Reviewer's report

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

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Reviewer: Fahdi Dkhimi

Reviewer's report:

Background:

Minor revisions:

P1: maybe a short overview of the health financing situation in Tanzania would help an international audience to “situate” the country from that perspective. A few sentences to present the main health financing indicators.

P1: The health financing strategy is based on several regimes. The core issue is indeed how to articulate or how to merge these sickness funds.

The description given for the SHIB programme is insufficient. I am not sure everyone knows what the NSSF in Tanzania is about, hence it is difficult to understand who is the core target of the SHIB scheme. I would simply put that it targets employees of the formal private sector.

P.1: Regarding the NHIF and CHF coverage, putting these figures like it is done now may be a bit confusing for readers. I would give them an idea of how effective these schemes are, comparing their current coverage to their total target population.

And I would precise that NHIF is surely more successful from this perspective, but that its task is easier, as it collects automatic deductions from civil servant salaries.

p.6: Something is missing at the end of the paragraph that tops the page

Methods:

The methods are well described and appropriate.

Minor comments:

There is, however, some confusion regarding the data collection period and the sampling frame for CHF members. The list used for data collection – i.e. the list of members registered between September 2010 and September 2011 – is subsequent to the date of data collection (July to sept 2010). If your sampling frame was all those who enrolled between sept 2010 and sept 2011, then it is not clear when data collection took place.

Regarding the study variables, I am a bit perplex. Of course, everybody – or almost everyone – agrees with the concept of helping the poor in Tanzania.
However, I am wondering if, confronted to figures on the financial effort to be made to allow cross-subsidization would not have been helpful to get more consistent results. At that stage, in a nutshell, many people agree with the idea of helping the poor, as long as they do not have to do it themselves. I know this is difficult, but from experience, I noticed that people in rural districts have quite different, sometimes even contradictory answers when asked abstractive questions – e.g. do you think poor people need to be helped – and more down-to-earth questions – e.g. would you be ready to contribute Tsh 2000/year on top of your current contribution to help the poor being exempted?

No explanation/reference is given regarding the methods you used to build your asset and durable goods index. Could you refer to a methodology? Did you have the same wealth index for the two districts? Are they sufficiently similar to be able to rank people from two different geographical locations on the same scale?

Finally, references should be made to the Likert scale – from total disagreement to total agreement.

Results:
Generally, the result section is a bit short.

Major comments:
At no point in the analysis data are disentangled by district. This is Is there any difference by district under study? This is quite important because the CHF working in Tanzania is highly decentralized. The level of contribution is not the same throughout the country, there might be many factors in the environment that affects the presented results. Although the two districts are neighboring, you should still control for this geographical variability, since your answer can be influenced by several contextual factors, e.g. trust in the current leadership at the district level (the district being the CHF collector).

Second issue: regarding the interviewed. You explained, rightfully, that you had to consider the opinion of the HH head as a proxy for the HH opinion. I perfectly understand your choice, we always make some trade-offs. I thus do not question that choice, although from my experience in East Africa, contributions into a health insurance fund are sometimes made by other members of the HH – e.g. the spouse – sometimes without the husband knowing it.

My concern is more about the methods used to collect information about the HH characteristics. The state-of-the-art method is to set a household list and to ask the HH head to give an specific answer for each of the HH members. This is usually done to limit the biases related to data aggregation/averaging by the HH head. For example, the education level: it may be that the HH head is illiterate, but within the HH there might be someone/ some people with a higher education level, which may in turn influence greatly the living conditions of the HH. The same applies for the HH self-perceived health status.

Minor comments
p.11: “while households in the third wealth quintile are less likely to be supportive
I understand here that only people in the third wealth quintile are less likely to be supportive, while if I look at table 2, the odds are significantly below 1 for the 3rd, 4th and 5th quintiles (p>0.05). There is a need for rephrasing. Otherwise, the reader may understand that only the third wealth quintile is Discretionary Revisions

I find the description of the sample very short – too short in fact. Maybe would be good to present the results by scheme membership, i.e. CHF members, non-members, and NHIF members.

Discussion

In general, the discussion section is interesting and makes relevant references.

Major comments

My first comment is related to a point I made in the methods. Prior to enquiring whether interviewees were in favor of cross-subsidization towards the poor, have you tried to collect data on the self-perceived wealth status? I guess this is a very interesting, maybe even confounding factor. It would probably support your point on the theory of self-interest.

But – and this is my main point – it would also help you address one of the black box which is not clearly stated in your method: what do you mean by poor? It seems as if you left everybody made up their own definition. This point is critical: who is poor in Tanzania? Who do people see when they are asked “do you think poor people should be helped”? Without knowing that, can we come to the conclusion that poor people can also make a contribution so we should only subsidize part of the contribution for the poor? Is social policy to be based on opinions which are vague? I would make that point a bit clearer in the discussion section, especially since you can relate to the current debates on gays, lesbians and transsexual who may require special attention when it comes to healthcare.

“Willingness to accept poor members joining the CHF without paying the contribution further demonstrates positive beliefs about solidarity.” I would tend to argue that you cannot make this point here. What does it imply in terms of solidarity while people express ambiguous feeling of solidarity when it comes to contribute for it themselves?

Level of interest: An article of importance in its field

Quality of written English: Acceptable

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