ZANZIBAR RESEARCH CENTRE FOR SOCIO-ECONOMIC AND POLICY ANALYSIS

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CONDITIONALITY FOR DEVELOPING READINESS OF UNIVERSAL HEALTH INSURANCE (UHI) IN ZANZIBAR

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1. Introduction

Like many other low- and middle-income Countries (LMICs), the Revolutionary Government of Zanzibar has passed the law[2] to introduce the Zanzibar Health Service Fund (ZHSF) as a compulsory social security fund. It will be a strategic purchaser of health services under the national policy of using prepaid arrangements as a core source of healthcare systems. Zanzibar has moved to this form of dedicated health insurance (pre-payment arrangement) with a belief that it may provide solutions needed to solve pressing problems related to the financing and provision of health care.

The problem faced by the health system is not rooted from universal access because historically (since independence in 1964), access to health services has been extended to everyone for free. Actually, the main challenges of the health system, in particular, during the past two decades, are emanating from the poor quality of services attached to weak financing and efficient utilization of financial resources[3]. Although the country has just started to implement compulsory health insurance from the beginning of the fiscal year 2023[4] by covering the civil servants and then private sector workers.

Seemingly, there is a big hope that ZHSF would boost fiscal revenues for health care, as post-treatment out-of-pocket payments to providers would be replaced by pretreatment insurance premiums paid by members. At the moment, ZHSF only covers the formal sector, and the plan and roadmap to extend the coverage towards the informal sector and poor people is not yet clear. Without a clear plan and road which is credible, a mass population universal coverage of ZHSF would not occur.

A recent empirical study which evaluated the experience with health insurance in LMICs over the last 20 years, where health insurance illustrates that without a rapid coverage of the informal sector, including poor people, the UHI plans have not been fit for the purpose. Despite evidence that, to a certain extent, health insurance has provided financial protection; consumers in LMICs are not willing to pay for unsubsidized premiums. In most of LMICS, health outcomes unfortunately have not improved despite an increase in utilization[5].

2. Avoiding a Failure Trap

Without a rapid coverage extension, ZHSF is likely to encounter the same operational challenges as the National Health Fund (NHIF) which is based in Tanzania Mainland. As such, for ZHSF to succeed it needs to establish strong credibility by addressing these challenges: Low enrollment of Members, Inadequate Management Skills, Lack of Community Involvement, Poor Quality Care and Fraud[6]. "An adverse selection" problem due to low and stagnant coverage would be a classic and textbook reason for apparent lack of UHI coverage in LMICs.

As pointed out above, the challenges of introducing UHI are not unique to

[2] ACT NO. 1 of 2023

[3] Khalfan T. (2022). 'System Design Options for Introducing Universal Health Insurance in Zanzibar'. ZRCP Policy Note

[4] https://dailynews.co.tz/zbar-starts-implementing-compulsory-health-insurance/

[5] Das.J and Do. Q (2023). 'The Prices in the Crises: What We Are Learning From Twenty Years of Health Insurance in Low- and Middle-Income Countries'. NBER WORKING PAPER SERIES. Working Paper 30996. http://www.nber.org/papers/w30996

[6] Khalfan. S, Ngwali. A and Hafidh. H (2023). "Systematic Review of Lessons Learned from the Tanzania Mainland Health Financing System towards the Introduction of Universal Health Coverage in Zanzibar''. Asian Journal of Research in Nursing and Health, Vol 6, Issue 1

Zanzibar because many LMICs are struggling to maximize the benefits of this particular policy when poor people are not receiving public financed subsidies. In life, it can be much easier to be critical than to provide solutions. To avoid falling in the trap, we are providing the following solutions in "layman" language for "Developing readiness for fully operationalization of Universal Health Insurance (UHI) in Zanzibar":

3. Required institutional arrangements:

For accountability and sustainability of UHI system, the establishment of an institutional separation based on these functions is crucial:

1) Individual accredited health services providers (total 297: 168 public & 129 private clinics and hospitals) that submit reimbursement requests for services rendered into the Insurance Management Information System (IMIS).

2) The single / multiple purchaser(s) of health services (e.g ZHSF) who processes claims submitted in the IMIS, and issues reimbursements directly to each clinic account, are essential.

3) The role of the Ministry of Health needs to be newly defined as a health regulatory agency ensuring annual accreditation for quality assurance of each provider to be eligible for service reimbursements, ensuring continuous professional development of accredited health-workers at all facilities, and to define and update the minimum benefit packages to be covered by the insurance.

4) An independent regulatory framework that ensures insured members rights to quality services, that negotiates prices setting between services with providers and purchasers, that provides guidance on fund governance, investments and financial sustainability, and that serves as complaints and whistleblower mechanism needs also to be newly established.

4. Creating readiness to operationalize ZHSF:

1) Guarantee that a **sufficient** number of **accredited** clinics (public **AND** private) is available to deliver at all times high quality services to cover the increased demands by insured members who expect improved service delivery by ensuring,

- Quality assured health workers are present in all clinics.
- Performance supply systems (central and backup private prime vendors) that prevent stock-outs of medical devices and medicines in clinics.
- Physical infrastructure is commensurate with the level of services offered.
- Competence and compliance with management / administrative requirements at all clinics

2) Decentralize health financial management autonomy to each individual clinic (direct facility financing – DFF in mainland) and adapt financial accounting and reporting systems (FFARS) for use.

3) Adapt insurance management information system, IMIS, for claims management in Zanzibar.

4) Identify realistic sources of financing for the provision of subsidies on premiums (30%-100%) on premiums of means tested poor households.

5) Decide whether the purchaser of health services is a single national insurer (ZHSF) or consists of both national and private insurers.

6) Create an independent external regulator to ensure members rights to quality services is maintained, to negotiate prices for services with providers and purchasers, to guide on fund governance and investments, to provide a complaints and whistleblower mechanism.

7) IF conditions 1-6 above are not met, UHI should not be launched. If UHI is still launched in the formal sector, in spite of low system readiness, there is a high risk of negative experience by freshly insured members that will undermine confidence in the new UHI scheme or collapse the UHI right off the start.

8) If conditions 1-6 are met, the formal sector enrollment can commence.

9) The subsequent **rapid** numerical expansion of membership (exempted and informal) is the solution to prevent fraud and adverse selection which could undermine the functioning of UHI. High priority needs to be given to expand insured numbers fast.

10) As soon as a **sufficient** number of additional **accredited** clinics (public **AND** private) **is available,** enrolment of exempted households is initiated. Partial and full subsidy could be required for up to 1/3 of Zanzibar population.

11) Once additional delivery capacity is ascertained, in order to ensure universality, and then coverage of the informal sector needs to be incentivized (means to be defined). The Informal sector being very diverse, diverse incentives for differing segments of the informal economy need to be developed, motivating the purchase of UHI – i.e. for traders/tourist industry etc., obtaining a business license could be linked to membership in UHI; motorcycle or taxi drivers license could be linked to membership in UHI, etc. Concurrently, Proxy Means Testing (PMT) could be used to identify vulnerable groups that require partial subsidy of premiums.

12) A dynamic time series database of household surveys will have to be developed to identify the poor in a more efficient manner and avoid the exclusion and graduation problems which are connected to the PMT method.

13) Informal sector enrolment should initially focus on urban areas to grow membership very rapidly.

14) A key message to convey to the informal sector is that UHI services

will be of better quality than those offered today under “free” health services.

15) Engage dialogue between the purchaser and the third-party motor vehicle insurers to establish a reimbursement system by the latter into the UHI for street accident-related services.

Based on the experience from LMICs, this process should be expected to take 3-5 years! It is of utmost importance that full readiness must be established for UHI to be successful.