment for the extremely poor and unemployed is expected to be subsidized by the government of Tanzania. The definition of "extremely poor" is those living with incomes below the national poverty line. Schemes in Tanzania do not currently include or plan to include HIV services.

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