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 subsidized 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.

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.

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?

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.

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

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.

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 enrol into the scheme, as this subsidized enrollment does not exist yet and that they are requested to contribute to enroll?

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...)

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?

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.

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