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Social health insurance

Implementing social security health care

The experience of the National Health Insurance Fund

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Introduction

The National Health Insurance Fund of Tanzania (NHIF) is a result of the Health Sector Reform (HSR) programme which started in 1993. Under the HSR programme Tanzania had to initiate several strategies towards the improvement of the health care services which had deteriorated to the extent of collapse. Among the changes instituted by the government were:

- establishment of cost-sharing arrangements in public hospitals through user fees;
- introduction of Community Health Funds (CHF) at district/ local levels;
- introduction of the Drug Revolving Fund (DRF) to assist Tanzanians to purchase drugs at a reduced price (i.e. 50 per cent);
- introduction of an indent system in place of the "kit system";
- giving powers to the local councils and communities to supervise the health facilities in their locality through the establishment of District Health Management committees (DHM's) and hospital, health centre and dispensary health management teams;
- the private sector was also allowed to operate to supplement government efforts.

Socio-economic environment

The economic sectors

Since independence in 1960, Tanzania, has continued to be mainly an agricultural country, supported by mining, tourism and trade. The agricultural sector employs about 80 per cent of the working population who mostly live in the rural areas. The agricultural sector is still underdeveloped and heavily dependent on weather changes. Farm practices are still poor and productivity is low. Despite the low productivity of the sector, its contribution to the gross domestic product (GDP) has continued to be the largest of all sectors. In 2003 the agricultural sector contributed about 46.8 per cent of the total GDP. So far, the population in the agricultural sector is mainly covered by Community Health Funds, established by local councils in specific districts as a pre-payment plan. Those who are not members of the

community health funds are required to access health services through payment of a nominal fee at the point of accessing health care services.

The manufacturing sector contributed 8.6 per cent to the total GDP in 2003. This sector has become more active in recent years due to liberalization policies being implemented. The mining and quarrying sector has become an important contributor to the total GDP, contributing about 3 per cent in 2003. This was due to increased inflow of direct foreign investments in the sector.

The trade sector (including retail and wholesale trade, hotel and tourism) contributed about 16.8 per cent of the total GDP. Tourism is rapidly growing and has created a large number of job opportunities for non-farming employment in the rural areas. Its potentiality is the result of the abundance of natural attractions.

Population and demographic indicators

Tanzania's population was estimated to have increased to 36.3 million people by June 2004. This estimation recorded a growth rate of 2.9 per cent. The demographic structure shows that the majority of the population is young people. More than 44 per cent of the population is below 15 years of age and is projected to increase slightly. The elderly population aged 60 years and above, constitutes 4 per cent of the total population. The population aged between 15 and 59 years (about 52 per cent) constitutes the country's labour force.

The total labour force in the country has been estimated at 17.8 million people, of whom 2.5 per cent are employed by government and parastatal institutions.

By the year 2002 the male population was 16,427,702 while the female population was 17,156,905. Infants and children under five years constituted about 5 and 20 per cent of the total population respectively.

Female participation in wage employment is fairly low, due to obligations to family duties and a lower education level. It is estimated that about 30 per cent of the labour force is either unemployed or underemployed.

As noted above, about 80 per cent of the population lives in rural areas, and about 20 per cent lives in urban areas. It is estimated that only 7 per cent of the total workforce is engaged in wage employment. Approximately 700,000 people, mainly youths, enter the labour force each year. This compares unfavourably with about 30,000 jobs that are created each year. As a result of this, the informal sector has emerged as an important source of employment opportunities and income generation.

Mortality and morbidity indicators

The main causes of mortality in Tanzania are malaria, tuberculosis, cholera, HIV/AIDS and its related diseases. Malaria has been the leading cause of mortality and morbidity in Tanzania. It is estimated that 93.7 per cent of Tanzanians are at risk of diseases. There are more than 16 million cases of malaria each year. About 14 million people (42 per cent) of the total population live in areas where transmission is high the whole year around. Pregnant women and young children who have not yet developed immunity are more vulnerable: they have higher malaria mortality rates, a high level of anemia and low birth weight.

Literacy rate and population life expectancy

The adult illiteracy rate (for people above 15 years of age) for the year 2003 was 21.9 per cent. The national census of 2002 indicated that life expectancy at birth was 42.34 years. Male life expectancy is 41.0 years, while for females it is 43.78 years.

The health sector

The need to design and implement a national health insurance scheme in Tanzania was propelled by a number of socio-economic factors related to the financial sustainability of the health sector. The main concern was the observed decline in the amount of resources flowing into the health sector which resulted in a decrease in the availability and quality of health services provided by government health facilities.

The decline in financial sustainability in the health sector was a result of a number of factors and policy decisions taken within and outside the sector. For instance, since independence the government pursued the objective of ensuring equitable access to health services for all Tanzanians regardless of their social, economic and political status. This was expected to lead to a qualitative as well as a quantitative improvement in the health status of the population. This goal created a greater role for the public sector in the provision of health services, as a result each village was expected to have a health centre or dispensary as a centre for the provision of both curative and maternal/nutrition services.

Health policy statements initiated, following the Arusha Declaration 1967, attempted to support the goal of equitable access to services in two ways:

- by emphasizing the central role of the public sector in meeting the health needs of the population;
- by making health services available at no cost to the patients with an emphasis on the need to expand services in rural areas.

This policy led to a further development of a broad-based network of health facilities, particularly dispensaries and health centres. By 1992 it was estimated that about 70 per cent of the population lived within 5 kilometers of a health facility and about 90 per cent lived within a 10 kilometers radius.

In pursuance of this policy, the government health network in Tanzania improved and accounted for about 55 per cent of total hospital beds, 98 per cent of health centre beds and thus ran a network of 78 per cent of the total dispensaries countrywide by 1992. The other health providers are voluntary agencies, led by churches and charities – they account for 43 per cent of total hospital beds, 2 per cent of health centre beds and own 17 per cent of the dispensaries. The rest of the health facilities are owned by private organizations and individuals.

The economic crisis which faced most developing countries in the 1980s, made it difficult for the government to maintain its commitment to provide free medical care. As a result the country witnessed deterioration in its economic performance resulting in declining terms of trade. The increase in oil prices fuelled the economic crisis in the country. The result of this economic crisis was the tightening of government budgets, and the government found it difficult to meet the costs of large social sectors, including health. Donor assistance in the social sector also declined. The health sector was grossly under funded and thus began to compromise the goal for universal access to cost-sharing health provision. The public health

services lacked key provisions such as medical supplies and equipment, and experienced poor management, lack of supervision and poor morale among health sector staff.

In the early 1990s, the government adopted new social and economic development policies characterized by the structural adjustment programme, and internal changes in the health sector itself. More important the government recognized the need to change its approach in order to ensure provision of health services. The government redefined its role to be more focused on policy formulation and to increase support to the role of private sector development. Along with these changes, the government started to explore alternative sources of health financing such as cost-sharing in public facilities, pre-payment systems and insurance arrangements.

Health insurance schemes operating in Tanzania

Health insurance is still a new concept in Tanzania because up to the 1990s provision of health services delivery was to a large extent a prerogative of the State. The private sector was allowed to operate in the country in 1993, through the Health Sector Reform Programme.

The health sector schemes operating in the country are as follows:

Table 1. *Profile of health schemes in Tanzania*

	Nature of scheme	Existing programmes	Years
1.	Social assistance	Government run programmes (taxation) i.e. TB, leprosy, etc	-
2.	Compulsory health insurance	National Health Insurance Fund	Act No. 8/1999
		National Social Security Fund (medical care).	Act No. 28/1998
3.	Community health insurance	Community health programmes (run under 48 districts).	Act No. 1/2001
4.	Micro-Insurance	Schemes run by churches, informal sector groups, cooperatives, etc.	Registered under the Societies Act
		UMASIDA[1]	
		VIBINDO[2]	
5.	Occupational schemes	Some employers	-
6.	Private health insurance	National insurance corporations	Registered under the Insurance Commission as a broker
		MEDEX[3] (T) Ltd	Registered under the Insurance Commission as a broker
		AAR[4] health insurance	
		Strategies Insurance	

[1] UMASIDA = *Umoja wa Matibabu sekta Isiyo Rasmi Dar es Salaam* (mutual health insurance scheme in the informal sector).
[2] VIBINDO = *Vikundi vya Biashara Ndogondogo* (associations of petty traders with health schemes).
[3] MEDEX = Medical Express (company incorporated in Tanzania to operate private health Insurance).
[4] AAR = against all risks.

Health care expenditure

In the last two decades government expenditure on health has been about USD3.40 per capita as opposed to the World Development Report recommendation of USD12.00 per capita. Persistent under-funding of the heath sector caused additional problems due to the decline in the amount of resources flowing into the health sector, thus resulting in a decrease in the availability and quality of health facilities. In recent years there has been a progressive increase in the proportion of the government budget that is allocated to the health sector which reached USD8.50 per capita in 2004. The Ministry of Health has set a target of USD9.00 for the 2005-2006 financial year.

General observations

According to the Human Development Report, 2002, there has been very limited improvement in the income poverty status of Tanzanian households during the 1990s. This is especially the case for rural areas. This is of great concern since it is highly unlikely that the poverty reduction strategy (PRS) target of halving basic needs poverty will be achieved.

Over the last decade Tanzania has experienced a reduction in some key health indicators. The Human Development Index of the United Nations dropped from 126 in 1992 to 156 in 1997. Poor health in Tanzania has been identified as one of the key contributors to poverty. Nonetheless, in most cases, Tanzania's health status compares favourably with other countries in sub-Saharan Africa. The main exceptions are maternal care and child malnutrition. The data on health outcomes in Table 2 points towards stagnation or deterioration of some indicators during the 1990s. But the sentinel surveillance data offers a basis for optimism that an improving trend will resume as the economy picks up.

Table 2. *Tanzania versus sub-Saharan Africa: Key health indices*

	Indicator	Tanzania	Sub-Saharan Africa	Remarks
Health outcomes	Infant mortality	95	103	Better
	Under 5 mortality	153	174	Better
	Inequality ratio under 5 mortality	1.44	1.77	Better
	MMR[5] modelled estimate (2000)	1500	917	Worse
	Life expectancy at birth	51	49	Better
	HIV prevalence 15 - 49	7.0	7.5	Better
	Total fertility rate	5.6	5.6	Comparable
	Stunting (severe, moderate)	17.1 %; 43.8 %	15.3 %, 35.9 %	Worse
	Wasting (severe, moderate)	0.6 %, 5.4 %	1.3 %, 7.6 %	Better
	Underweight (severe, moderate)	6.5 %, 29.4 %	7.3 %, 27.3 %	Comparable
	Low birth weight	11. %	20 %	Better
Health outputs	DTP3[6] average 12 - 23 months	89 %	54 %	Better
	ANC[7] coverage	93 %	64 %	Better
	%<5yrs ARI[8] cases treated at a health facility	70 %	45 %	Better
	%<5yrs diarrhea cases treated at a health facility	63 %	32 %	Better
	% skilled birth attendance	76.7 % urban 26.4 % rural 35.8 % total	78.4 % urban 38.0 % rural 47.0 % total	Comparable Worse Worse
	Delivery in health facility	82.8 % urban 34.5 % rural 43.5 % total	74.8 % urban 35.5 % rural 45.5 % total	Better Comparable Comparable
	Delivery by C-section	6.8 % urban 2.1 % rural 2.9 % total	6.0 % urban 2.4 % rural 3.4 % total	Better Worse Worse
Inputs	Medical doctors per 100,000	-	-	Worse
	Health expenditure per capita (public, private)	USD6.5 USD4.0		Worse
	Health expenditure % GDP	4 %		Comparable
	Aid per capita (total ODA)[9]	USD35		Better
	Aid (total) % GDP	13 %		Better

Source: Reviewing Health Progress in Tanzania (DFID) by Paul Smithson, January 2005.

[5] MMR = Maternal Mortality Rate.
[6] DTP3 = Diphtheria, Tetanus, Peruses.
[7] ANC = Anti-natal clinic.
[8] ARI = Acute respiratory infections.
[9] ODA = Official Development Assistance.

Description of the NHIF scheme

Establishment

The National Health Insurance Fund was established by Act of Parliament No. 8 of 1999. The Fund is administered by a board of directors which is autonomous but reports to the minister responsible for health.

The main objectives for the establishment of the health insurance scheme are:

a. To create a permanent and reliable system for the provision of health services to formal sector employees and later on to other groups as the scheme gains experience.
b. To improve the accessibility and quality of health services by introducing competition among health care providers from the government and private health providers.
c. To establish a reliable method which will enable formal sector employees to contribute towards their own health and those of their families.
d. To reduce the financing gap by supplementing the government allocation to the health sector.
e. To invest in economically viable projects in the health sector.

Contribution rate

The contribution rate which took cognizance of "members' ability to pay" is stipulated in the Act which established the Fund. The current rate is 3 per cent each to be paid by the employee and the employer of the employee's salary. The total contribution is therefore 6 per cent.

Membership and scope of coverage

The scheme is compulsory; it covers all public sector employees. However in the first two years of operations the Fund covered only central government employees. The membership base was extended to cover all public servants in 2002 in a move to expand coverage until all formal sector employees are covered.

The membership includes principal members, their spouses and four children and/or legal dependants. In the event a couple (man and woman) are both workers in the public service, they have equal rights to register four different children or dependants. The current membership of principal members is 248,343 which amounts to a total of 1,142,378 beneficiaries. The Fund therefore covers 3 per cent of the population in the country.

Identity cards

The Fund provides a portable membership card free of charge. Cards are issued to a member and his/her spouse and dependants. In order for the identity cards to be issued, members are required to fill NHIF 1 forms and submit (through their employer) the duly-filled forms with photographs. As of 31 January 2005 the Fund had already issued and distributed to members and beneficiaries a total of 949,153 identity cards (83.1 per cent of the target of producing 1,142,378 identity cards).

Benefit package and exclusions

The package

The NHIF provides a wide range of portable medical care benefits within mainland Tanzania. The National Health Insurance Fund Act Section 30 (j) empowers the board of directors to review and make some improvements to the benefit package, including a review of the rates used to reimburse the health care providers. Currently the benefit package includes:

- registration fees/consultation fees fixed per visit per level of health facility;
- fees related to basic diagnostic tests;
- out-patient services which include medications as per the National Essential Drug List (NEDLIT) and those which are generically prescribed;
- in-patient care at fixed rates per day per level of heath facility (i.e. referral/regional/district hospital, health centre or dispensaries);
- surgery (minor, major and specialized).

Excluded services

There are few exclusions and limitations to the above benefit package. Public funded programmes, major epidemics, public health programmes and socially disapproved acts are among the exclusions.

Accreditation

The accreditation process is an important stage in the management of a health insurance scheme. In Tanzania there are 4,284 health facilities available in the market, there has been accreditation of 3,196 facilities owned by the government and 1,088 owned by voluntary agencies, NGOs and private institutions. As of 31 January 2005, the Fund had accredited 3,705 out of the existing 4,284 health facilities (86.5 per cent) and 36 pharmacies as shown in the following tables:

(i) *Government facilities (group accreditation)*

Facility	Accredited	No. of active	Performance
Hospitals	91	91	100 %
Health centres	298	243	82 %
Dispensaries	2,780	1,401	50 %
Total	3,196	1,735	55 %

(ii) *Non-governmental facilities*

Facility	Accredited	No. of active	Performance
Hospitals	87	85	98 %
Health centres	6	55	72 %
Dispensaries	346	167	48 %
Total	509	307	60 %

Payment method "fee-for-service"

The fee-for-service is the payment mechanism that was adopted at the start of the operations of the Fund. Although this method needs extensive administrative control, the Fund's experience with this system has demonstrated that this is the best payment mechanism for developing countries like Tanzania. The Fund is however still working on cost-efficient and effective provider payment mechanisms, as the volume of business and the complexity of the benefit package increases.

Quality control

Risk management has been the major undertaking which the Fund has been heavily involved in since the inception of the scheme. In managing risks the Fund is using its quality controls department to ensure that providers offer quality services and are operating in accordance with the standards and regulations. In undertaking this important task the Fund has been insisting that providers comply with the following:

- Standard treatment guidelines: these are professional guidelines, examined, adopted, taught and put into practice.
- Standard facility guidelines: issued by the Ministry of Health.
- Adherence to the NHIF price list on medicines and medical supplies.
- Adherence to standard and rational prescribing, including use of generic names.
- Use of the National Essential Drug List (NEDLIT).

Inspection

The Fund has been conducting inspections of employers, members and health service providers. The inspection performed has enabled the Fund to enforce compliance and improve efficiency on the part of stakeholders.

Computerization

The Fund has managed to computerize most of its functions including linking its head office with zones under a wide area network (WAN). This move relieved the Fund from carrying out its duties manually. In 2004-2005 the Fund managed to procure software for claims management and accounting system (PREMIA) to hasten claims processing and to detect the incidence of fraud.

Actuarial valuation

The Fund conducted its first actuarial valuation during the 2004/2005 financial year. This exercise was carried out by the Fund's internal staff, whereas the International Labour Organization (ILO) was consulted as an external actuary.

Accounts and auditing

The Fund continues to perform its duties in accordance with the established financial regulations and other governing standards. For three years the Fund has received a "Certificate of Clean Audited Accounts".

Investments

The law directs the investments of the Fund, and governing policies require that investments be made in short term avenues. The aim is to ensure that the Fund has sufficient resources to be able to meet its short-term liabilities.

Corporate governance

The National Health Insurance Fund is administered by an independent and autonomous body of the board of directors who are accountable to the Minister of Health. At the present time the board is comprises of nine members representing health care providers (public and private), the government, trade unions and experts in economics and insurance.

The chairman of the board and the board members are appointed by the minister responsible for health. The day-to-day matters of the Fund are entrusted to the director general, who is also secretary to the board. The Fund's head office is in Dar es Salaam, with seven zones headed by zonal managers. The Fund's administrative expenses are 8 per cent of the total income for a specified year.

Issues and challenges facing the scheme

The operating environment of the scheme poses a number of issues and challenges to the Fund. Some of these are the result of the health insurance scheme being a new phenomenon in the Tanzanian environment, whereas other impeding factors arise from the system itself of which NHIF is a component. The major challenges include those described below.

Coverage of retirees

Coverage of retirees is a challenge likely to increase the cost of the scheme. The NHIF Act provides that members who retire from work are entitled to medical care services for a period of three months from the date of retirement. Members and politicians are demanding for a longer period of cover. The Fund has taken up the challenge and has undertaken some studies to explore the possibility of covering the retiree under specified conditions.

Quality of health care services

The quality of services offered by government health facilities is relatively poor especially in rural areas, although some improvements have started to emerge. The services provided by these institutions do not attract members of the Fund who are free to choose where they receive medical care services. At the present time, the government of Tanzania, in collaboration with the World Bank and other international agencies, has launched a three year programme to rehabilitate all district hospitals, health centres and dispensaries in mainland Tanzania, which amount to more than 3,000 spread throughout the country.

Availability of drugs and medicines

In Tanzania the sole importer of medicines, drugs and medical supplies for the public sector is the "Medical Stores Department" (MSD) which is a an autonomous institution responsible to the Ministry of Health. Various studies carried out in Tanzania on the availability of

medicines and drugs, show that on an average, there is 30 per cent out of stock in most government facilities, at any particular time. The government in collaboration with an international agency - Management for Health Sciences (MHS) of America, jointly established a project which aims at establishing and/or improving the present rural medical shops, such that they are manned by qualified personnel, and that the scope of stocks of drugs is expanded to provide a wide range of medicines in the rural areas. The project is known as the "Accredited Drug Dispensing Outlets" (ADDO).

Slow implementation of health insurance in rural areas

The implementation of the scheme has been slow in the rural areas as compared to the urban areas. The slow pace in implementing the scheme in the rural areas is mainly attributed to lack of knowledge about the scheme and the low level of education among health staff in the rural areas.

Extending the scope of coverage (universal)

While the management of NHIF has been examining the scope for extending coverage to retirees and to persons in religious foundations, private and foreign companies, there has been a growing interest and movement within the government and international community to make NHIF into a true national scheme providing the minimum/basic benefit package on health insurance services and sickness benefits.

Portability of benefits within East Africa and the Southern African Development Community (SADC) region

Regional integrations, especially the formation of the East African Community and in particular the signing of the East African Customs Union Agreement that allows the free movement of persons across borders is another challenge. It is likely that members of a health insurance scheme will now start moving from one country to another. Coverage of such migrant workers poses a future challenge to health funds.

Improving compliance and enforcement

During its years of operation, the Fund succeeded in introducing mechanisms to improve compliance and enforcement. Both internal and external operating machinery has been introduced.

This machinery includes the preparation of quality assurance guidelines, compliance manuals, price lists and disease matrix. Others are facility guidelines and standard treatment guidelines (STG).

Establishment of zonal offices was a milestone in this endeavour. Zonal offices were introduced to make sure that functions are performed near, and as much as possible, closer to members, providers and other stakeholders. The Fund has also established a "Risk and Fraud Unit" to track down all doubtful claims.

Information communication and technology (ICT)

For any health insurance scheme to succeed, information transfers, communications and computerization are vital factors in a number of ways, which includes the establishment of a membership database and a tracking system for monitoring and control. The processing of claims under the fee-for-service is effective but tedious and thus cannot be done manually.

The challenge which still lies ahead is continued improvement in ICT, firmed up, with the general improvement in staff capacity.

Recent and future reforms

In the light of experience and developments made since the National Health Insurance Fund was established, the board and management of the scheme are in the process of implementing a number of reforms to improve its performance, which are described below.

Enhancement of the benefit package

The Fund has been making some adjustments especially on the prices of drugs and medical supplies in order to respond to the market prices. These adjustments are made following actuarial reviews that are carried out twice a year. So far there has been a cumulative increase of 62.5 per cent on drugs and consumables since 2001/2002.

Study on identity cards

The Fund has commissioned a study to improve its identity card system. Current identity cards have successfully permitted the health facilities to identify members. However, there are problems associated with the management of the identity cards especially in the case of members who cease their membership. The Fund therefore plans that the future generation of identity cards will assume a new role of becoming an intrinsic part of the claims processing. A number of issues will be considered in the study so as to introduce a cost effective identity card system.

Extension of scope of coverage

As noted above, the Fund management has taken on the challenge and some studies are now being undertaken to examine the possibility of providing coverage to retirees under specified conditions. However, currently about 9 per cent of the Fund's beneficiaries are retirees and/or persons of more than 60 years who are registered as dependants.

Organization, reengineering/investment

In an effort to supplement government efforts to solve problems hindering efficiency in the provision of health services, the Fund intends to review its investment policy in order to make some provision for loans to health facilities so that they can improve their infrastructure and purchase medical equipment to provide better services.

The Fund hopes that investments in medical supplies will enhance the referral system and thereby reduce the number of cases that are currently referred abroad.

Public attitude towards the scheme

Since the establishment of the National Health insurance Fund almost four years ago, there has been a growing general awareness of the concept of health insurance as opposed to when the scheme began in July 2001.

Widespread awareness of the scheme is the result of the advocacy programme which is being developed by the Fund management on a continuous basis.

In future, the Fund intends not only to continue with its advocacy programme, but also to further educate its members, providers, and the general public on the need to guard the scheme against moral hazards, adverse selection and increases in the costs in order to make the scheme sustainable.

Conclusions and proposed recommendations

The need to provide protection for the population by guaranteeing their basic income has long been recognized as a fundamental objective of social security schemes. In Africa, the need for effective social protection, especially in the area of medical care, is of paramount importance given the fact that most countries in this region have large sectors of the population who cannot afford quality health care on their own. In recent years, the need for health care for the population has been more apparent as compared to forty years ago when family ties and assistance were strong and effective.

Many African countries are now debating on how to reform their old health care systems, so that more modern and comprehensive systems are developed, covering a much wider segment of the population, especially the vulnerable groups in societies who are usually women, children, the disabled and elderly persons.

As observed by many scholars, for any country to realize its socio-economic and political potential, its population must not only be healthy but also be assured of a sustainable system of health care. This can be done through the establishment of pre-payment scheme(s) such as health insurance that can gradually be extended to cover the country's entire population.

In view of the above, this report makes the following proposals:

1. African countries should strive to establish "social" health insurance schemes to cover the majority of the population as health care costs/expenses and the multitude and complexity of diseases become unmanageable at individual or family levels. Both political and government support is necessary at all times.

2. The main focus should be to establish sustainable schemes that can grow and prosper as opposed to schemes that will depend on foreign assistance. Also, the issue of good governance and best management practices should form part of the scheme.

3. In the preparatory process, before any health insurance scheme(s) is established, adequate studies, consultations with trade unions and other stakeholders, education of target groups, and documentation are required for a smooth implementation process, to avoid complaints and resentment.

4. To bring about a competitive spirit among health care providers in a country, both public and private health care providers should be mobilized to seriously take part in the delivery of health care under the new social schemes established.

5. The International Social Security Association (ISSA), International Labour Organization (ILO), the World Bank (WB) and other international agencies should give priority to the development of social health insurance schemes in Africa as has been the case for pension schemes for many years.