Author's response to reviews

Title: Household perceptions towards a redistributive policy across health insurance funds in Tanzania

Authors:

Eunice N Chomi (e_chomi@yahoo.com)
Phare GM Mujinja (pharemujinja@yahoo.co.uk)
Kristian Hansen (Kristian.Hansen@lshtm.ac.uk)
Angwara D Kiwara (angwarakiwara@yahoo.com)
Ulrika Enemark (ue@soci.au.dk)

Version: 4
Date: 13 December 2014

Author's response to reviews: see over
Reviewer's report

Title: Household perceptions towards a redistributive policy across health insurance funds in Tanzania

Version: 3

Date: 10 November 2014

Reviewer: Fahdi Dkhimi

Reviewer's report:

Introduction No revision

Methods: Major revisions

1. I still have issues with the appropriateness of the methods to address the research questions. Beliefs underlying solidarity are very subjective and diverse. Isn’t this something that could be investigated only with quantitative methods? Maybe to be more explicitly quoted in the limitations (right now there is no limitation mentioned).

I would argue that what people answer to a questionnaire probably needs to be explored further before we can draw any conclusions. It is easy to answer: Yes I agree that the poorer groups get subsidised. But it does not say how this subsidy will be provided. In the Tanzanian context, many people equate subsidy with external support. Furthermore the question remains theoretical if not priced. Without valuing necessary financial efforts to be made, without clear figures (e.g. Would you be ready to contribute an extra Tsh 500/1000/2000... on top of your current yearly contribution so as to subsidised the contribution of the poor?), I do not know if answers are really meaningful. What do you think about this? This is a comment I had already made, but I think you need to explain and justify your choice more clearly.

Authors Response:

The authors acknowledge the limitation of using quantitative methods to study perceptions towards solidarity and this has been included among the limitations.

As for how the subsidy will be provided, apart from asking whether or not poorer groups should be subsidised (‘Poor members of the community should be facilitated to join the CHF without paying the contribution’), there were questions on willingness to contribute towards achieving this (willingness to contribute towards subsidised CHF membership by paying a higher contribution than the current one, or for NHIF members acceptance that part of NHIF revenue could be used to subsidise the CHF/ poor groups to join CHF ). The reviewer has rightly pointed out that a subsidy is equated with external support, which
has also come out in the results that show a lower proportion willing to contribute towards providing poorer groups with a subsidy compared to the proportion that supported the statement concerning provision of a subsidy (please see discussion section on willingness to contribute towards subsidised CHF membership, paragraph 2).

The authors also acknowledge that specification of an amount people would be willing to contribute towards the subsidy would have made for more concrete conclusions regarding actual willingness to contribute. Contributions vary from one district to another depending on what has been agreed by the community itself, so it is likely that even what people would be willing to pay as an extra contribution will vary. Furthermore, specification of an amount cannot be done arbitrarily, but would require consideration of the subsidy itself, the potential alternative sources from which revenue for the subsidy can be drawn and how much can be drawn from these alternative sources. This study was exploring the perceptions towards cross-subsidisation in a country where the concept is still relatively new and not very well understood, hence such considerations would be beyond the study scope. Perhaps, the questions on willingness to contribute could have been followed by an open-ended question on how much more the people would be willing to pay on top of their contribution would have served the purpose. This would have provided a range that the people would be willing to accept as an increment to their membership contributions. This has been included as part of the limitation of using quantitative methods alone for this study.

Minor revisions

1. Sampling method: You wrote: “In each district multistage sampling was used to select first wards, then villages, followed by hamlets and finally households.” I suppose you meant to select randomly”.

2. Two lines later, you wrote: “for the purposes of” – grammatically “for the purpose of” is better.

Authors Response:

This has been corrected as advised.

Why was the sample size calculated based on the report CHF enrolment and not on the NHIF enrolment as well? Especially since you end up with a very high level of NHIF enrolment (quasi 32% of the sample, very high as compared to the underlying population) which seems to indicate that you captured mostly urban or peri urban areas in rural districts. Is that the case? Could you please give any explanations?

Authors Response:

Since the main interest was to compare the responses from the three groups (NHIF, CHF and non-members), it was decided to select equal numbers of households from each group and since CHF had more reliable enrolment data (at the time of designing the study
it was difficult to obtain NHIF enrolment estimates for districts), this was used as the basis for the size of each group.

We captured households from both urban and rural areas. In rural areas there are agricultural extension workers, teachers and health workers (clinical officers, nurses, medical attendants). Therefore the 32% of NHIF workers did include those living in rural areas.

Results

Major revisions:

1. The descriptive characteristics of the sample are not used at all to make sense of the data presented further below, while some can be explanatory factors of the response collected (e.g. large household less likely to support redistributive mechanisms or female headed households more positive about pro-poor strategy). Furthermore, there is most likely overlapping: uneducated households are most likely female headed HH in greater proportion, and poor HH in greater proportion as well. Maybe good to check what mediates the observed differences.

Authors Response:

We are not sure that we understood the comment. Is that the descriptive characteristics were to be used to explain the findings from the analysis? This was done in the discussion section in relation to the influence of gender, education level, age of HH head, household wealth status, and household membership status on the perceptions that were explored. However this was done mostly for the variables that showed statistically significant results.

Household size was not discussed because CHF membership does not depend on household size – membership contribution is the same regardless of household size, hence may not influence support towards subsidised membership. While household size may influence willingness to pay a higher contribution to provide subsidy for poorer groups, the same influence has been captured by household wealth status.

We are not sure what was meant by ‘Maybe good to check what mediates the observed differences’. We will try to respond to your specific query on female-headed households. It is only among non-member households that a higher proportion of those that are poor and uneducated are female headed. Among CHF households a higher proportion of the female-headed households have primary education and there is a roughly equal distribution among the lowest to fourth wealth quintiles. Among NHIF households a higher proportion of the female-headed households are wealthy and have post primary education and above (not surprising since most government employees have at least secondary education. This was a requirement for employment and for retention, hence those with only primary education have been mandated to upgrade to secondary). This probably explains the differences observed in the regression results, where female headed
NHIF and CHF households were more likely to express willingness to contribute towards subsidised CHF membership. We have included this in the discussion (in section on willingness to contribute towards subsidised CHF membership, paragraph 4).

Again perhaps we have misunderstood the comment and stand to be corrected.

Minor revisions:

1. You do not use age as a descriptive variable. Why?

**Authors Response:**

Age has been used as a descriptive variable: presented in the descriptive statistics table (table 1) and mentioned in the discussion (in section on willingness to contribute towards subsidised CHF membership, paragraph 4).

Discussion: Major:

1. Is the fact that the HH had been affected by a disease - here showed as a mediator towards greater acceptance of cross-subsidization – not an evidence of the solidarity of self-interest rather than altruism and compassion? I would tend to believe so, thus disagreeing with your own interpretation. Maybe you need to be more explicit on why it is for you a sign of compassion rather than self-interest.

**Authors Response:**

Not all HH affected by disease are eligible for the subsidy (i.e not all of them are in the lower wealth quintiles, some of them are NHIF members who would be the net payers), hence the inclination for compassion rather than self-interest. This has been explained in the discussion (section on perceptions towards subsidised CHF membership, paragraph 2) as advised.

2. Willingness to accept to contribute towards CHF membership:

You evoke the fact that non-members may have failed to understand the question (an anomaly). Well, I disagree here. I think the choice not to join CHF is very rational. As you mention non-members (in greater proportion female-headed HH) are in favor of a subsidized registration for the poor, as they see themselves as net recipients. Why would it be surprising that they did not enroll into the scheme, as this subsidized enrollment does not exist yet and that they are requested to contribute to enroll?

**Authors Response:**

The authors agree that the choice not to join is very rational and may be for both financial and non-financial reasons. The question in the discussion posed was, why would more
than 80% agree to join only when poorer groups receive a subsidy, given that less than 40% were actually very poor? The question posed to non-member households was not whether they would be willing to enroll if a subsidy were provided for them, but whether they would be willing to enroll (paying the full contribution) even when there are other members of the community (poorer groups) who enroll with a subsidy. This was meant to measure whether people are willing to accept the fact that some people who are deemed too poor to afford the contribution will enjoy the same benefits as those who paid the full contribution. Given the willingness expressed by this group, we were of the view that perhaps those non-members who accepted misunderstood the question as asking whether they would be willing to enroll at a subsidised contribution.

Minor

1. “Careful consideration should be given to the amount of subsidy, such that there is minimal if any resistance but at the same time the poor are enabled to join the CHF.”: Not only on the amount, but also on the way this is collected (what period of the year, how is it paid...)

Authors Response:

The amount of subsidy refers to the extent to which the poorer groups should be subsidised, not what people will be asked to contribute towards achieving the subsidization of that group. Furthermore, although extent of subsidy may also be an indication of how much people will be asked to contribute, it is likely that the contributions will be part of the regular CHF contributions and NHIF salary deductions. The timing and payment methods for CHF contributions are set by the community itself and vary from one district to another.

2. You mention that from your answers, we could derive a form of resistance to fully subsidized premium. Maybe to confront these findings with the only contributory systems that have shown some interesting results in Africa: Rwanda and Ghana where poor people are 100% subsidized. Contradictions? Sustainability of such measures?

Authors Response:

Thank you for pointing out that our findings depart from the experience of Ghana and Rwanda that have implemented a 100% subsidy for the poor, which we had not thought about. In fact it does raise questions about reasons for the difference. Is it the design of the health insurance system, the longer history of health insurance, higher level of solidarity? There are so many questions and perhaps understanding why people preferred a partial rather than a full subsidy is required. For this qualitative studies would be more suited, which again supports your earlier comment about using a qualitative approach to measure beliefs about solidarity. We have included this in the discussion (section on perceptions towards subsidised CHF membership paragraphs 2& 3)
3. You ask: “Could there be trust issues regarding quality of care and scheme management, such that they are only willing to join with a subsidized membership contribution?” This is already demonstrated. The terms proposed to the target population are not worth the investment required. Or maybe only for large families.

Authors Response:

This has been addressed and the question put as a statement.

Level of interest: An article of importance in its field

Quality of written English: Needs some language corrections before being published

Statistical review: Yes, but I do not feel adequately qualified to assess the statistics.

Declaration of competing interests:

I declare that I have no competing interests