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Two decades of Tanzanian health policy

Examining policy developments and opportunities through a
gender lens

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Abstract: Tanzania has undertaken important health sector reforms in the new millennium, and the most recent Health Sector Strategic Plan (2021–26) lays out ambitious targets to achieve universal health coverage. Yet, women in Tanzania continue to face significant barriers in accessing healthcare and the country is grappling with important gender-biased health challenges disadvantaging women. The aims of this paper are two-fold. First, we examine the evolution of Tanzania’s health policy over the past two decades (2000–21) from the perspective of enhancing financial protection for working-age women. Second, we explore policy options for gender-responsive health insurance expansion in the context of Tanzania. Methodologically, the paper draws on a scoping study of diverse literature and data and a review of evidence from other contexts with public health insurance schemes. We find that Tanzania has a fragmented health system that relies on several independent schemes introduced throughout the years, characterized by insufficient risk-pooling. Such a system provides insufficient financial protection for working-age women and female-headed households, which are financially less secure than dual-earner households. Although expanding health insurance coverage represents a viable corrective measure, future reforms must account for women’s lower financial contribution capacity to enable equitable access. Additionally, the policy design requires gender-mainstreamed investments in awareness-raising, service quality, and benefit packages.

Key words: Tanzania, women, health policy, financial protection, health insurance

JEL classification: I13, J16

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1 Introduction

Health and gender constitute key themes on global development agendas. Sustainable Development Goal (SDG) 5 seeks to ‘achieve gender equality and empower all women and girls’, and SDG 3 promotes a range of health objectives specifically targeted at women, including the elimination of infectious diseases, reduction of maternal mortality, and universal provision of reproductive services, among others (United Nations n.d.). SDG 3.8 focuses on achieving universal health coverage (UHC). This has been equally pursued under the World Health Organization’s UHC agenda (WHO 2021), and the Social Protection Floors initiative initially introduced by the International Labour Organization (ILO 2012). These policy agendas have attracted further attention to equitable health systems alongside disease-focused policy objectives and highlighted access to health largely as a social and human right. At the same time, investments in gender equality and health improvements represent key policy instruments to enhance economic growth. Better health yields positive impacts on productivity and increases the share of active labour force in the economy—while growing saving rates for retirement years and reducing dependency ratios (Mkandawire 2004). Investments in female health are particularly pertinent for growing effective labour supply and human capital in the long term and intergenerationally, given the spill-over effects on improved child health and children’s educational attainment, among others (see Bloom et al. 2020).

Interconnections between health and gender equality are intricate and multifaceted. Women have additional health needs related to pregnancy and childbirth; greater prevalence of infectious diseases (e.g., HIV/AIDS), malnutrition, and inter-partner-violence; and they experience more health risks and hazards related to lower-quality employment than men. This has been evidenced most recently in the context of the COVID-19 pandemic, where women’s greater share in the service sector and unpaid care work has made them particularly vulnerable to the coronavirus as well as its broader economic consequences (Azcona et al. 2020; Berkhout et al. 2021). Simultaneously, poverty continues to disadvantage women disproportionately. Being overrepresented in unpaid and low-wage informal work, women and female-headed households have restricted access to healthcare due to service-related, transportation, and opportunity costs (Witter et al. 2017). Women with a low level of social independence and access to household resources are particularly hindered from accessing health services (WHO 2019a). It is also noteworthy that households typically invest more in men’s health because of the greater instantaneous utility gain (Bloom et al. 2020). This highlights the deep-seated interlinkages between inequitable access to health and broader gender inequalities.

Public health policies play a crucial role in responding to women’s health needs and barriers impeding their access to care. Ensuring adequate financial protection against out-of-pocket (OOP) expenses for health is particularly important, given that women experience greater vulnerability to medical spending that results in financial distress, also known as catastrophic health expenditure¹ (Njagi et al. 2018; Salari et al. 2019; Shikuro et al. 2020). This is a result of women’s lower financial status and higher potential exposure to diseases and other health needs. OOP costs have also been associated with poorer health outcomes; a 10-percentage-point increase of OOP payment in the share of total health expenditure increases adult deaths by 3.4 per cent, based on a global data set (Moreno-Serra and Smith 2015).

¹ Typically considered as expenses exceeding 40 per cent of non-food household expenditure.

Health insurance constitutes a key mechanism protecting citizens against the financial risks related to regressive OOP payments. Fee exemptions, waivers, and abolitions are also important instruments in mitigating the negative effects of health service costs. However, several challenges underpin the potential gender-equalizing effects of different financial protection mechanisms, by which we mean policies that protect the population from damaging costs incurred in the event of different health needs. As women represent a particularly important share of informal sector workers in the Global South, expanding health insurance beyond the formal employment contract is vital for increasing women's coverage (Stuart et al. 2018; Vijayasingham et al. 2020). This is also relevant for decreasing dependence on a spouse in formal employment, promoting recognition of women's social rights as individual citizens, and increasing coverage among female-headed households (see Cook and Razavi 2012). However, health insurance schemes targeting the informal sector often suffer from a limited range of benefits, which makes them unattractive, while remaining often unaffordable particularly to women in poverty (Adebayo et al. 2015; Shewamene et al. 2021; Van Hees et al. 2019). Moreover, although a free national health service has been introduced in a handful of Sub-Saharan African countries (e.g., Botswana, Mauritius, Seychelles) and user fees for primary healthcare services have been abolished in several others, most countries have maintained user fee-based systems with targeted fee exemptions and waivers. These concessions are typically related to maternal, reproductive, and/or epidemical healthcare, or services for specific population groups such as children under 5 years, pregnant women, or the elderly. However, these provide limited protection against broader health needs and do not cover all population groups, and evidence shows that the quality of such services has remained limited in general (e.g., in maternal healthcare; see Ansu-Mensah et al. 2020).

Countries in Sub-Saharan Africa have increasingly invested in expanding and developing their health systems to meet the SDGs. Tanzania is one among such countries: while grappling with important health challenges, the current government has shown a strong interest in expanding its health insurance system as one of its leading social policy goals (George et al. 2021). This adds to previous efforts in the country to provide health insurance, particularly for informal sector workers. At the same time, several national policy documents, including the most recent Health Sector Strategic Plan (2021–26; see URT 2021a), have stipulated a particular focus on addressing women's health needs and access to services. Despite these policy developments and ambitions, the extant literature lacks analyses addressing the gender-based effects and implications of Tanzanian health policy. A mature body of medical literature has dealt with women's access and use of obstetric and other key health services in the Tanzanian context (e.g., Konje et al. 2020; Mahiti et al. 2015; Moshi and Nyamhanga 2017), and several comparative studies have examined health insurance uptake in the informal sector in Sub-Saharan Africa (e.g., Adebayo et al. 2015; Alex and Mwamfupe 2020; Fadlallah et al. 2018; Shewamene et al. 2021; Van Hees et al. 2019). However, no focus has been afforded to the specific impacts of the overall health system on the level and type of financial protection provided for working-age women in Tanzania. This knowledge gap stands in the way of developing informed, gender-responsive future policies and achievement of UHC.

This paper remedies the knowledge gap by presenting a comprehensive analysis of health policy in mainland Tanzania from the perspective of working-age women² and examines opportunities for gender-inclusive health insurance expansion. More specifically, using the scoping study methodology, it answers the following research questions:

² By this we refer primarily to all women in Tanzania between the ages of 15 and 64 years regardless of their labour force status, while acknowledging that women outside of this age group may equally engage in productive activities, particularly in the informal sector.

1. To what extent have the past policy developments in the Tanzanian health sector enhanced the level of financial protection against health-related expenses for working-age women?
2. What lessons can be learnt from other contexts to expand Tanzania's health insurance system in a gender-responsive manner?

The second research objective is largely motivated by the current policy trajectory in Tanzania, seeking to move towards a universal and mandatory health insurance system. As such, this paper examines the limitations of and opportunities for gender-responsive health insurance expansion across the four key dimensions of UHC as defined by the WHO: *population coverage*, *benefit packages*, *financial protection*, and *service quality*. This is supported by a review of evidence from several Sub-Saharan African countries having previously introduced progressive health insurance systems. Finally, this paper seeks to also contribute towards future policy practice to ensure women's equitable access to health by discussing potential approaches to financing gender-inclusive health sector investments.

In the following sections, the paper summarizes Tanzania's health policy landscape and health challenges with a focus on women to provide background (Section 2) and explains the adopted research approach (Section 3). Section 4 examines Tanzanian policy developments and their implications for working-age women in terms of financial protection. Section 5 then discusses the potential future options for the expansion of the Tanzanian health insurance system with gender-equalizing effects, drawing on evidence and lessons learnt from elsewhere. Section 6 adds further to the discussion related to health insurance expansion from the perspective of financing, and the paper concludes with Section 7 summarizing key findings.

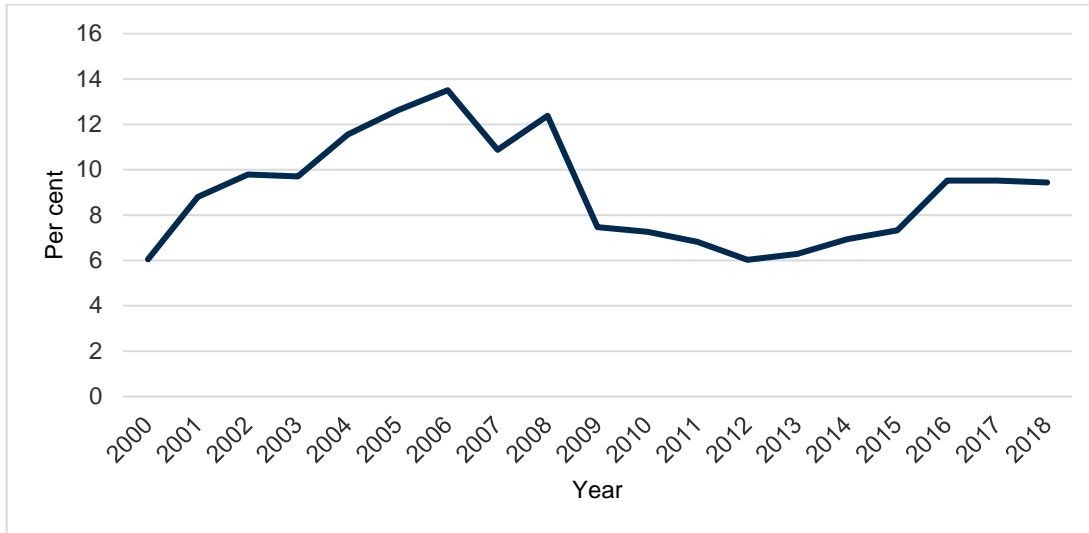
2 Background: understanding health policy and gender in the Tanzanian context

Health policies have held a central stage in the various phases of Tanzania's post-independence era. As a pioneering country of African socialism, Tanzania invested heavily in public healthcare provision particularly in rural areas during its first development programme (the Ujamaa project) in the 1960s and 1970s. In 1977, private health service provision was banned (Kida and Mackintosh 2005), and by 1978 around 90 per cent of the population was situated at a distance of no more than 10 km from a public health clinic (Thomas 1983, in Benson 2001: 1,905). However, in the early 1980s, the country's health sector development was curtailed by public austerity policies introduced under the Structural Adjustment Programme, adopted owing to economic hardship experienced in the country. This implied drastic policy reforms, including halving of the share of government's health spending between 1978 (7.5 per cent) and 1989 (3.9 per cent); the introduction of user fees in public services in 1993; and the easing of regulation around non-state healthcare provision (see Buckley and Baker 2009). These reforms have had longstanding effects on Tanzania's health sector arrangements.

Driven by the renewed focus on health targets under the Millennium Development Goals, the government of Tanzania increased its health expenditure radically in the first decade of the new millennium, but investments dropped again in 2008–12. The government expenditure on health has recuperated since and represented 9.4 per cent of general government expenditure in 2018, although still remaining below the 15 per cent target agreed under the 2001 Abuja Declaration (see

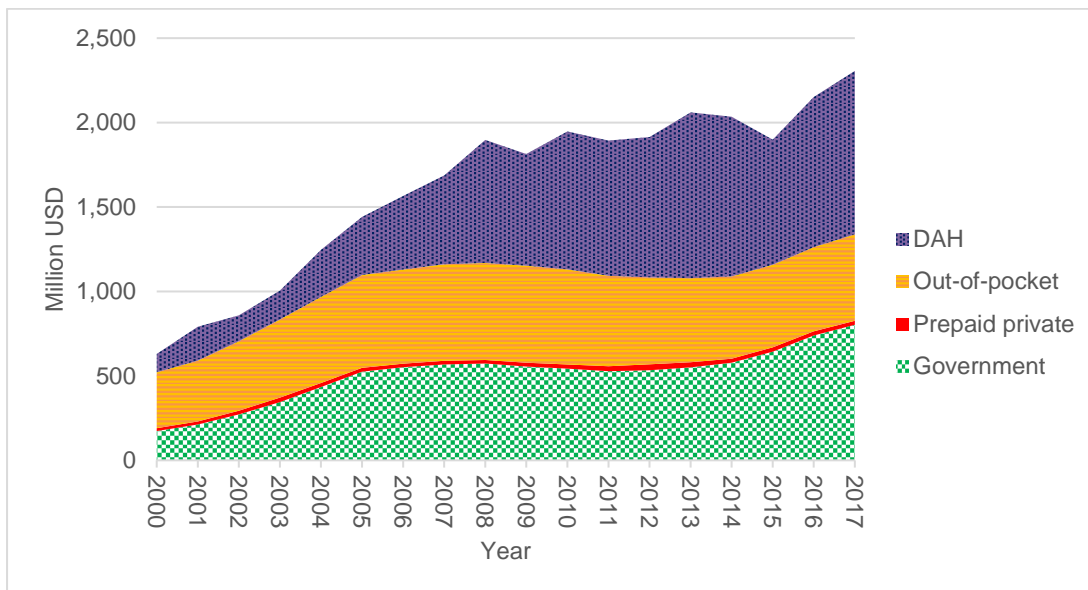
Figures 1 and 2).³ However, in 2021, the government committed to nearly doubling its health expenditure by 2026 under the Health Sector Strategic Plan V (URT 2021a), from 2.6 to 5 per cent of gross domestic product (GDP).

Figure 1: Government health expenditure as percentage of general government expenditure in Tanzania (2000–18)



Source: authors' illustration based on WHO's Global Health Expenditure data (see World Bank n.d.a)

Figure 2: Health spending in Tanzania by source (million US\$, 2000–17)



Note: methodologies and sources differ for latest numbers and do not always match the demographic and health survey numbers. Development Assistance for Health (DAH) includes only reported programmatic expenses at the country level.

Source: authors' illustration based on global health spending 1995-2017 data by the Institute for Health Metrics and Evaluation (IHME), data in illustration used in accordance with the IHME free-of-charge non-commercial user agreement.

³ Additionally, while government expenditure on health has increased since 2000, the population has also experienced a steady increase. As a result, government health expenditure per capita has not increased between 2008 and 2016.

When looking at the total health expenditure, it becomes evident that Development Assistance for Health has constituted a major source of health financing in Tanzania throughout the past decade, constituting 42 per cent of total health expenditures in 2017. In contrast, the relative share of OOP payments in total health expenditure has decreased, but it remains significant (24 per cent) (see Figure 2). It is therefore unsurprising that the level of catastrophic health expenditures (measured as the share of households spending over 15 or 25 per cent of their non-food expenditures on healthcare) remains high in Tanzania (32 and 20 per cent, respectively) (Ssewanyana and Kasirye 2020).

In terms of resource allocation for health, the government of Tanzania has invested in important supply-side measures over the past decades, including investments in health infrastructure, particularly in rural regions, especially under the 2007–17 Primary Health Services Development Programme. More recently, the 2018–19 health sector budget made important provisions for the upgrading and building of health facilities, including the construction of 67 new district hospitals, while the government has also invested in human resources and medicine availability (Piatti-Fünfkirchen and Ally 2020; Wang and Rosemberg 2018). The Health Sector Strategic Plan V shows further commitment to long-term investment in health facilities (see URT 2021a).

Increasing accessibility and quality of health is particularly important from a gender perspective, given that Tanzanian women experience lower levels of physical mobility compared with men as a result of safety threats, cultural norms, and lack of resources. These factors have translated into heightened barriers in accessing health services owing to long distances (Bintabara et al. 2018; Konje et al. 2020; Mahiti et al. 2015; Maluka et al. 2020; UNDP 2018). The extant challenges in health service delivery are exacerbated by the COVID-19 pandemic. For instance, a study by Pallangyo et al. (2020) has highlighted midwives' limited ability to carry out reproductive health education and service provision to women in the context of the COVID-19 pandemic, as a result of women's lower service attendance because of fears of becoming infected. This may hinder progress towards maternal and neonatal mortality rates, which remain high in the country alongside other important health challenges affecting women disproportionately (see Table 1).

Furthermore, contextual evidence highlights the pertinence of sociocultural factors, alongside policy choices, in explaining some of the failures in health service provision to women in Tanzania. For instance, use of skilled birth attendants for delivery remains highly unequal between urban and rural regions (80 per cent and 50 per cent, respectively), whereas almost 70 per cent of the country's population resides in rural areas (Konje et al. 2020). This is partially explained by the use of traditional birth attendants, who are often willing to assist during labour for free of charge and considered to offer better emotional support than staff at health facilities (Konje et al. 2020; Mahiti et al. 2015). Simultaneously, perceived risks of home delivery are generally seen to be low (e.g., Moshi and Nyamhanga 2017), whereas delivery at health centres may be deemed culturally inappropriate. This is evidenced by a study by Konje et al. (2020), showing that (especially older) Tanzanian women are reluctant to deliver at health facilities because of the high volume of young male staff, and the style of delivery that differs from one typically adopted at a home delivery. Also lack of knowledge of women's health issues among both men and women often results in limited access to health. For example, Bateman et al. (2019) show that men's beliefs about cervical cancer being sexually transmissible and caused by unfaithful sexual behaviour increases the fear of separation and hampers health-seeking behaviour among women. The study also highlights women's low level of knowledge about the importance and effectiveness of early treatment even when they had been screened. Relatedly, several other studies have highlighted women's experiences of discrimination and stigma related to HIV, which often causes them not to seek care or to drop out of treatment (Kisigo et al. 2020; McMahon et al. 2017; Sanga et al. 2019). This underscores the importance of health education needs in the country alongside other health system investments.

Table 1: Selected health indicators for Tanzania

Indicator	Measure (year)	Men	Women	Tanzania average	Average SSA	Rank (year)
HIV/AIDS ^a	Prevalence, per cent of population aged 15–49 years (2019)	3.6	6	4.8	3.7	12th out of 134 countries (2019)
Malaria	Incidence, per 1,000 population at risk (2019)	/	/	124.3	209.1	3rd for world malaria deaths (2019)
Tuberculosis	Incidence, per 100,000 people (2019)	152	84	236	226	32nd out of 112 high-incidence countries (2019)
Child mortality	'Under-5' deaths per 1,000 live births (2019)	53.9	46.6	50.3	75.8	35th out of 188 countries (2018)
Neonatal mortality	Deaths per 1,000 live births (2019)	/	/	20.3	27.5	45th out of 193 countries (2019)
Maternal mortality	Deaths per 100,000 live births (2017)	N/A	524	524	533	19th out of 184 countries (2019)
Anaemia	Prevalence of anaemia, per cent of pregnant women (2019)	N/A	48.1	48.1	45.8	27th out of 192 countries (2019)
Cervical cancer	Age-standardized incidence rate, per 100,000 women (2018)	N/A	59.1	59.1	34.5	5th out of 185 countries (2018)

Note: ^aalthough the reported HIV/AIDS prevalence is higher for women, men's infections are usually detected less frequently because of a lack of testing in the context of pregnancy (Fonner et al. 2019). Additionally, in 2020 in Tanzania, 13,000 AIDS deaths of men versus 11,000 of women were recorded (see UN AIDS n.d.).

Source: authors' illustration based on compiled data (see Cancer Atlas 2021; IARC 2018; Public Health England 2019; WHO 2019b, 2020a, 2020b, 2021b; World Bank 2019; *The World Factbook* 2019; UN IGME 2021; UNICEF 2017, 2019).

Finally, it is important to underscore the significant health needs experienced by women in Tanzania, which require particular attention in policy design and implementation. Table 1 presents some key health indicators that illustrate the impact of epidemical diseases and health issues related to pregnancy affecting women in Tanzania. It equally highlights the country's heavy burden of disease; Tanzania has the world's third highest malaria death rate, it ranks fifth out of 185 countries for cervical cancer rate, and remains a high-incidence country for HIV/AIDS as well as for tuberculosis. This health profile warrants further analysis of and investment in gender-responsive health policy expansion in the country, which will be addressed in the remainder of this paper.

3 Research design

This is a desktop-based scoping study that draws on a wide range of literature, available statistics, and other data sources. Scoping studies present an increasingly common method of evidence synthesis. They allow compiling from a broader range of sources of evidence than systematic literature reviews, which typically focus on a narrowly defined research question through published academic literature (Munn et al. 2018). Given the research objectives of this study, as described earlier, a scoping study was selected as the best suited research approach for this paper.

In line with the scoping study methodology, the analysis followed a defined search strategy. Literature searches were made primarily using Google Scholar and PubMed search engines, and the reviewed literature consisted of peer reviewed journal articles, book publications, and research publications by leading international organizations (e.g., World Bank, UNICEF, Oxfam). Policy

documents by the Tanzanian government, in turn, were accessed primarily through Google searches and analysed to map and identify key policy developments over the period 2000–21. Also, relevant media sources (e.g., journalistic articles and website information) were solicited to gain up-to-date contextual insights on the most recent policy developments in the health sector in the Tanzanian context. Quantitative data, publicly available or upon request from the provider, and indicators within the defined timeframe (2000–21) were examined and plotted to inform the analysis and compare identified policy developments with measured outcomes.

The overall data compilation was conducted with defined inclusion and exclusion criteria set to ensure the quality and relevance of the examined data sources (see Table 2). Additionally, the data collection approach enabled a ‘snowballing effect’, by which frequently cited and other relevant publications and information sources became known in the context of data compilation. Importantly, the use of diverse data sources also facilitated information triangulation and contributed towards the validity and reliability of the analysis (see Yin 2014).

Table 2: Data sources and criteria

Data source	Inclusion criteria	Exclusion criteria	Number
<i>Academic publications</i> (journal articles, book chapters, books, working papers)	<ul style="list-style-type: none"> • Ranked peer reviewed journals and publications • Sound research methods 	<ul style="list-style-type: none"> • Student dissertations • Non-ranked journals • Publications not focused on/including Tanzania 	47
<i>Policy/programme evaluations</i> (by implementing organizations, contracted evaluators or other organizations)	<ul style="list-style-type: none"> • Conducted by recognized and established research bodies • Sound research methods 	<ul style="list-style-type: none"> • Project briefs and publications that do not specify research methods or design • Publications not focused on/including Tanzania 	3
<i>Quantitative data sets, available statistics and indices</i> (provided by publicly available data banks)	<ul style="list-style-type: none"> • Conducted by recognized and established development organizations • Commonly utilized indices 	<ul style="list-style-type: none"> • Unreliable surveys (e.g., online surveys, small population) • indices and data provided by politically oriented NGOs 	30
<i>Government documents</i> (URT policy documents, development plans, legal provisions)	<ul style="list-style-type: none"> • All relevant documents by the central government, ministries, local authorities, and other relevant government agencies considered 	<ul style="list-style-type: none"> • Documents not focused on/including issues related to the health sector and/or gender 	11
<i>Media sources</i> (journalistic publications, news pieces, website information)	<ul style="list-style-type: none"> • Recognized Tanzanian and other relevant news outlets • News reports of government statements and measures • Information on government agency websites 	<ul style="list-style-type: none"> • Opinion pieces; social media content • Documents not focused on/including issues related to the health sector and/or gender 	7

Source: authors' illustration.

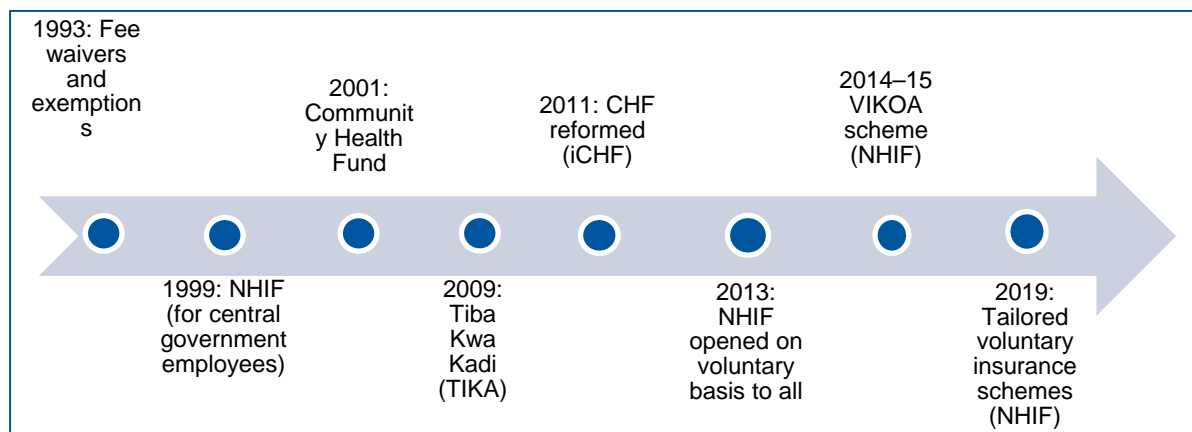
Moreover, to answer the second research question, targeted literature searches were made to map examples and experiences of health insurance arrangements in other Sub-Saharan African countries with their gendered effects. Searches were made using the keywords ‘health insurance’, ‘health coverage’, ‘health system’, ‘CBHI’ (i.e. community-based health insurance), and ‘UHC’ in

combination with the Boolean operator ‘AND’ and the geographical keywords ‘Africa’, ‘Sub-Saharan Africa’, and ‘LMIC’ (i.e. low-to-middle-income country). A limited number of countries was selected for more focused analysis of extant evidence, including Ghana, Kenya, Rwanda, and Senegal. The compiled evidence was then analysed in parallel with findings from the scoping review to assess options for gender-responsive health insurance expansion in the context of Tanzania.

4 Examining health policy developments in Tanzania: what implications for women?

Tanzania’s health system consists of several financial protection mechanisms, including fee waiver and exemption policies as well as compulsory health insurance and voluntary health insurance schemes. These measures have gone through several reforms and complementary, temporary programmes over the past two decades (2000–21) (Figure 3). These will be examined with a focus on the level and extent of financial protection mechanisms available to women in the following sub-sections.

Figure 3: Timeline of key health policy measures in Tanzania



Source: authors’ illustration.

4.1 Fee waivers and exemptions

User fees are the most regressive form of health financing as they result in direct OOP payments and affect service utilization rates. Fee abolitions in Kenya, Uganda, and South Africa, for instance, have translated into increased use of services and particularly curative care, up to 50 per cent on occasion (McIntyre et al. 2018; see also Garchitorena et al. 2017).

In Tanzania, fee exemption and waiver policies were introduced at the same time as fees for health service utilization in 1993. Up until today, people aged 60 years or above,⁴ pregnant women, and children under 5 years are entitled to access free services, as well as patients with prioritized epidemical health conditions such as HIV, tuberculosis, or leprosy. However, while the exemption scheme for women and children has been widely applied, the implementation of the waiver policy targeting the poor and the elderly has remained weak. This is largely owing to the cumbersome identification of the ‘poor’; the lack of compensation to health facilities for free service provision by the government; and a low level of awareness among the poor about the bureaucratic process

⁴ The 2003 National Ageing Policy clearly stipulates that people ≥ 60 years are entitled to free healthcare services (see URT 2003)

of how to access a fee waiver (Wang and Rosemberg 2018). Empirical evidence from other contexts also shows that the typically bureaucratic processes of obtaining a waiver and the stigma associated with the ‘indigent status’ can discourage entitled people from pursuing one (McIntyre et al. 2018).

In 2020, there were over 2.5 million Tanzanians aged 60 years and above (56 per cent women) (United Nations 2019),⁵ and according to most recent data from 2015, the health spending in this age group is over double that in other age groups, women’s OOP payments being over a third higher than men’s (URT 2018). Also, the share of catastrophic health expenditures has been reported to be disproportionately shouldered by the poor (Ssewanyana and Kasirye 2020), and service fees continue to represent one of the most important barriers experienced by women in accessing health (Bintabara et al. 2018). This highlights the cost of poorly implemented waiver policies among the vulnerable female population in Tanzania.

Moreover, the evidence shows that women continue to incur costs related to antenatal and delivery care (e.g., charges for equipment used by health professionals such as gloves, a plastic cover, and even kerosene), which should be provided free of charge under the exemption policy (Konje et al. 2020; Mselle et al. 2019) and are sometimes asked to pay bribes or other forms of informal fees at the point of care (Mahiti et al. 2015). To this are added other hidden costs for attending health services, such as transport expenses and opportunity costs (e.g., losing a day’s wages for attending health check-ups), which also disincentivize visits to health facilities (Konje et al. 2020; Kuwawenaruwa et al. 2019). Given that women report having less say over health-related and household expenditure than men (URT 2018), it may be expected that the lack of free healthcare coupled with hidden costs and low intra-household empowerment impede many women from accessing services altogether. In fact, findings by Wang and Rosemberg (2018) suggest that financial barriers experienced by women in accessing healthcare have increased during the period 2005–15. They report that especially women in rural areas face problems in accessing money to cover expenses for medical treatment (53.8 per cent compared with 49 per cent of women in urban areas).

4.2 Health insurance schemes

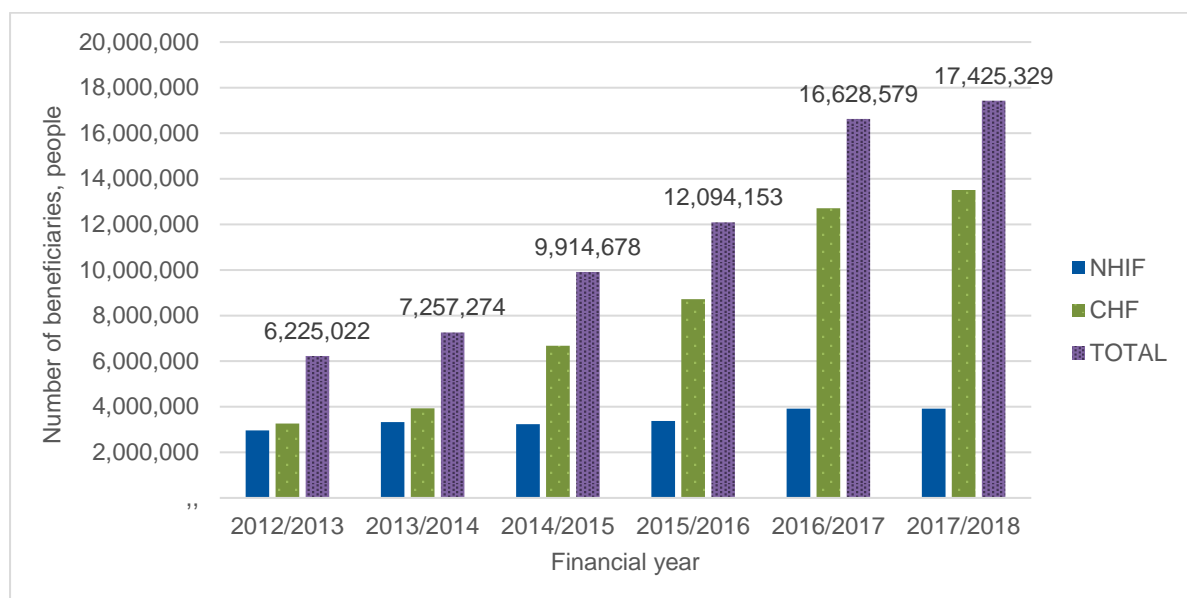
Tanzania’s health insurance provision is dominated by three separate programmes: (i) the National Health Insurance Fund (NHIF; mandatory for civil servants and voluntary for other population groups); (ii) the Community Health Fund (CHF, including its sister scheme *Tiba kwa kadi* (TIKA), a voluntary community-based health insurance for informal sector workers run by district authorities); and (iii) the National Social Security Fund (NSSF; contributory health insurance for the formal and semi-formal sector employees alongside other social insurance). Although the health insurance coverage of informal sector workers has expanded considerably over the past few years, only 31 per cent of the total population is covered by either CHF or NHIF, based on numbers from 2017–18.⁶ Other estimations suggest even lower coverage; the Tanzania Demographic and Health Survey 2015–16 reports that 91 per cent of women aged 15–49 years remained uninsured in 2015–16, whereas 90 per cent of men lacked health insurance (see MoHCDGEC et al. 2016). The low numbers of NHIF and CHF beneficiaries are illustrated in Figure 4. While statistics on the NSSF insurance coverage limited to the formal sector remain

⁵ Note that nearly half of the population remained unregistered in 2018, which may further challenge waiver arrangements and access (World Bank 2018a).

⁶ Authors’ calculation based on data from UNICEF (2020) and World Bank (2018b).

inaccessible, the available data point to a low share of insured as part of the total population nearing 60 million (World Bank 2018b).

Figure 4: Total number of NHIF and CHF beneficiaries (2012–18)



Source: authors' illustration based on compiled data and NHIF factsheets for 2016–17 and 2017–18 (personal communication) (see NAO 2019; NHIF n.d.; UNICEF 2020; URT 2016b).

Several issues underpin the introduced insurance schemes from the perspective of women, who are overrepresented in the informal sector, lower wealth quintiles, and single-parent households (33 per cent of the overall households are female-headed in Tanzania; URT 2018). First, the two insurance schemes covering the formal sector, the NSSF and the NHIF (covering primarily civil servants), have fewer female members than male members owing to women's underrepresentation in the formal sector. In 2020, only 9.1 per cent of women in mainland Tanzania were hired as employees (compared with 18.6 per cent of men). In contrast, 48.2 per cent were working for their own account and another 41.9 per cent were engaged as unpaid contributors on family farms and businesses (URT 2021b). Second, the NHIF scheme was opened on voluntary basis to all citizens to increase coverage of informal sector workers in 2013, but premiums for voluntary enrolment remain relatively high in comparison to the low wage levels of most Tanzanians, as elaborated further in Section 4.3.

Furthermore, the Tanzanian government has sought to expand the health insurance coverage among informal sector workers through the CHF, launched in 2001 to focus on the rural population, and its sister scheme TIKA, introduced in 2003 to cover urban areas. Although the CHF and TIKA schemes are costed at a lower rate than the NHIF, the poorest wealth quintile remains the least insured in Tanzania (see Umeh 2018; Wang and Rosemberg 2018). Moreover, despite lack of conclusive evidence on women's enrolment and renewal under the CHF scheme (cf. Kagaigai et al. 2021; Kapologwe et al. 2017; Modest et al. 2021), the flat rate annual premiums covering households of two adults and four children may be expected to disadvantage the large number of single-earner female-headed households with several dependents. Women may also lack awareness about the existing schemes, given that districts have made little investment in publicly promoting the programme and even less so in designing gender-sensitive information campaigns (Kapologwe et al. 2017; Wang and Rosemberg 2018). This is a pertinent caveat particularly from the perspective of low-income and ethnic minority women, who have more restricted access to media outlets and hold lower levels of language and analytical skills (see e.g., Lidofsky et al. 2019; Mpenbeni et al. 2019; Rwabilimbo et al. 2020).

4.3 Recent developments: expanding health insurance coverage in the informal sector

The Tanzanian government has sought to reform the CHF/TIKA scheme aimed at informal sector workers through the launch of ‘Iliyoboreshwa CHF’—an improved Community Health Fund (iCHF, including the auxiliary iTIKA) whose geographical coverage has slowly expanded since 2011. As of July 2018, there have been efforts to implement the iCHF in all regions (Modest et al. 2021) with the aim of effectively replacing the old CHF—although this has not been fully achieved. Several design features of the iCHF denote significant progress for women’s access to healthcare. To begin with, the scheme covers a much broader benefit package than the old CHF by including inpatient services, including X-rays, surgery, medicines, and ultrasound (see Government of Tanzania n.d.). Furthermore, the Health Sector Strategic Plan V also mentions introducing transport for maternity waiting homes under the iCHF benefit coverage (URT 2021a). Besides offering much-needed services for women, these represent provisions that are not covered under free health service arrangements for pregnant women nor in the old CHF and may therefore increase the attractiveness of the scheme. Importantly, the iCHF has also sought to improve access to the scheme by replacing enrolment during health centre visits to active enrolment with the aid of mobile technology, which has been shown to be significant in incentivizing subscriptions (Kagaigai et al. 2021). Ease of access may be considered a key factor encouraging enrolment among women, who face multiple challenges in accessing health services (e.g., Bintabara et al. 2018). Additionally, to facilitate actual access to services, the benefits under the iCHF have been made portable and individual insurance cards are provided to all beneficiaries rather than households. Given evidence on women’s restricted access to health services due to single household cards often carried by men from other contexts, such as Kenya (Suchman et al. 2020), this may be expected to lead to women’s increased service utilization.

However, the annual premiums for the iCHF are likely to represent an important financial barrier to most disadvantaged populations (e.g., Alex and Mwamfupe 2020). As a reference, for Tanzanian households that are at or below the national basic needs poverty line (constituting 26.5 per cent of the population), we estimate that iCHF premiums represent a single payment corresponding to around 30 per cent of a month’s non-food consumption.⁷ Since saving capacity is typically low, if not inexistent, among the lowest income groups, such an expense may be unaffordable.

Another noteworthy and recent development is the expanding range of voluntary health insurance schemes for the informal sector provided by the NHIF (see Table 3 for details). These include two components, diverse health insurance micro-schemes and voluntary benefits packages. First, the Vikoa health insurance scheme was introduced in 2014–15. This encompasses several micro-schemes tailored for organized professional groups, including entrepreneurs in Savings and Credit Cooperative Societies, the VIBINDO society (*Jumuia ya Vikundi vya Wenye Vivanda na Biashara Ndogondogo*, umbrella organization for associations of small producers and small business), the Village Community Banking; agricultural workers part of Agricultural Marketing Cooperative Societies; and other entrepreneurs such as food vendors, *machinga* (street vendors), and *bodaboda* drivers (motorcycle taxi drivers). Second, as of 2019, different voluntary benefits packages, priced according to household composition and age of the main contributor, became available, such as Najali Afya Premium, Wekeza Afya Premium, and Timiza Afya.

⁷ Authors’ calculations using the 2017–18 Household Budget Survey (see MoFP-PED and NBS 2019). The computed number is an approximation obtained by converting the basic needs poverty line of 2018 for mainland Tanzania (TZS 33,748 per adult equivalent per month) into a per household equivalent per year and assumes a similar non-food consumption to total consumption ratio for households on the poverty line as the one provided for the Tanzanian population. For reference, the average consumption per household per month in mainland Tanzania was TZS 416,927 in 2017–18 (see MoFP-PED and NBS 2019).

Table 3: Public health insurance schemes and characteristics in Tanzania⁸

	NHIF	NSSF	CHF/TIKA	iCHF/iTIKA	Najali Afya, Wekeza Afya, Timiza Afya	Vikoa schemes
Population coverage	7% of the population (beneficiaries, 2017–18)	<0.1% of the population (beneficiaries, 2016–17)	23.8% of the population (beneficiaries, 2017–18)	(Included in CHF/TIKA coverage)	<1% of total NHIF members (contributors, 2018)	3.85% of total NHIF members (contributors, 2018)
Target population	Civil servants, formal sector employees	Formal and semi-formal sector	Informal sector (rural/urban)	Informal sector (rural/urban)	Informal sector workers	Members of workers' associations
Voluntary/mandatory	Mandatory to civil servants, voluntary access to others	Contribution under mandatory social insurance	Voluntary	Voluntary	Voluntary	Voluntary
Enrolment unit	Household (up to 6 individuals)	Household (up to 6 individuals)	Varies across districts: individual/household up to 6 individuals	Household (up to 6 individuals)	Individuals and/or household with different compositions	Household (up to 6 individuals)
Payment type and level	Monthly payment: 3% payroll contributions from both employees and employers	Monthly payment: 10% payroll deduction	Annual premium: TZS5,000 (US\$2.16)–TZS30,000 (US\$12.94) depending on district	Annual premium: TZS30,000 (US\$12.94)/household (<i>Dares Salaam</i> : TZS40,000 (US\$17.25)/individual, TZS150,000 (US\$64.68)/household)	Annual premium: TZS192,000 (US\$82.79)–TZS2,220,000 (US\$957.31) depending on household composition and benefit level	Annual premium: from TZS76,800 (US\$33.11) for farmers to a minimum of TZS100,000 (US\$43.13) for other groups.
Benefit level	Generous inpatient and outpatient care countrywide (including physiotherapy and rehabilitation services, eye care, dental care, medical/orthopaedic appliances)	Inpatient and outpatient care countrywide (contributions must be made for 3 months before accessing benefits)	Limited to primary healthcare in one's area of residence	Inpatient and outpatient care countrywide (including medicine, laboratory tests, X-ray, and ultrasound; excluding CT scans, MRIs, medical appliances, and major operations such as heart and brain surgery)	Scheme dependent (contributions must be made for 1–2 years before accessing benefits)	Scheme dependent (e.g., package for farmers includes inpatient and outpatient care countrywide, including minor and major surgery, medicine, dental care, eye care, and physiotherapy)

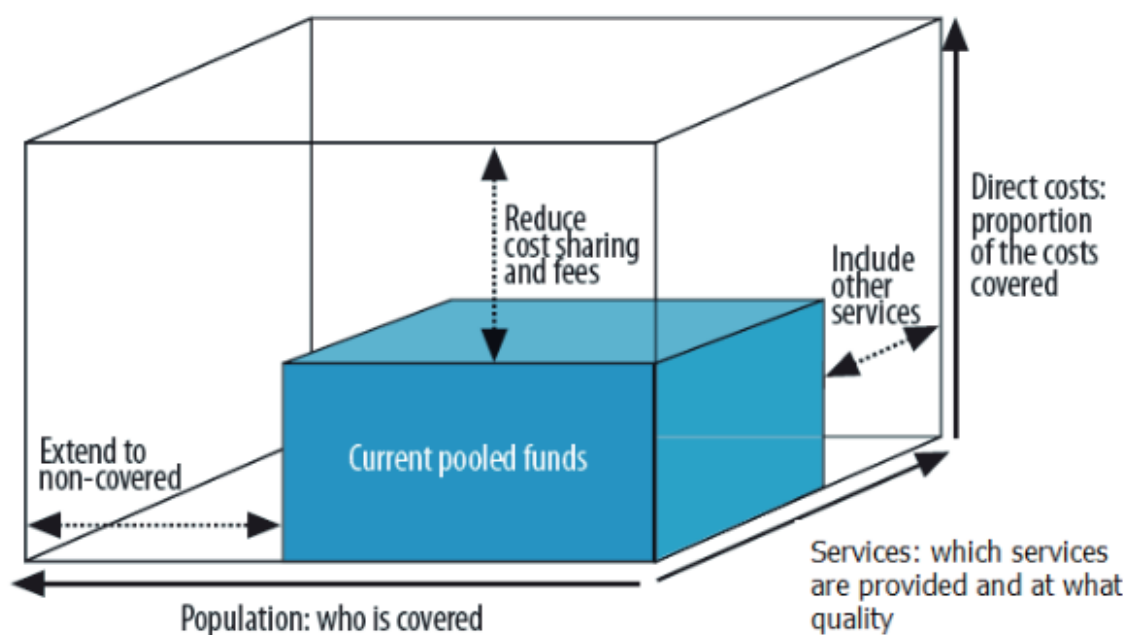
Source: authors' illustration based on compiled data and NHIF factsheets for 2016–17 and 2017–18 (personal communication) (see Government of Tanzania n.d.; NAO 2019; NHIF n.d.; Piatti-Fünfkirchen and Ally 2020; UNICEF 2018, 2020; URT 2016b, 2019a, 2019b; Wang and Rosemberg 2018).

These developments within the NHIF have several implications for women. On the one hand, increased collaboration with workers' associations and provision of insurance schemes with relatively generous benefit packages (including ultrasound scans, for instance) are likely to increase health insurance coverage among women in the informal sector—although enrolment rates remain low (see Table 3). On the other hand, the introduced VIKOA schemes, in particular, fail to account for those outside of workers' associations and omit many female-heavy professions. This bears potential gender biases and reinforces women's dependence on spouses in accessing health services. Moreover, the NHIF schemes are substantially more costly than the iCHF, with annual premiums twice as expensive for agricultural workers, three times more expensive for other groups under VIKOA schemes, and 20 to 70 times more expensive for a couple with two children under the Najali Afya, Wekeza Afya, and Timiza Afya schemes. Although interest-free loan schemes for premium payments are currently being offered to VIKOA insurance scheme members in the agricultural sector (Malanga 2021; Mulisa 2018), broad-based subsidies are currently lacking.

5 Towards UHC through health insurance expansion: opportunities for Tanzania and lessons from other countries

In this section, we explore evidence and lessons learnt across Sub-Saharan Africa with diverse types of health insurance systems that could inform Tanzania's future efforts in developing its health insurance system, focusing on the key dimensions of UHC. The WHO's definition of UHC consists of three key dimensions: expansion of population coverage, extension of benefits package, and increasing proportion of health costs covered by financial protection mechanisms (see Figure 5). Improving the quality of provided services could also be considered as a separate fourth dimension, based on the WHO's more recent definition of the UHC, described as a set of strategies that 'enables everyone to access the services that address the most important causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them' (WHO 2021a).

Figure 5: The WHO's universal health coverage cube

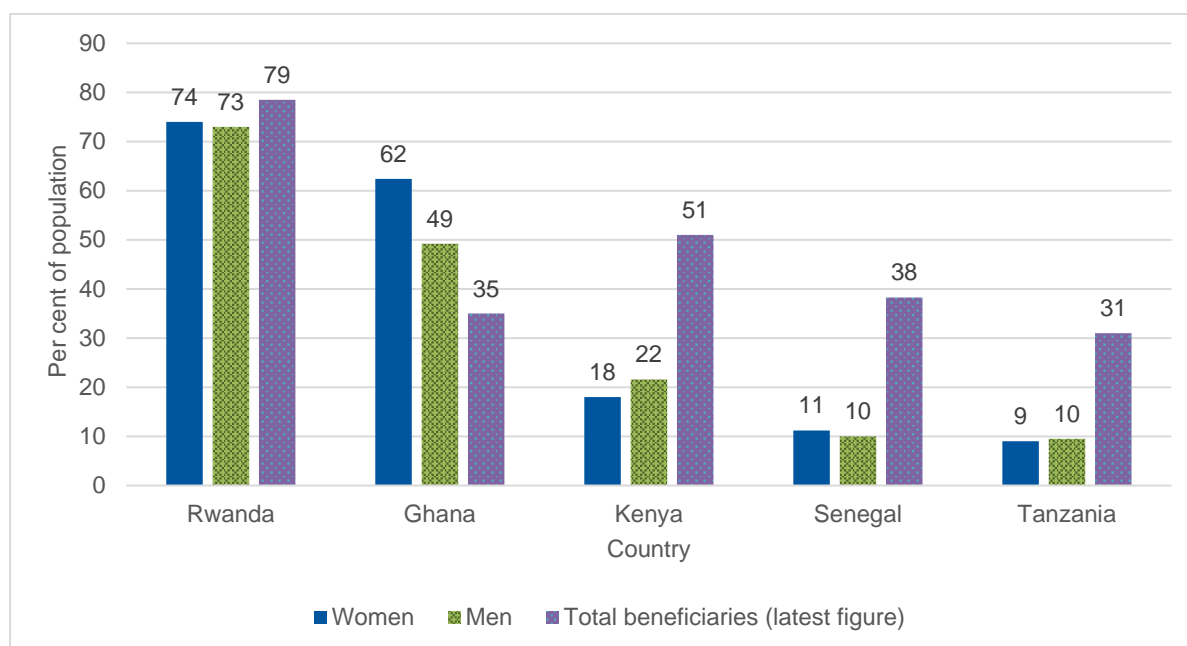


Source: WHO (2010), reproduced via licence: CC BY-NC-SA 3.0 IGO.

5.1 Maximizing population coverage

Tanzania’s fifth Health Sector Strategic Plan (2021–26) emphasizes the country’s commitment to achieving UHC and puts forth the amelioration of the health insurance system as the government’s key strategy in doing so (URT 2021a). However, Tanzania’s currently low health insurance coverage as previously presented (Table 3) is not unsurprising in the light of the existing evidence showing that voluntary health insurance schemes implemented alongside mandatory schemes for the formal sector remain ineffective in reaching significant population coverage, and often leave the poorest populations uninsured (Fenny et al. 2021; McIntyre et al. 2018). For instance, systems relying on voluntary enrolment for the informal sector have yielded membership rates as low as 3 per cent for Nigeria and 6 per cent of Uganda (NPC and ICF 2019; UBOS and ICF 2018). In contrast, Ghana’s Universal Health Insurance system and Rwanda’s Community-Based Health Insurance scheme show that mandatory, (near-to) universal insurance systems can reach impressive rates of population coverage (see Figure 6). These two countries have also achieved a particularly high level of coverage for women, largely thanks to exemption policies covering insurance premiums for pregnant women and poor households through existing social assistance programmes or other generous targeting measures, as elaborated further.

Figure 6: Health insurance coverage in selected countries as percentage of population (2014–19)



Note: methodologies and sources differ for total beneficiaries (latest figure) and gender disaggregated data.

Source: authors’ illustration based on compiled data (ANSD and ICF 2020; GSS et al. 2015; ILO 2021; Kenya National Bureau of Statistics et al. 2015; MoHCDGEC et al. 2016; NISR et al. 2016; Nsiah-Boateng and Aikins 2018; ROK 2020a; RSSB 2019).

However, mandatory schemes do not automatically lead to full population coverage and policy design must account for enforcement mechanisms. In Rwanda, compliance has been sought through a peer-pressure system in which several households form a group (*ibimina*) in which one inhabitant is responsible for collecting and delivering premium payments (Nyinawankunsi et al. 2015). In Ghana, membership in the National Health Insurance Scheme (NHIS) is stipulated as mandatory in the existing law, but no penalty is in place for uninsured Ghanaians and the requirement has never been enforced, which may partially explain its lower level of achieved population coverage (van der Wielen et al. 2018).

Tanzania aims to increase its share of population covered by health insurance up to 58 per cent by 2026, through a shift to a mandatory insurance system with provisions for disadvantaged populations (URT 2021a). Mandatory health insurance systems allow avoiding adverse selection (i.e. overrepresentation of individuals and households with existing health needs) and financial unsustainability due to larger pools of contributors (Adebayo et al. 2015). However, the extent to which equitable results are achieved in terms of actual coverage depends on the overall policy design. Drawing on the examples of Ghana and Rwanda, sufficiently extensive coverage of poorer populations through well-implemented premium waiver and subsidy schemes is necessary, while also community-based reinforcement mechanisms⁹ ought to be considered to encourage registration and re-enrolment through culturally appropriate measures. Additionally, although the literature has remained largely silent on the issue of enrolment unit, promoting household enrolment may be recommended to avoid preferential insurance purchasing for male household members at the expense of women, while pricing should consider different household compositions to ease access particularly to female-headed households.

5.2 Minimizing direct costs through financial protection

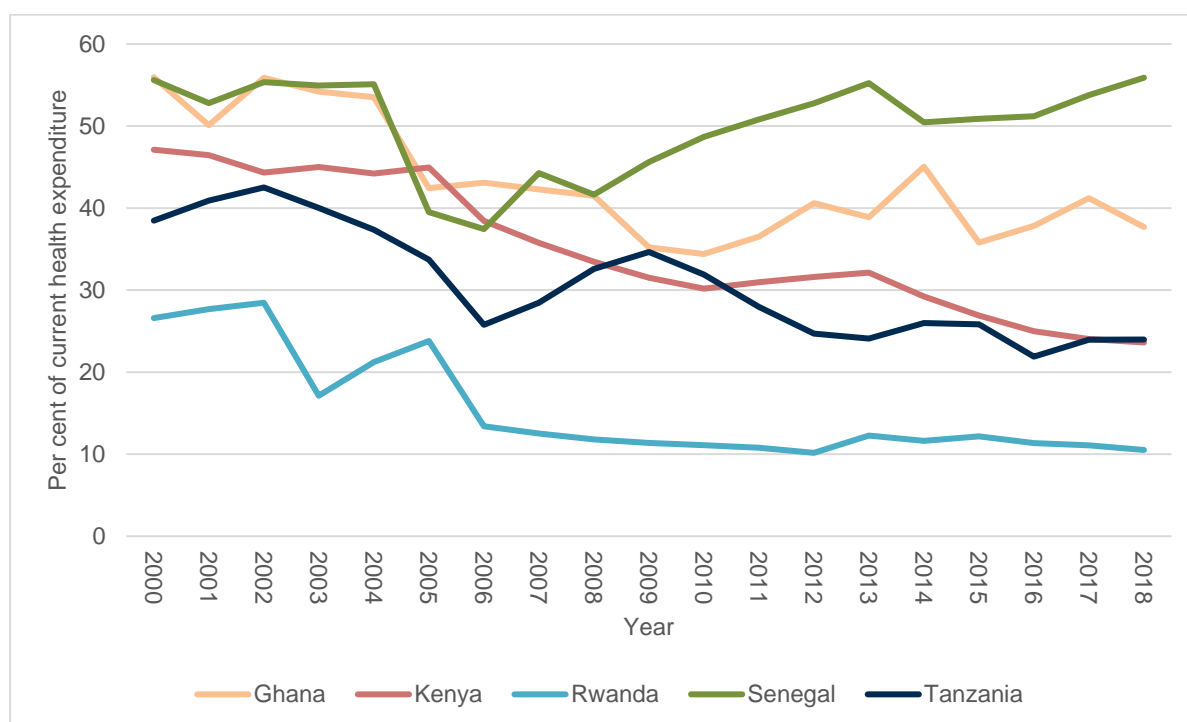
Health insurance schemes can act as an important financial protection mechanism against health-related costs incurred by women. However, unlike universal and tax-funded free health services, insurance-based health systems involve financial contributions (premiums or payroll contributions) sometimes added by co-payments for services. While co-payments are typically introduced as a result of perceived benefits for overall financing of the health system, evidence suggests that the actual revenues often remain lower than expected because of expenses related to revenue collection and administration (McIntyre et al. 2018). More importantly, unaffordable co-payments constitute a barrier for the poor in accessing care. For instance, evidence from Rwanda shows that women in poverty have avoided attending more than one antenatal visit owing to costs (Wang et al. 2017). As illustrated by Figure 7, Senegal has experienced a persistently high level of OOP costs, which may be partially explained by relatively high co-payment responsibilities, as well as less generous benefits package without portability and a lower level of insurance coverage (Daff et al. 2020; Paul et al. 2020).

Furthermore, different types of premium payment arrangements have varying effects on women's insurance uptake. It has been observed that in countries such as Senegal and Kenya, insurance premiums are set at a flat rate and on an annual basis for all informal workers. At the same time, Kenya's exemption policy (targeted at the extremely poor through means testing) reaches only a limited number of people in extreme poverty (see Table 4). This has resulted in important gaps in population coverage, arguably related to payment inability. Although flat rate premiums are also deployed in Ghana, a broader range of exemption measures are put in place. These cover children below 18 years, adults over 70 years, pregnant women, indigents, and beneficiaries of the Livelihood Empowerment against Poverty (LEAP) programme covering around 5 per cent of the total population,¹⁰ which has enabled greater level of access to health. Rwanda, in turn, has opted for sliding-scale insurance premiums, determined by household assets as identified under its Ubudehe system that categorizes the entire population into different income groups. Individuals with the fewest assets (amounting to 25 per cent of the total population) have their premiums and co-payments entirely covered by the government and donor partners (Nyinawankunsi et al. 2015). A recent study by Chirwa et al. (2021) indicates that the sliding premium system is particularly beneficial for female-headed households, typically falling into lower income groups.

⁹ These mechanisms should be designed so that they render participation voluntary and attractive (Winkler et al. 2017).

¹⁰ Based on World Bank estimations (see World Bank 2021).

Figure 7: Trends in OOP payments as percentage of current health expenditure in selected countries (2000–18)



Note: the current health expenditure indicator does not include capital health expenditures such as buildings, machinery, information technology, and stocks of vaccines for emergency or outbreaks (see World Bank n.d.b). Estimates of current health expenditures include healthcare goods and services consumed during each year.

Source: authors' illustration based on WHO's Global Health Expenditure data (WHO n.d.).

There is mounting evidence that fragmented health systems (i.e. co-existence of numerous schemes often run by different administrative bodies) hinders income cross-subsidies across the system and thus threatens the financial sustainability of schemes with less revenue-generating capacity compared than universal ones (Adebayo et al. 2015). This creates financial constraints for heightening the level of financial protection under informal sector-focused schemes. In Tanzania, attempts to merge the systems into a Single Universal Health Insurance scheme have faced important political resistance (Fenny et al. 2021), partially driven by the institutional arrangements of health insurance provision. The two mandatory schemes, NHIF and NSSF, as well as the voluntary CHF aimed at the informal sector are run by separate agencies (NHIF, NSSF, and the President's Office—Regional Administration and Local Government, respectively), and risk-equalization between them has been challenged by fears of weakening formal sector provisions if funds were pooled with the informal sector scheme CHF/TIKA. Additionally, given the ineffective reimbursement of user fee exemptions and waivers from the government's tax base, some of the already limited insurance funds are being utilized for basic necessities in facilities rather than the needs of insurance members (e.g., John et al. 2018). This has also disincentivized providers to grant waivers, resulting in OOP expenses for poor people (Wang and Rosemberg 2018).

Table 4: Health insurance systems and characteristics in Ghana, Rwanda, Senegal, and Kenya

Country	Overall model	Payments	Benefit coverage	Financing approach
Ghana National Health Insurance Scheme (NHIS)	Mandatory universal health insurance covering the formal and informal sectors	<i>Unit of enrolment:</i> individual <i>Annual premium:</i> GHS30.00 (US\$6.33) per person for informal sector <i>Formal sector workers:</i> employees and employers pay a contribution to the Social Security and National Insurance Trust (SSNIT) equal to 5.5% and 13% of the salary, respectively <i>Exempt groups:</i> children under 18 years, elderly over 69 years (both categories pay a processing fee of GHS8.00/US\$1.69), pregnant women, LEAP beneficiaries, indigents, and people with mental disorder	<i>Included:</i> outpatient and inpatient services (including oral and eye care, medication on the NHIS medicines list, minor surgeries) at over 3,500 public and private providers <i>Excluded:</i> heart and brain surgery, cancer treatments other than breast and cervical cancer, organ transplants and dialysis; vision, hearing, orthopaedic and dental aids and prostheses <i>Portability:</i> members must select a preferred primary provider, but can go to any healthcare facility in case of an emergency	<i>Overall model:</i> earmarked 2.5% VAT (70%); contributions from SSNIT (18%); premiums (4%); interests from NHIF investments; donor funds and gifts <i>Co-payments:</i> none
Rwanda CBHI	Mandatory community-based health insurance (CBHI) Additional schemes for civil servants (ex-RAMA) and the military (MMI)	<i>Unit of enrolment:</i> household <i>Annual premium:</i> graded based on household income (Ubudehe system) Category I: RWF2,000 (US\$2.03) per person; category II: RWF3,000 (US\$3.05) per person; category III: RWF7,000 (US\$7.12) per person <i>Exempt groups:</i> category I households	<i>Included:</i> outpatient and inpatient care at public facilities; most health needs covered, including medicines <i>Excluded:</i> non-essential drugs, community-based eye care screening, eyeglasses, and eye care, prostheses, MRI, CT scan, and dialysis <i>Portability:</i> across all public facilities nationwide	<i>Overall model:</i> premium contributions (66%); government (14%, predominantly through taxes); Global Fund (10%); patient co-payments (6%) <i>Co-payments:</i> RWF200/US\$0.20 for health centre visits and 10% of the medical bill for hospital visits Category I is exempt from co-payments
Senegal CBHI	Voluntary community-based health insurance for informal sector (CBHI) Free healthcare for children ≤5 years and elderly ≥60 years Mandatory scheme for formal sector	<i>Unit of enrolment:</i> individual <i>Annual premium:</i> CFA3,500 per person (US\$6.5) <i>Exempt groups:</i> disabled individuals, Bourse de Sécurité Familiale beneficiaries (approximately 15% of the population in 2018), and school pupils (subsidised fee of CFA1,000/US\$1.9)	<i>Included:</i> primary curative consultations, preventive consultations, hospitalizations, childbirth, medicines <i>Excluded:</i> major surgery and numerous complex healthcare interventions. <i>Portability:</i> limited; only with providers in partnership with contributor's <i>mutuelle</i> (local organization running the CBHI for community members)	<i>Overall model:</i> premium contributions; government subsidies (primary source of funding) <i>Co-payments:</i> 20% for public services and 50% for special drugs sold in private pharmacies; no co-payments for C-sections and delivery
Kenya National Hospital	National health insurance system mandatory for formal	<i>Unit of enrolment:</i> household <i>Premiums:</i> sliding-scale monthly premium deducted from salaries for formal sector	<i>Included:</i> inpatient and outpatient care, medicine, counselling, vaccines, antenatal care, deliveries,	<i>Overall model:</i> premium contributions (83%), subsidies from the government (15%),

Insurance Fund (NHIF)	sector, voluntary for informal sector Linda Mama scheme for pregnant women with free antenatal, delivery, postnatal and newborn care	employees from KES150 (US\$1.5) to KES1,700 (US\$15.77); monthly premium of KES500 (US\$4.64) for informal sector workers <i>Exempt groups:</i> poor households selected by proxy-means testing (0.34% of the population in 2019–20).	family planning, renal dialysis, surgery, radiology, and cancer treatment <i>Excluded:</i> dental and optical services (except for students and pregnant women), and cosmetic procedures <i>Portability:</i> full portability for inpatient services; members must choose a preferred facility for outpatient services	interests from NHIF investments (2%) ^a <i>Co-payments:</i> none
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Note: ^aauthors' calculations based on data from NHIF 2018–22 strategic plan (see NHIF 2018).

Source: authors' compilation from diverse sources (Agence CMU n.d.; ANSD and ICF 2020; Chemouni 2018; Fusheini and Marnoch 2020; GSS et al. 2015; ILO 2021; Kenya National Bureau of Statistics et al. 2015; Mukangendo et al., 2018; NHIF 2017, 2018; NHIS n.d.; NISR et al. 2016; Nsiah-Boateng and Aikins 2018; Nyandekwe et al. 2020; Nyinawankunsi et al. 2015; ROK 2020a, 2020b; ROS 2017; RSSB 2019; Wang et al. 2017).

Furthermore, the Tanzanian CHF/iCHF scheme relies on regressive, annual flat rate premiums, while access has been facilitated only through temporary, geographically uneven, and donor-supported subsidy schemes without institutionalized rights to health insurance.¹¹ The Health Sector Strategic Plan V enshrines that *‘innovative methods of payment for iCHF (e.g., through labour or in-kind) will be investigated’* to facilitate payment ability (URT 2021a: 50). In the light of the extant evidence, Tanzania could significantly improve women’s access to healthcare through a universal insurance system with sliding-scale payment approaches and extensive exemption policies including pregnant women and the elderly (at a minimum). Coverage of particularly vulnerable populations could also be enhanced by providing free access to insurance for beneficiaries of existing social assistance programmes, such as the Productive Social Safety Nets that has largely targeted women and covers around 9.3 per cent of the total population (World Bank 2020).

5.3 Moving towards a comprehensive benefit package

Comprehensive benefit packages are essential to expanding health insurance coverage, since perceived benefits represent a key factor influencing enrolment (Fadlallah et al. 2018; Van Hees et al. 2019; Wipf and Garand 2010). From the perspective of women, the range of benefits covered by insurance schemes are particularly important given their reproductive health needs and higher exposure to many health conditions owing to their lower socio-economic status and gender discrimination at societal and household levels. Crucially, underinsuring (i.e. financial protection for limited benefits or to a limited amount) can lead to higher rates of catastrophic health expenditures incurred by women (Umeh 2018).

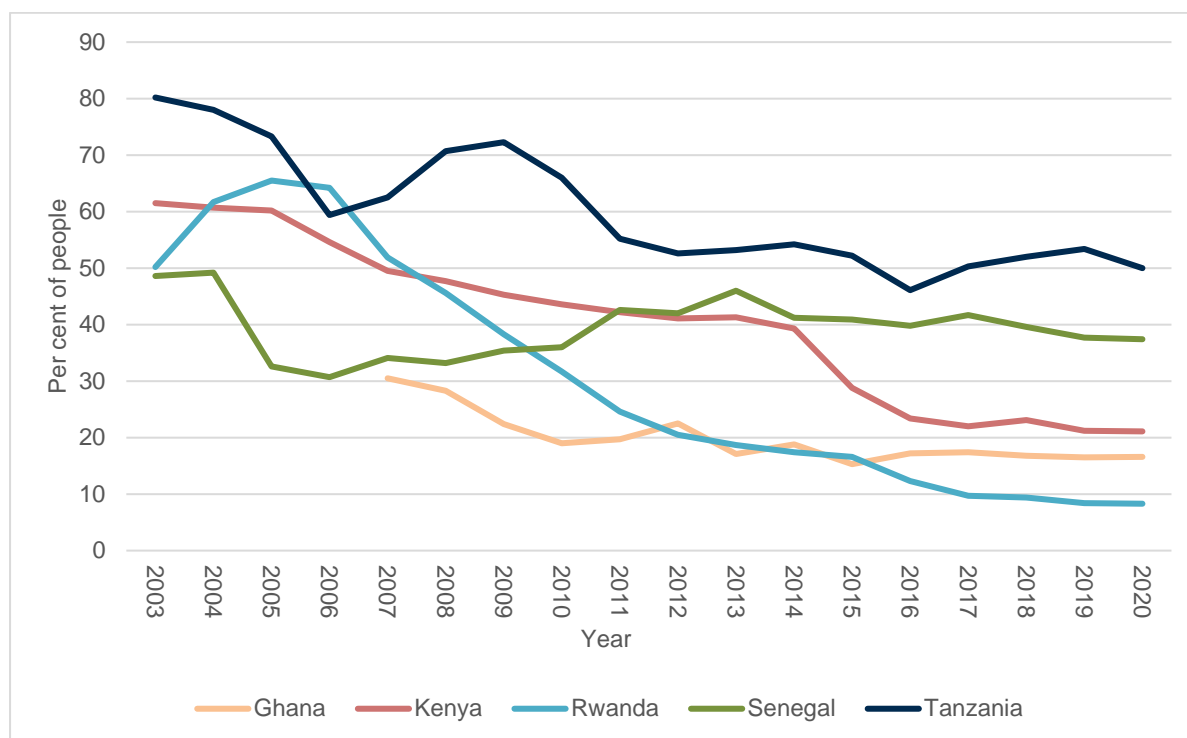
Medicines and high health cost needs constitute an important source of catastrophic health expenditures in LMICs. In Senegal, for instance, health insurance does not cover heavy surgery or other important health-related financial shocks (ILO 2021), causing an important risk of catastrophic health expenditures (see Figure 8). At the same time, expenses related to cancer drugs, for instance, have resulted in escalating catastrophic health expenditures and debt (Wone et al. 2020). Also surgery-related medicines and anaesthesia have driven up levels of OOP payments in countries such as Rwanda, Ghana, Malawi, and Uganda (Okoroh and Riviello 2021). In Ghana, the NHIS has reduced the financial burden of healthcare, but 6–18 per cent of the insured still make catastrophic payments owing to medicine-related expenses caused by poor levels of stock at facilities and reimbursements of pharmacies by the NHIS (Okoroh et al. 2018). Indeed, medicine availability in public health facilities is a key issue in Sub-Saharan Africa (Masters et al. 2014; Tesema et al. 2020), which may drive people to purchase medicine from other outlets or forego treatments altogether.

In Tanzania, those covered by the NHIF and NSSF pools enjoy the greatest levels of benefits and financial sustainability of the schemes, whereas informal sector workers covered by the old CHF have access to much more restricted benefits that exclude important services such as ultrasound scans, MRIs, cardiac aids, and high-cost services such as surgery—while the renewed iCHF scheme often remains unavailable or unaffordable. Nevertheless, important efforts have been made to expand the available care and services to informal sector workers under the iCHF in Tanzania. At the same time, the Health Sector Strategic Plan V states that the current National Essential Healthcare Interventions Package in Tanzania *‘will be revisited in the context of the creation of the mandatory*

¹¹ From 2021 onwards, the President’s Office—Regional Administration and Local Government distributes iCHF cards to vulnerable households (child-headed households; households with elderly and chronically ill as caregivers, or children living with HIV; extremely poor households) in 25 of the 31 regions in Tanzania in collaboration with the United States Agency for International Development and the President’s Emergency Plan for AIDS Relief under the Kizazi Kipya (‘New Generation’) project. (see: USAID and PEPFAR 2021).

health insurance scheme (URT 2021a: xiv). To avoid the most disadvantaged incurring the most costs when needs arise, it is paramount that broad benefit packages are universally available and that supply-side issues (related to medicines as well as services) are effectively addressed, as elaborated in Section 5.4. It is also crucial that future policy design accounts particularly for women’s health needs reflected in the country’s health profile (see Section 2 in this paper) and that culturally appropriate modes of delivery for treatment are provided.

Figure 8: Risk of catastrophic health expenditures for surgical care, percentage of people at risk (2003–20)



Source: authors’ illustration based on World Bank data (see World Bank n.d.c).

5.4 Improving service quality

The perceived quality of services constitutes another key driver of health insurance take-up and renewal (Amu et al. 2018; Fadlallah et al. 2018; Kotoh et al. 2017; Okoroh et al. 2018). A wealth of studies has also underscored the negative effects of poor-quality health services on female service utilization in Sub-Saharan Africa, for instance in accessing antenatal care (Okedo-Alex et al. 2019) and obstetric services (Geleto et al. 2018; Kyei-Nimakoh et al. 2017), while poor attitude of healthcare workers has been reported to act as a barrier to women’s access to cervical cancer screening (Lim and Ojo 2016).

A positive example of the benefits of investing in health service quality can be drawn from Ethiopia, where the voluntary CBHI scheme introduced for the informal sector in 2011 saw an uptake of nearly 50 per cent within two years from scheme launch. This has been largely associated with the important investments in the health system before the launch of the scheme, including increases in the number of public health service points as well as human resources and the provision of new services (Degefa and Hoelscher 2020; Mebratie et al. 2019; Lavers 2019).

In Tanzania, health service delivery¹² has seen a downward trend since 1996 (Wagstaff and Neelsen 2020). This is also evidenced by health system indicators, such as the density of nurses and midwives (per 1,000 people) which is lower in Tanzania (0.58) than in its neighbouring countries Kenya (1.2), Uganda (1.2), Rwanda (1.2), and Mozambique (0.7) (see World Bank n.d.d). Service provision suffers from supply and staffing shortages as well as poor access to running water, electricity, and basic equipment (John et al. 2018). Qualitative studies drawing on experiences of health professionals (e.g., Baker et al. 2017; John et al. 2018) have witnessed the difficulties in providing good quality healthcare for expecting and new mothers, because of resource shortages at health facilities, under-staffing, and other limitations. Those focused on service user perspectives, in turn, have described poor attitudes towards female patients among health professionals (e.g., Ansu-Mensah et al. 2020; Konje et al. 2020).

Issues in health service provision have been exacerbated by the COVID-19 pandemic. Support for protective equipment, oxygen, and other materials necessary to treat coronavirus patients has been provided primarily by private actors, including banks and individual philanthropic donors (e.g., Lavoe et al. 2020; *The Citizen*), while the government approach to the COVID-19 pandemic has attracted international attention because of an initial reluctance to recognize the threat of the disease to its citizens and health system and refusals to accept vaccines from Western countries (Makoni 2021). Disruptions and gaps in health service provision cause a serious threat to the realization of quality care for all citizens, and women in particular following their high level of exposure to the virus and other health needs. As such, investments in the broader health systems and the quality of services are key for Tanzania to increase the attractiveness and coverage of its health insurance system. This includes investments in the infrastructure, equipment, and staffing, as well as continuous professional development of health professionals.

6 Discussion: shifting towards mandatory health insurance arrangements with financial sustainability

Health insurance schemes constitute a key policy tool in enhancing access to health. This is supported by recent evidence from Tanzania, showing that women with health insurance are more likely to utilize health services, including those related to pregnancy (e.g., Kibusi et al. 2018; Tungu et al. 2020). Given the important contributions that health insurance may generate for equitable access to health, it is paramount to introduce financing protection mechanisms which enable insurance take-up and re-enrolment for all Tanzanian women. As posited by Kalk (2008), in contexts where insurance coverage is impeded by poverty,

the discussion around an insurance approach for the poor should focus very much on the following three questions: What percentage of the population targeted by the envisaged or existing insurance scheme are too poor to enrol on their own? By which kind of corrective measures can they be included? What consequences do these measures have for the financial viability of the scheme?

The discussion here addresses the findings of this paper through these angles.

To begin with, the analysis in this paper shows that even in the case of the most affordable insurance option (i.e. the old CHF scheme), premiums represent a significant financial barrier to

¹² Including preventative services (antenatal visits, full immunization, breast cancer screening, cervical cancer screening) and treatment services (skilled birth attendance, treatment for acute respiratory infection, treatment for diarrhoea and inpatient admission in previous 12 months) (Wagstaff and Neelsen 2020).

health insurance, whereas the level of OOP payments and catastrophic health expenditures remains high. Several corrective measures, then, can be proposed based on evidence from other high-performing countries in terms of health insurance coverage. These include, but not exclusively, a shift to mandatory health insurance with generous benefit packages to avoid OOP payments; a broad range of exempt groups, including pregnant women and vulnerable households; and a sliding payment scale adjusted to differing levels of household income combined with other more flexible payment options than a single annual payment.

Issues of financial viability are naturally pertinent for undertaking reforms. Based on the reviewed literature, we argue that Tanzania has several options to increase its financial resources for bolstering its health insurance system. First, Tanzania could consider innovative taxation approaches, since its health insurance funding currently relies on payroll contributions and investment returns for the NHIF (Piatti-Fünfkirchen and Ally 2020), and a combination of member contributions and matching grants paid by the central government for the CHF (Wang and Rosemberg 2018). Different ‘sin taxes’, for instance, have been widely promoted to strengthen health system financing (see Umeh 2018). For example, the Philippines has successfully utilized an earmarked tax on alcohol and tobacco to subsidise insurance premiums for the poor, generating a threefold increase in revenue and coverage in 2012–16, accompanied by a decline in tobacco consumption (Cashin et al. 2017).

Also other tax reforms offer viable solutions. Gabon, for instance, has introduced special measures to finance health insurance to low-income groups. These include a combination of earmarked taxes on mobile telephone companies and international money transfers since 2007, replaced by a 1 per cent tax on the purchase of goods and services in 2017 (Aboubacar et al. 2020; Mibindzou Mouelet et al. 2018). It has been estimated that in the particular context of Tanzania, comprehensive value-added tax and excise tax reforms alone could increase gross tax revenue by 2.5 and 1–1.2 per cent of GDP, respectively (Akeel et al. 2021), with important opportunities for health sector financing. Other taxation approaches considered particularly in the African context include taxes on ‘luxury items and services’, such as tourism services, vehicles, airplane tickets, and financial transactions (Mathauer et al. 2019; Olugbenga 2017).

Furthermore, reinforcement of tax collection systems represents an alternative approach to additional taxes to finance social policies in African countries, which have limited redistributive capacity (Niño-Zarazúa et al. 2012). The benefits of this approach have been evidenced in several countries (Kenya, Lagos state in Nigeria, and South Africa), which have effectively increased tax revenue by improving tax collection systems (RESYST 2015). Enhancing revenue collection approaches both through direct and indirect taxation represents one viable solution to increasing public resources for health also in Tanzania, where the tax collection gap is at 6–7 per cent of the GDP (Akeel et al. 2021).

Finally, a growing body of literature is recognizing and proposing solutions for effective expansion of government fiscal space through revenue from the extractive industries, to foster sustainable development (Addison and Roe 2018; Löf et al. 2021). Bolivia, for instance, has introduced a direct tax on hydrocarbons to fund cash transfers for children and the elderly. The country also introduced a universal social pension scheme in 2008, funded by tax revenue from oil and gas, as well as profits generated by state-owned companies (UNRISD 2016). Given Tanzania’s important natural resources in for example gold, diamonds, and new offshore gas discoveries, opportunities for strategically utilizing the generated revenue for health sector investment are numerous. Additionally, pooling philanthropic funding to strengthen the financial viability of the health system would increase government resources while reducing fragmentation of development efforts at the country level more generally. This is already facilitated, to some extent, in Ghana (where the

NHIF receives gifts, donations, and grants; see Amu et al. 2018) and Senegal (which has a special platform for receiving donations towards the CMU; see Sunu CMU n.d.).

7 Conclusions

To our knowledge, this paper presents the first available study drawing on a comprehensive range of literature and evidence from diverse sources to examine the gendered effects of Tanzanian health policy and to make policy recommendations drawing on lessons learnt from other contexts. The paper set out with two key objectives: (i) to examine Tanzania's health policy evolution with its effects on the extent of financial protection for working-age women, and (ii) to explore relevant policy options for gender-responsive approaches to expanding the country's health insurance system to achieve UHC.

The findings show important developments in the existing financial protection mechanisms for poor populations since the early 2000s, notably through the introduction and further development of health insurance schemes for informal sector workers. Yet, significant inequalities arise from the fragmented and tiered health insurance system, in which women covered by compulsory formal sector schemes benefit from broader and better-quality services, whereas those in the informal sector are dependent on more restricted benefit packages on a voluntary (and often unaffordable) basis. At the same time, the extant fee exemption and waiver policies add to the 'patchy' approach to financial protection without effective risk-pooling and offer limited protection against health-related expenses on a targeted rather than universal basis. Consequently, women and female-headed households incur higher levels of OOP payments and experience catastrophic health expenditures more frequently than men, if not foregoing healthcare altogether. The extant gender-based inequalities in access to care result, then, in unequal health outcomes persisting in the country.

In the light of the presented evidence, Tanzania's ambition to shift towards a mandatory health insurance system with higher rates of population coverage is commendable. Drawing on evidence from other Sub-Saharan African countries with health insurance systems, it is obvious that consideration must be given to effective premium subsidy mechanisms enabling insurance access to women in poverty, to expansion of portable benefit packages in a manner that does not 'underinsure' women given their more diverse health needs, and to broader investments in health systems to improve the overall quality of service provision. Increasing risk-pooling and reducing fragmentation within the health insurance system is equally essential for cost-effectiveness and ensuring equal, generous benefits for all Tanzanian women. Additionally, gender-sensitive health education and awareness-raising campaigns are needed to increase women's positive health-seeking behaviour and access to different financial protection mechanisms.

The findings of this paper stress the pertinence of gender-responsive health sector reforms in the context of Tanzania, which account particularly for women's needs in the informal sector. Health represents a crucial human capital particularly to rural populations, because of the largely physical nature of agricultural work (Mihyo et al. 2020). Informal sector work, more generally, is also characterized by hazardous work environments and few opportunities for adequate rest due to low incomes, increasing the likelihood of accidents and different health needs. Given women's arduous double-burden of paid work and unpaid care work in Tanzania as well as their overrepresentation in the lowest quality jobs, their health needs are intensified (Chopra 2021). Consequently, limited access to health among female informal sector workers has significant economic impacts on households and society more broadly. Furthermore, Tanzania has committed to the realization of UHC and SDGs across its policy documents. To realize its international policy commitments, it is

important that the government addresses gender-based inequalities in access to healthcare. Given that the government has set the expansion of its health insurance system as the primary pathway to achieving UHC, the realization of women's equitable coverage by equally generous health insurance schemes must be ensured across income groups, employment types, household compositions, and areas of residence based on the rights of citizenship.

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