PERCEPTION OF BENEFICIARIES ON HEALTH INSURANCE SERVICES OFFERED BY NHIF: A CASE OF HIGHER LEARNING INSTITUTIONS STAFF IN DODOMA

By

Calystus Adson Mpangala

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CERTIFICATION

The undersigned certifies that he have read and hereby recommends for acceptance by the University of Dodoma of dissertation entitled**: *"Perception of Beneficiaries on Health Insurance Services Offered By NHIF: A Case of Higher Learning Institutions Staff in Dodoma"*** in partial fulfillment of the requirements for the award of the degree of master of public administration of the university of Dodoma.

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Dr. Ajali M. Nguyaambi

(SUPERVISOR)

Date……

DECLARATION AND COPYRIGHT

I, **Calystus Adson Mpangala**, declare that this thesis is my original work and that it has not been presented and will not be presented to any other university for a similar or any other degree award.

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DEDICATION

This work is entirely dedicated to my lovely mother Agnes Mnenje, who strived much for my early education. May the almighty God bless you.

ABSTRACT

This study focused on assessing the perception of beneficiaries on health insurance services offered by National Health Insurance Fund with specific focus to examine the beneficiaries' awareness on health insurance scheme following the introduction of NHIF, to Explore the NHIF beneficiaries' perceptions on the accessibility and quality of health services between patients with health insurance cover and those without and to determine the challenge from beneficiaries' perspective facing NHIF towards accessible and quality delivery of health services. Literature Review related to the study topic was carried out whereby conceptual framework and theoretical framework that guided the study was informed by the relationship between variables.

The study employed cross sectional research design whereby sample size 68 respondents utilized. Probability and non probability sampling employed to get the targeted sample. Data collected by using social survey and Interview method of data collection whereas questionnaire and interview guide tools for data collection employed. Data analysis employed both qualitative and quantitative methods with the help of SPSS Version 21.

Research findings indicate that well addressed of emerged challenges by both NHIF management and Government may generate highly improved delivery quality of Health services. The study, therefore, recommends for the need to review health policy so as to make CHF to be compulsory to every citizen who is in informal sector so that to reach Universal coverage before the year 2020.

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LIST OF ABBREVIATIONS

AHRQ	Agency for Health Care Research and Quality
AIDS	Acquired Immune- deficiency Syndrome
CBE	College of Business Education
CHF	Community Health Insurance Fund
DFID	Department for International Development
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IRDP	Institute of Rural Development Planning
MDG	Millennium Development Goals
MKUKUTA	Mkakati wa Kupunguza na Kuondoa Umasikini Tanzania
MoE	Ministry of Education
MoHSW	Ministry of Health and Social Welfare
MOI	Muhimbili Orthopaedic Institute
NGO	Non-Government Organization
NHIF	National Health Insurance Fund
NHIP	National Health Insurance Programme
NHS	National Health Services
NSSF	National Social Security Fund
SHI	Social Health Insurance
UDOM	University Of Dodoma
UN	United Nations
US	United States
WHO	World Health Organization

CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

This study aims to explore the views of beneficiaries regarding the provision of health services following the establishment of the National Health Insurance Fund (NHIF). A qualitative approach was used, whereby individual interviews, observation and field notes were used to obtain a thick description the employees' perceptions concerning provision of health services under social health insurance. In this part a researcher provided background information, Statement of the problem, objectives of the Study, Research Questions and Significance of the Study.

1.2 Background Information

The costs of health care strain governments and individuals around the globe (Burrill, 2010). From the World Health Organization report, more than 100 million people a year are pushed into poverty by their medical bills (Burrill, 2010). The challenges of funding health care by Government are increasing because of aging populations, a growing burden of chronic diseases, and the introduction of more expensive treatments (Burrill, 2010).

Health insurance is a type of insurance coverage that covers the cost of an insured individual's medical and surgical expenses. Depending on the type of health insurance coverage, either the insured pays costs out-of-pocket and is then reimbursed, or the insurer makes payments directly to the provider. In health

insurance terminology, the "provider" is a clinic, hospital, doctor, laboratory, health care practitioner, or pharmacy. The "insured" is the owner of the health insurance policy; the person with the health insurance coverage (Carrin, at el., 2008).

In countries without universal health care coverage, such as the USA, health insurance is commonly included in employer benefit packages and seen as an employment perk.Broadly speaking there are two types of health insurance: Private health insurance - the CDC (Centers for Disease Control and Prevention) says that the US health care system is heavily reliant on private health insurance. 58% of Americans have some kind of private health insurance coverage (USA, 2003).

Public (government) health insurance - for this type to be called insurance, premiums need to be collected, even though the coverage is provided by the state. Therefore, the National Health Service (NHS) in the United Kingdom is not a type of health insurance - even though it provides free medical services for its citizens, it does not collect premiums - it is a type of universal health coverage. Examples of public health insurance in the USA is Medicare, which is a national federal social insurance program for people aged 65+ years as well as disabled people, and Medicaid which is funded jointly by the federal government and individual states (and run by individual states), SCHIP which is aimed at children and families who cannot afford private insurance (NIH, 2003).

Health insurance becomes a global agenda due to the fact that Health is central to development. Health-related issues are prominent in the current Millenium Development Goal (MDG) framework, with three out of the eight goals directly referring to health conditions. The Millennium Development Goals (MDGs) are

eight international development goals that were established following the Millennium Summit of the United Nations in 2000, following the adoption of the United Nations Millennium Declaration. All 189 United Nations member states at the time (there are 193 currently) and at least 23 international organizations committed to help achieve the following Millennium Development Goals by 2015: 1. To eradicate extreme poverty and hunger 2, to achieve universal primary education 3.To promotes gender equality and empowers women 4, to reduce child mortality 5. To improve maternal health 6. To combat HIV/AIDS, malaria, and other diseases 7. To ensure environmental sustainability 8. To develop a global partnership for development. This has been stipulated in Health UN system Task team on the post 2015 UN development agenda. From the above goals; goal no.4, 5 & 6 are health related goals (MDG, 2000).

The Millennium Development Goals, despite any weaknesses, remain a powerful tool for focusing the world's attention on development issues. While intended as one means of monitoring progress, the way goals are defined inevitably influences how the world understands development and the ways in which it can be advanced. Goals are thus interventions in their own right, shaping the meaning of development and influencing resource transfers within and between nations and institutions. This has a number of consequences for goal setting in the future which are relevant for the coming debate in health (MDG, 2000).

Firstly; the process will be highly competitive, not just to include a wider range of topics, but also to influence the discourse on the approach to development. Examples are the current discussions on increasing the focus on human rights, on gender, on equity versus aggregate achievement, and on ways of measuring growth beyond

GDP. Secondly; Political and economic transitions combined with the universality of development challenges requires that the post-2015 agenda must be relevant to all societies. Poverty, financial insecurity, urbanization, ageing, climate change, ill health and food security are not problems of developing countries to be addressed by resource or technological transfers; they are problems requiring global solutions (Post 2015 UN development agenda, 2012).

Thirdly; the debate on the future development agenda has become intricately intertwined with the debate of the future of sustainable development. A new generation of development goals in this context offers a means of measuring progress across the economic, social and environmental pillars of sustainability. At the same time, given limited progress in realizing the institutional reality rather than the theory of sustainable development, there is a risk that a new set of sustainable development goals overly privilege environmental over other development issues. (Post 2015 UN development agenda, 2012)Each of these factors raises important questions for the health community: how to handle the competition? How to frame health goals from a global rather than developing country Perspective? And how to position health in the context of sustainable development?

In Africa, about half of health care expenses are out-of-pocket payments. Health care costs are a major barrier in health seeking behaviour and lead to an unequal access to health care, disadvantaging the poor. Introducing a health insurance programme is one way to ensure the poor of access to health care facilities and protect them against catastrophic health payments. In the past 25 years, several countries in Sub-Saharan Africa introduced a form of Social Health Insurance (SHI). In the majority of the countries these were small projects, only covering a city or region.

The major setback with SHI schemes in Africa is the limited number of enrolled people: 95% of the insurance schemes count less than 1 000 members. The small scale of an insurance scheme implies poor financial viability due to limited risk pooling, and danger of bankruptcy. Therefore, implementing a national health insurance – managed by professionals – may be the solution for African countries on their way to universal health coverage. Currently, Ghana is the only country in Sub-Saharan Africa that successfully implemented a national health insurance scheme. In 2008, five years after implementation, 45% of the Ghanaian population is enrolled (ranging from 13-70% per region).

The insurance scheme covers all primary health services, outpatient and inpatient services and medication. First evaluations show that the number of visits per cardholder to out-patient-departments has increased since its introduction. Uganda and South Africa show great interests in a large-scale insurance system, but both fail to carry out such a programme. We should have to study these issues today because we are approaching year 2015 (UN development agenda, 2012).

Experience can be observed from many different countries worldwide as follows; Australia - has a combination of a public health system, called Medicare, and private health insurance organizations. Medicare provides free universal access to hospital care, as well as subsidized non-hospital medical treatment (Bump, et al., 2010). Canada - has a publicly funded universal healthcare system, which is nearly all free at the point of use. Most of the public health services are provided by private organizations. Approximately 27.6% of Canadian citizen's health care requirements are received through the private sector. Private health insurance is used to cover services that Medicare does not provide for, such as optometry, dentistry and

prescription medications. Three-quarters of all Canadians have some type of supplementary private health coverage - many get this as a job perk. A report issued in May 2012 by researchers from the Universities of Toronto and British Columbia found that about 10% of Canadians are not able to take their prescription drugs as directed because they cannot afford it (Bump, et al., 2010).

France - The French public health insurance program was established in 1945 and its coverage for its affiliates has undergone many changes since then. All working French citizens have to contribute from a portion of their salaries to a not-for-profit health insurance fund, which mutualizes the illness risk, and reimburses patients at different rates. Insured people's spouses and offspring are eligible to be covered in the same policies. Each fund is financially autonomous, and is used to pay for medical expenses at pre-arranged prices. Recent reforms have harmonized many prices and benefits provided by different insurance funds (Bump, et al., 2010).)

Germany - this country has Europe's longest-standing universal healthcare system, which started during the last 20 years of the 19th century. 85% of German citizens are covered by a basic health insurance policy which the state provides - this provides "a standard level of coverage". 15% have chosen private health insurance plans. WHO (World Health Organization) says 77% of Germany's health care system is state-funded while 23% comes from the private sector (Bump, et al., 2010).

Japan - the country has an Employees Health Insurance and a National Health Insurance system. The National Health insurance is aimed at those who are not eligible for Employees Health Insurance. Even though the country also has private health insurance, everybody in Japan, including foreigners with a one-year visa must

be enrolled in an Employees Health Insurance plan or National Health Insurance (Bump, et al., 2010).

United Kingdom - the NHS (National Health Service) provides free medical and hospital care and subsidized or free prescription medications to all its citizens. The NHS is a publicly funded universal healthcare system, which is not really an insurance system as no premiums are collected and costs are not charged at patient level. Nevertheless, the NHS achieves the same aim as insurance in spreading financial risk arising from ill-health. All NHS costs are met directly from general taxation. The UK also has private health care which is paid for mainly by private insurance. Less than 8% of the country's population has any private health insurance. The largest private health insurance companies in the United Kingdom are BUPA, AXA, Aviva, Groupama Healthcare, PruHealth, and WPA (Carrin, et al., 2005).

In Sub- Saharan Africa, Ghana is the most successful country to implement Health Insurance Scheme followed by Ghana and South Africa. There are several key differences between Ghana, Uganda and South Africa that may explain why Ghana successfully implemented a national health insurance scheme and Uganda and South Africa fail to do so (NHIS, 2011). First of all, Ghana was the first Sub Saharan country that became independent from colonial rulers and eventually installed a government that led to a stable political climate in the following years.

Uganda’s post-colonial development, however, is shaped by Idi Amin’s military dictatorship (1971-1979) which destroyed much of the country’s health care infrastructure. When eventually democracy was initiated, health care reforms failed, causing a corrupt public health care system. In South Africa, the years of apartheid

entrenched inequity into the provision and financing of health services, producing a lack of access to essential health services for the majority of the population. The post-independence stage is of major importance in creating a suitable environment in which governments are able to carry out strong social health reforms. Ghana evidently made more constructive progress in developing a suitable health care system than Uganda and South Africa (WHO, 2010).

Also, there are differences in how current health systems are organized and financed. In Ghana, the government is the main financer of health. But in Uganda, one quarter of all financial means comes from international donor organizations, and one third of health expenses is paid by out-of-pocket payments ((WHO, 2011).

Moreover, an important share of health services in Uganda is managed by religious organizations. In South Africa, the government finances 40% of health care expenditure and 40% is financed through private health insurances. Countries in which health care is mainly funded and organized by private or external organizations are less likely to convert into a government controlled social health insurance (WHO, 2010).

Furthermore, the extent of the health insurance sector is an important predictor of a successful implementation. In Ghana there were only small-scale insurance programmes active, and in Uganda only 2% of health expenses are paid through insurance programmes. In contrast, in South Africa there are more than 120 private health insurance programmes. Efforts to replace these insurance programmes by a national health insurance caused major resistance by private insurance companies.

Private companies fear to lose their share of the insurance market once a national system is installed (WHO, 2010).

Quality of care is another important factor. Although Uganda's health expenditure is comparable to that of Ghana, Uganda's health services are of lower quality and the distance to health clinics is bigger. Low quality and unequal distribution of health services play an important, discouraging role in the patients' willingness to pay for any type of health insurance. Also, societal characteristics influence the success rate of a national health insurance. Since rich inhabitants will pay higher premiums than the poor and usually suffer from fewer diseases, the wealthy share of the population partly subsidizes the health care for the poor population. In order to maintain a social health insurance, a minimal level of solidarity is essential.

In South Africa, income per capita is exceptionally unequal and solidarity across socioeconomic classes is limited. A lack of solidarity causes resistance against implementing a national health insurance. In Ghana, the reforms of a national health insurance started with an election promise by one of the bigger political parties to abolish out-of-pocket payments. After being elected, this party put great efforts in developing the insurance scheme, implementing it before the end of the term. It shows that major national reforms call for strong political willingness (NHIS, 2011).

In Tanzania like other developing countries cost-sharing programme in health sector was introduced in 1988 as results of failure of the government to provide free health care to all its citizens through tax financing, increase of treatment costs, emergence of pandemic diseases such as HIV/AIDS and the overall poor performance of the economy (Quijada and Comfort, 2002). The system requires people to pay a certain

amount of money in order to get health services from the government hospital and health centers (URT, 2001). The amount to be paid has to be set by the district councils or municipal authorities to raise additional funds and improve access to health care for the poor and vulnerable groups (Munishi, 2001).

Differrent studies for instance Mtei (2007) revealed that Tanzania, like many other countries in Developing countries faces the same pressures of a tight public health care budget as a results financing mechanisms have been added including the introduction of prepaid insurance schemes such as the National Health Insurance Fund (NHIF), Community Health Funds (CHF) "*Tiba kwa kadi*" and various Micro Health Insurance Schemes for instance National Social Suport Fund (NSSF) to improve health care services delivery (Mtei and Mulligan, 2007).

The same concerns regarding the financial sustainability of the health sector were raised in Tanzania, which resulted in the introduction of user fees as a cost-sharing measure in 1993. After five years of user fee implementation, experience highlighted the need for an alternative means to finance health care, hence the introduction of a national health insurance scheme (Minja, 1999; Bituro, 1999).

Tanzania started experimenting with social health insurance in 2001 after the National Health Insurance Act (Act 8 of 1999) was passed in Parliament (United Republic of Tanzania, 1999). This new form of health care financing is part of the ongoing health sector reforms in the country that were instituted to improve, inter alia, the quality and accessibility of health services in the country. As in most Sub-Saharan countries where the implementation of this type of system is still in its early stages, the impact of social health insurance on the provision of health services in

Tanzania has not yet been adequately documented. It is due that fact the researcher intend to conduct the study on that issues.

1.3 Statement of Problem

Cost of accessing health care has been a growing concern among many poor communities. Countries have been opting health insurance as a market as well as government mechanism to deal with inability of poor families to get quality health services, yet such interventions are prone to both market as well government failures in many parts of the world including Tanzania. Literature review presents that countries with stable health insurance have assurance of having healthy communities that can engage actively in production activities and eventually contribute to both household as well as national income (Quaye, 2001). This has been possible in countries that finance their poor communities by either cost sharing or fully financing the communities to have access to free health services. This is not so common in many least developed countries. The existence of those who are insured and not insured has been common in African Countries such as Kenya, Uganda and Tanzania (Mwabu *et al*., 2002).

Generally Health Insurance aims at providing health services which are more reliable, cost minimized, sustainable services and improved services in general. However in Tanzania Health Insurance Scheme provide negative impact in provision of health insurance services. This is due to number of problems; First, it is difficult to establish the perception of health insurance at individual level in terms of health promotions, contribution level set and limited benefits package and exempted poor ; second, data on the extent of health insurance is patchy and limited ; third, there is no

evidence as to what extent employees do not have enough income to pay for health insurance despite the existence of cost sharing policy; and lastly, there is no empirical evidence on how lack of health insurance has affected their engagement in economic activities.

Therefore, acquiring an insider's perspective of beneficiaries in higher learning institutions concerning the quality and accessibility of health services under social health insurance will complement what may be known from an outsider's perspective and provide valuable insights and understanding into the issues leading to the challenges being faced. In addition, the findings will compliment the efforts of the Millennium Development Goals, Decentralization by Devolution policy, MKUKUTA II as well as National Health Policy towards ensuring equitable, accessible and efficient health services to the community. Hence, this study intends to explore the perception of beneficiaries on Health insurance services offered by NHIF for a case of Higher learning institutions staff in Dodoma.

1.4 Objectives of the Study

In an attempt to address the problem stated above, the proposed study has divided a set of objectives that include general and specific objectives as follow

1.4.1 General Objective

Examine the perception of beneficiaries on health insurance schemes taking higher learning institutions staff in Dodoma as a case study

1.4.2 Specific objectives

In order to achieve the above general objective, the following specific objectives are proposed

(i) Examine the beneficiaries' awareness on health insurance scheme following the introduction of NHIF.

(ii) Explore the NHIF beneficiaries' perceptions on the accessibility and quality of health services between patients with health insurance cover and those without.

(iii) Determine the challenge from beneficiaries' perspective facing NHIF towards accessible and quality delivery of health services.

1.5 Research Questions

From the specific objectives above the research intends to answer the following questions:

(i) To what extent do beneficiaries of health insurance schemes aware of the introduction of NHIF services? (Policy & Laws, Objectives of NHIF and Benefits of NHIF)

(ii) How do health services been accessible to NHIF beneficiaries? (Time management, Availability of health providers and Performance of health workers)

(iii) What are the challenges facing by NHIF towards accessible and quality delivery of health services? (Best practices, Bad practices and The way forward)

1.6 Significance of the Study

The study intends to provide researchers with useful insights on various factors that affect implementation of policy measures to achieve efficiency in the adoption of health insurance schemes. It will also be used to add new concepts and approaches to academicians on provision of health services using insurance schemes in Tanzania. The finding of the study will enable the government, insurance administrators and policy makers to be conversant with various issues that affect the successful implementation of insurance schemes for health services provision. This enables the policy makers also to come up with more effective measures that will lead to successful implementation of health insurance schemes. Foreign and Local Investors use the study to understand the health insurance administration policies in Tanzania with respect to their rights and obligations governing the provision of health services.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This part presents a review of the literature related to the subject of the study as presented by various scholars. The review is divided into four main parts namely theoretical review, empirical review, information gap and the conceptual framework.

2.2 Meaning of Key Concepts

There are two terms that need to be conceptualized in this study namely Health insurance and Community-based Health insurance.

2.2.1 Health Insurance

A form of health financing that pools risks across patients and across time. The objective is to increase equity and protect against catastrophically expensive illness (Witter, 2005). Insurance is the term used in context to denote and mean "risk financing; risk transfer and risk combination (Bennett, 2004:167) Insurance gives protection against loss. As quoted by Acharya, A et al**…"***Social health insurance schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations. Recently, apart from governments, several non-government organizations at the community level provide social health insurance in developing countries"* (Churchil, 2006; Dror et al, 2002).

There are three main kinds of health insurance scheme as well listed and analyzed by Banta el al.(1997:320) and include among others: Hospital expense such as daily costs of room and board during a hospital stay; surgical expense which pays for all or part of surgeon's fee for an operation; physician's expense such as doctor's bill for no surgical care. It covers treatment in hospital, the doctor's office or the patient's home; Government health insurance schemes and programmes which include individual health insurance and group health insurance.

2.2.2 Community-Based Health Insurance

Community-based health insurance is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor (Carrin, 2003). CBHF is a mechanism whereby community members (households) finance or co-finance costs associated with health services, offering them greater involvement in the management of community financing scheme and organization of health services (Carrin, 2003)

2.3 Theory of Demand for Health Insurance

Many scholars have spent time to analyze why do people buy health insurance. Conventional theory holds that people purchase insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. Conventional theory also holds that any additional health care that consumers purchase because they have insurance is not worth the cost of producing it (Nyman, 2003). Therefore, economists have promoted policies such as co-payments and managed care-to reduce consumption of this additional, seemingly low-value care.

This study reviews a theory of consumer demand for health insurance. It holds that people purchase insurance to obtain additional income when they become ill (Zweifel, 2007). In effect, the intention of insurance companies has been to transfer insurance premiums from those who remain healthy to those who become ill. This additional income that is obtained from well planned insurance policies generates purchases of additional high-value care, often allowing sick persons to obtain lifesaving care that they could not otherwise afford.

This theory also assumes that consumers actually prefer the risk of a large loss to incurring a smaller loss with certainty. Therefore, if consumers purchase insurance, it is not because they desire to avoid risk. Instead, the theory further suggests that the consumers do simply pay a premium when they are healthy in exchange for a claim on additional income (effected when insurance pays for the medical care) if they become ill (ibid). Health insurance is substantially more valuable to the consumer depending on the types of services rendered. The theory moreover implies that co-payments and managed care as central health policies of the last 30 years—were directed at solving problems that largely did not exist. Because these policies either reduced the amount of income transferred to ill persons or limited access to valuable health care, they may have done more harm than good. The theory also provides a solid theoretical justification for insuring the uninsured and for implementing national health insurance (Alderson, 1998). Hence; Conventional theory highlights the factors that affect beneficiaries' perception on health insurance schemes towards health service delivery.

However, this theory has been silent on how to deal with moral hazard that seems to be a common problem in social insurance. Moreover, the theory has not given

attention to how the positive impacts of rural health insurance should be sustained, with particular focus on improving the ability to co-pay among the vulnerable groups and poor households.

2.4 Empirical Literature Review

This part presents a review of different studies in relation to the specific objectives of the study as presented by various scholars. It includes Awareness of Health insurance Scheme, Accessibility of Health services under Health Insurance Scheme, Quality of Health services provided under Health Insurance Scheme and operations of National Health Insurance Fund.

2.4.1 Awareness of Health Insurance Scheme

Despite all the benefits of introducing health insurance as a health financing option, there are doubts about its feasibility and applicability in developing countries. Some authors argue that, instead of improving access to health services, health insurance creates barriers, especially for the poor and those living in rural areas (Quaye, 2004; Bennett and Gilson, 2001). Disparities such as these relating to access to health services between urban and rural populations can be created by the misdistribution of both health staff and facilities, as these tend to be located in urban centres where there is greater demand and ability to pay (Quaye, 2004; Bennett and Gilson, 2001).

The same concerns were raised by a number of Sub-Saharan countries at the Department for International Development (DFID) Health Insurance Workshop in 2002 (DFID Health Insurance Workshop Report, 2002:18). The introduction of health insurance in Latin America occurred long before it was instituted in most

developing countries, especially Sub-Saharan countries. However, although access may have improved for all population groups, the insurance schemes have also created inequity in both access to and quality of health services among the different groups, for example between urban and rural communities and formal and informal sector employees. The reforms that have been instituted have not been able to address the problem of inequity adequately (DFID Health Insurance Workshop Report, 2002).

Using the National Hospital Insurance Fund of Kenya as an example, Quaye (2004) cites limited coverage as one of the drawbacks of health insurance. He argues that health insurance does not address the barriers to access adequately because, firstly, most governments prefer using a flat rate contribution without taking into consideration level of income and, secondly, the service providers belonging to the fund are concentrated in urban centres and this creates or enhances geographical barriers to accessing health care.

Other authors also agree that limited coverage is a drawback to health insurance, but with reference to quality of health services (Bennett and Gilson, 2001; DFID, Health insurance Workshop Report, 2002). It is their view that, while quality improvement can be achieved for the few insured, this may be done at the expense of the services for the uninsured. This may result from resources being shifted from funding public health services for the poor and uninsured to subsidizing the insurance scheme in order to make it more attractive to the beneficiaries (Bennett and Gilson, 2001; DFID Health Insurance Workshop Report, 2002). Similarly, a study in Kenya revealed that most people covered by the National Hospital Insurance Fund of Kenya were not

satisfied with the services in the public hospitals and therefore did not utilize them (Wang'ombe, et al, 2002 in Quaye, 2004).

Health reform, health policies and programmes require the understanding and support of the implementers, which include the providers of health services. Service providers who are dissatisfied and skeptical about changes associated with reform may be a threat to the success of such reforms. This is the view of some authors who contend that the success of health reforms depends on staff commitment and, without the support of the staff, reforms are difficult to introduce and may even fail (Martinez and Martineau, 1998; Martineau and Buchan, 2000). The same may be true concerning the introduction of a scheme like the NHIF.

2.4.2 Accessibility of Health Services under Health Insurance Scheme

Health financing reforms were introduced to address the concerns about problems regarding the quality of health care, financial constraints and the problem of access and equity in health care (Sekwat, 2003). Social health insurance seems to be a leading alternative health financing strategy for many Sub-Saharan countries. Ghana introduced a National Health Insurance Program (NHIP) similar to Tanzania's NHIF with the primary objective of assuring equitable universal access for all residents of Ghana to an acceptable quality package of health services. Other countries in the process of introducing social health insurance include Malawi, Nigeria, South Africa, Uganda and Zimbabwe (DFID Health Insurance Workshop Report, 2002).

Access to health care is closely linked to health service financing in developing countries and is a key challenge to the health systems (Harderman, 2004; Gilson and Lake, 2002). Health insurance can improve access to health services by reducing the

financial barriers associated with seeking treatment. According to experts in South East Asia, evidence shows that health insurance has been associated with higher utilization among insured people than among those with less or no insurance (World Health Organization, 2003). Bennett and Gilson (2000), in their analysis of different health financing mechanisms, contend that social health insurance promotes access since no payment is required at the point of use. Access to health care can also be improved by freeing up resources that could then be better targeted to subsidize the non-insured, poor population (Leighton, 1995).

In Sudan the primary objective for implementing the insurance plan was to increase access. In a study to investigate the different aspects associated with the adoption of health insurance for curative services in Sudan, it was found that the insurance plan contributed greatly to the enhancement of access by reducing the cost of curative services (Suliman, 2002). Similar results were obtained from an Indonesian study where the effects of mandatory health insurance on equity in access to outpatient care were measured and the conclusion drawn that the scheme had a positive impact (Hidayat, 2004).

2.4.3 Quality of Health Services Provided under Health Insurance Scheme

Quality of health services can also be improved following the introduction of health insurance by introducing competition among the various health care providers. This can be achieved by giving members of a health insurance fund the choice of health care provider. The NHIF uses the same strategy to improve quality of health care (Humba, 2005b:14). Health insurance can also improve the quality of health care by providing an additional source of revenue to fund the costs of better services.

Leighton (1995; 76) points out that, "*Improving quality is a two-way street: cost recovery reforms are most likely to work when fee revenues are ploughed back into the delivery system to improve quality. Thus, the link works both ways: quality improvements generate support for financing reform and financing reform can generate the revenues to sustain quality improvements*."

This appears to be the case with the NHIF; quality improvements such as renovations to health facilities and availability of drugs have been attributed to the payments made by the NHIF to health care providers (Humba, 2005b). Conversely, the Sudan study reported no significant improvement in quality following implementation of the health insurance scheme (Suliman, 2002). Similarly, other literature sources do not show a direct association between improved quality of health services and a health insurance scheme similar to the NHIF. For instance, the experience of European countries with well-developed social health insurance schemes evinces difficulty in establishing whether higher quality of health services can be directly associated with social health insurance (DFID Health Insurance Workshop Report, 2002).

2.4.4 National Health Insurance Fund (NHIF)

The National Health Insurance Fund (NHIF) was introduced following the passing of the National Health Insurance Act, 1999 (Act 8 of 1999) by the Tanzanian parliament (United Republic of Tanzania, 1999). The Fund envision to becoming the leading Health Insurance scheme of Choice in sub-Saharan region in terms of sustainability and quality of services. On the other hand Dedicated in providing

support to our beneficiaries to access health services through a wide network of accredited quality facilities throughout Tanzania is a mission of NHIF.

The objectives of the scheme include to: Increase financial resources and reduce the financial gap in the health sector. Financial resources will be increased through strengthening cost-sharing by providing an opportunity for the formal sector employees to contribute through their contributions. Furthermore financing gap will be reduced by supplementing the government budgetary allocation to the health sector by contributions from formal sector employees. Another objective is to facilitate private financing in curative care and shift resource allocation to preventive and public health programmes. Lastly but not least is to Improve accessibility and quality of health services by introducing competition among health care providers from public, Faith-based, Non-government organization (NGO's) and Private Health Providers (Humba, 2005).

NHIF is guided set of principles which include; Prepayment before one enjoys benefits; that means beneficiaries are required to pay their contributions at least one month before starting getting medical services. Contributions are supposed to be paid according to earnings i.e. those with a higher salary pay more compared to those who earn a low salary. Another principal is that for those who are healthy will subsidize those who have health problems. That is to say if a member will not get sick he/she is not required to claim for his/her contributions because it is assumed that sick members have already utilized them.

All members enjoy same cover irrespective of their contributions. This refers that there is no any form of discrimination among members and beneficiaries as far as

medical services is concerned. In other words we can say that Every member benefits according to health needs within the framework of stipulated "NHIF benefits" hence the concept of pooling. The last principle is that for those who have higher income "cross subsidize" those with low income (Humba, 2005).

The benefit package offered by NHIF includes the followings; Registration and medical consultations fees; this refers to all costs incurred in registration of new patient at the facility and consultations rendered by medical specialist. Basically these fees vary depending on the level of facility. Medical investigations; this includes all investigations from basic laboratory investigations such as urinalysis to advanced imaging investigations CT Scans, ECGs, EEG, diabetes control etc. By December, 2013 there were about 318 investigations which are supposed to be paid by NHIF (NHIF, Actuarial and Statistical Bulletin as of 30 June, 2011).

Outpatient services plus Prescribed Generic medicines and medical supplies; these include those services rendered without the need of the patient to be admitted in the facility. The providers issue medicine in accordance with the National Essential medicine list and an additional list drawn by NHIF. They are also required to use generic names and adhere to the mutually agreed NHIF medicine price Schedule. The price schedule is prepared after taking into account the macroeconomic changes such as price index (infalation) and all other relevant economic indicators (NHIF, Actuarial and Statistical Bulletin as of 30 June, 2011).

Another benefit package is surgical operations (from minor procedures such as surgical toilet to all major and specialized surgeries conducted by specialist surgeons) Hospital admissions is also one of the NHFI package whereby members

are entitlement to be admitted at grade 1&II wards for all your admission period subject to availability of a bed in such grades at the time of admission) or availability of such grades in the hospital (NHIF, Actuarial and Statistical Bulletin as of 30 June, 2011).

Physiotherapy sessions (Frequency as determined by the attending physician). Eye tests and Plain reading glasses**, (**except for bifocals) repeated every 3 years for principal members**.** Dental and oral health services which includes Tooth extraction, tooth refills maxillofacial surgeries such as cleft lip and pallet, dislocations and maxillary and mandible fractures fixation (NHIF, Actuarial and Statistical Bulletin as of 30 June, 2011)**.**

Medicines for opportunistic infections are also services provided for those who are HIV positive as well as other chronic diseases such as Diabetes and Hypertension etc. Retirees health benefits (includes comprehensive lifelong treatments for retired members and their spouses). This package started to be offered in July 2009 after amendment of NHIF act. NHIF also offers some of the medical and orthopaedic appliances such as implants, pair of auxiliary crutches, White cane, Neck collar Hearing Aid and Braces (NHIF, Actuarial and Statistical Bulletin as of 30 June, 2011).

Apart from the above benefit package there are also excluded Medical services which includes the following; Purchase of wheel chairs or prosthetic appliances, Illegal abortion, Illness arising from abuse of drugs and alcoholism, Cosmetic Surgery, Transportation of corpse(s), Public health care services undertaken by the Government, such as immunization, Subsistence allowances, Cost of transport to and

from health facilities, Food, Ambulance services, Clinical post-mortem services and Burial expenses and Mortuary services (NHIF, Actuarial and Statistical Bulletin as of 30 June, 2011).

The fund is mandatory for all civil servants, with benefits extending to their spouses and not more than four children or legal dependants. Furthermore the Fund amended its act to include other groups such as Students, Special group like priest, retirees and private individuals. This coverage is expected to expand gradually to become universal. Funding is obtained mainly from contributions by the employee and the employer; this constitutes an amount of 6% of the employee's salary (3% as a direct deduction and 3% as a contribution by the employer) (Bituro, 1999; NHIF, 2002) on monthly basis. For the case of other groups they pay their contributions annually (Students 50,400 each, Priest Tzs 100,000/= each, Private individual Tzs 964,800/=). The fund was implemented in 2001 and currently has a total of 1,353,266 members and a total of 6,225,022 beneficiaries (Humba, 2005). The fund has regional office in each region all over the country including one office in Zanzibar.

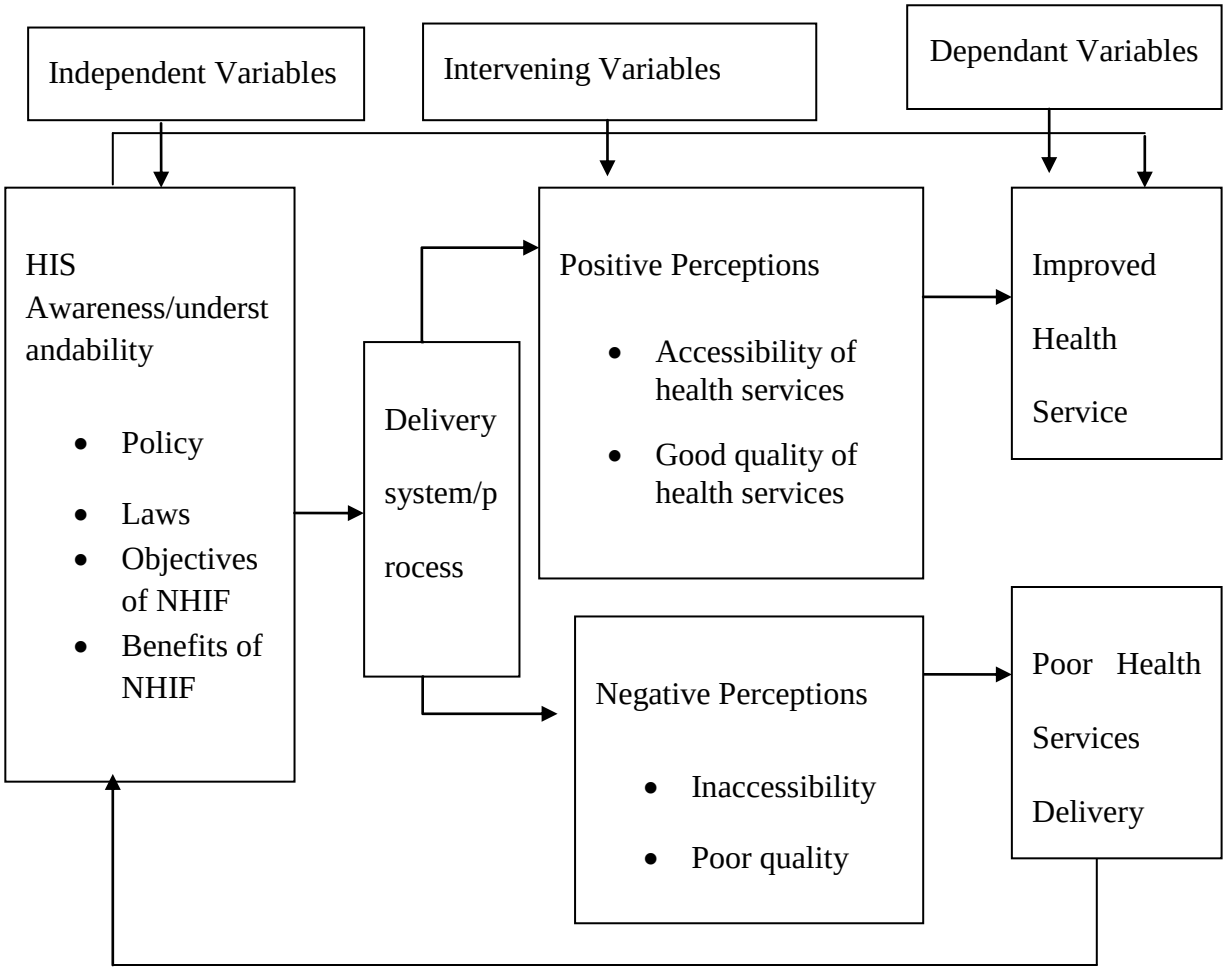
To date, the NHIF has reported a number of achievements. These include improved health services due to the payments being made to service providers from the fund, which have risen from 247.36 million Tanzania Shillings (Tsh) in 2002 to Tsh 42.7 billion in 2012. These moneys are meant to be used by service providers for curbing of drug shortages, renovation of hospital facilities and motivation of hospital staff. However, the scheme also faces many challenges, which include fraudulent tendencies and non-adherence to Ministry of Health (MOH) standards by service providers (Humba, 2005a; Humba, 2005b). A preliminary study by Quaye (2004)

also reported complaints of abuse and inferior services from NHIF members and lack of awareness on the part of service providers about the fund.

2.5 Conceptual Framework

From the literature review the researcher tries to explain the relationship between the variables as follows; the independent variables are the awareness and understandability of the NHIF scheme, intervening variables are the delivery systems and processes whereby dependent variables are the health services delivery. The health service delivery depends much on the understandability of the NHIF scheme among the actors. These include the awareness on the policy, laws, objectives and benefits obtained through the introduction of NHIF. Also the health services delivery can be intervened positively as well as negatively by delivery systems or process of the scheme. Figure 1 illustrates the relationships of the variables.

Figure 2.1: Conceptual Framework



Source: Researchers' Design, 2014

2.6 Research Gap

Review of the literature found no mention of the views of beneficiaries of health insurance scheme in high learning institutions. Perhaps this is because the concept of social health insurance is still relatively new in African countries and more attention is, therefore, being focused on the views of the general population for which the scheme is intended. This reinforces the need for more qualitative research to be done with the beneficiaries' views in mind.

Studies have been conducted on different aspects of health insurance schemes in Tanzania. In spite of those researches, little has been written on how do beneficiaries of health insurance schemes with different levels of education and variety of occupations perceive the effectiveness of the use of this modern health insurance scheme. Hence this study will focus on examining the perception of beneficiaries on the health insurance schemes towards health services delivery in Tanzania taking higher learning institutions staff in Dodoma Urban as a case study; by exploring the awareness of health insurance scheme, accessibility of health services by NHIF, and the quality of health services offered by NHIF.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Overview

This chapter describes the methods and materials that were employed in conducting the research. It described the study area, research design, data type and sources as well as sampling design, it gone on to explain the data collection methods, detailed field work, data processing, data analysis and presentation.

3.2 The Study Area

This study was conducted in Dodoma Urban and it included collection of data from higher learning institutions staff which are, University of Dodoma (UDOM), Institute of Rural Development Planning (IRDP), St Johns' University and College of Business Education (CBE). Among other reasons, Dodoma is selected due to presence of many higher Learning Institutions as the study focused on staff from those Institutions. These institutions have significant number of beneficiaries of NHIF health services. This helped the study to come out with sound findings and to avoid bias due to diversities that prevails as far as different institutions are concerned.

Furthermore, convenience with the study is another reason for selection whereas the researcher had easy access to different staff (both academicians and non-academicians) because researcher is working in Dodoma Urban.

3.3 Research Approach

When conducting a research it is necessary to determine which approach is being implemented, because "scientific inquiry in practice typically involves alternating between deduction and induction. Both methods involve interplay of logic and observation. And both are routes to the construction of social theories" (Babbie, 2010, p.53). In this study Qualitative research approach is used for formative, exploratory purposes with data gathered from only a small number of respondents. This is because the methods used such as in-depth interviews are time and labour intensive but also because a large number of people are not needed for the purpose of statistical analysis or to make generalizations from the results.

3.4 Research Design

Orodho (2003) defines research design as the scheme, outline or plan that is used to generate answers to research problems. In this study a case study approach was adopted in investigating the perception of beneficiaries on NHIF health services. A case study approach was taken into consideration an in-depth investigation into the underlying causes of negative perception among beneficiaries of the National Health Insurance Fund (particularly University staffs).

3.5 Type and Sources of Data

Both primary and secondary data was collected for the study. The primary data such as quality of services offered, awareness about the scheme, time taken to get services by using NHIF cards and quality of training provided by NHIF were obtained from health insurance beneficiaries to examine the effectiveness of its adoption, benefits

gained by beneficiaries of health insurance schemes, find out the challenges facing the health insurance schemes on provision of health services and explore suggested measures for improvement of health services offered by health insurance schemes. White (2002) defined secondary data as the data which being obtained from written documents or collected by other people for some other objectives, but are useful in the current study. Secondary data such as statistical reports, NHIF act and its amendments, brochures and other training materials were obtained from past studies, reports and journals either published or not to examine the perception of beneficiaries on health insurance schemes. For the purpose of achieving the objectives of the study secondary data were considered to be correct because most of them are permanent in nature, it costs less time and money to obtain.

3.6 Data Collection Methods

In carrying out this study data were collected through methods and tools in relation to specific objectives.

3.6.1 Interview

The interview was guided by interview guideline as a tool to obtain information from various beneficiaries of NHIF. This method was selected because it gives in-depth information about particular cases of interest to researcher and it is systematic, in the sense that researcher will intensively investigate a particular issue before moving to the next one (Kombo and Tromp, 2006). It was also given the researcher a complete and detailed understanding of the issue from the respondent by asking or investigating one respondent after the other on a particular issue before questioning the other. The data obtained through interview includes; level of awareness about

NHIF and other Insurance Schemes, extents of satisfaction for the services offered by NHIF, Accessibility in getting medical services using NHIF cards, quality of the services offered and opinion or suggestion on how to improve quality of services delivered.

3.6.2 Questionnaire Survey

The questionnaires were used as an important instrument of data collection to the respondents due to its strength of capturing empirical data in both informal and formal setting. Quantitative data were collected through the use of questionnaires. This is very popular method of data collections among researchers and was used because it saves time, given the fact that the study was subjected to time limit. Furthermore questionnaires were used due to the reason that they can be administered to a large number of respondents at a time (White 2002). Therefore, questionnaires placed less pressure to respondent for immediate response, and respondents had greater confidence in their anonymity and thus felt freer to express their views. In this study both closed ended and open ended question were used to save time and provide flexibility on providing opinions respectively. The data obtained through this tool includes; Level of education of respondents, proposed corrective measures, challenges encounter by beneficiaries, Degree of satisfaction, extent of awareness and quality of services delivered.

Table 3.1: Data collection Methods

Objectives	Methods	Tools	Respondents
Examine the effective adoption of health insurance schemes on provision of health services.	Survey	Questionnaire & Interview (Perception, awareness, accessibility of the services)	NHIF beneficiaries
Determine the benefits gained by beneficiaries of health insurance schemes	Survey	Questionnaire, Interview (Benefit Package & Quality of services)	NHIF beneficiaries
Find out the challenges facing the health insurance schemes on provision of health services	Survey Documentary review	Questionnaire & Interview (Policy or Implementation related)	NHIF beneficiaries
Explore suggested measures for improvement of health services offered by health insurance schemes	Survey Documentary review	Questionnaire & Interview (Availability of Drugs, Satisfaction of services, Act amendments)	NHIF beneficiaries

Source: Designed by Researcher, 2014.

3.7 Sampling Design

This refers to that plan that indicates how cases are to be selected for observation. Sampling designs are divided into two broad areas. These include probability design and non-probability design. The non probability design has four categories; these are simple random sampling, stratified sampling, systematic sampling and cluster random sampling. While non -probability sampling has got three categories which are quota sampling, convenience sampling and purposive sampling (Kombo and Tromp, 2006). In case of this study the researcher employed probability sampling especially simple random sampling was used for junior staff because it gives chance for each unit of the population to be selected as population has an equal chance of

being included in the study. Furthermore purposive sampling was used to interview Human resources officers from each higher leaning Institution.

3.7.1 Sampling Frame

Rwegoshora (2006) defines sampling frame as the complete list of all units or elements from which the sample is drawn. In this study sampling frame were the beneficiaries of NHIF services in higher learning institutions in Dodoma urban. Sampling frame is also called the working population because it provides the list that can be operationally worked with. However sample frame is not a sample but the operation definitional of the population that provides the basis for sampling.

3.7.2 Sample Size

Since the number of NHIF beneficiaries who uses health services is not known with certainty and keeps on changing every day, the study will employ the use of the formula for sample determination for infinite population. Following Kothari, (2004) the formula to be used will be as follows:

$$n = \frac{z^2 \cdot p \cdot q}{e^2}$$

Where;

n = sample size.

z = standard variant at a given confidence level.

σ = standard deviation of the population.

e = acceptable error (the precision).

For the unknown population and standard deviation below formula is used to calculate the sample size; according to Kothari, (2004) p= 0.5 will give **n** the maximum and the sample will yield at least the desired precision, where p is the sample proportion, **q= 1- p**, z is the standard variety at given confidence level (95% for the study) which 1.68 and the e = 10% for this study.

$$n = \frac{z^2 \cdot p \cdot q}{e^2}$$

$n = [(1.68)^2 \times (0.5) \times (0.5)] / (0.10)^2$

n = 68

Therefore sample size of 68 respondents was contacted for the study

3.8 Detailed Fieldwork

The researcher started by reporting to the NHIF Dodoma for self-introduction and approval in data collection. In addition to that the research had to seek clearance letter from University of Dodoma and that letter was handled over to Regional Commissioner and District commissioner as far as protocol is concerned. The researcher also had to set the means of reaching the required respondents by introducing the objectives of the study to beneficiaries so that they understood it clearly and became willing to respond.

3.9 Data Processing

Data processing refers to the process of converting data from one format to another. It transforms plain data into valuable information and information into data. Clients can supply data in a variety of forms, be it. Excels sheets, audio devices, or plain printed material. Data processing services take the raw data and process it accordingly to produce sensible information. Data consists of facts and figures, based on which important conclusions can be drawn. Data processing ensures that the data is presented in a clean and systematic manner and is easy to understand and be used for further purposes. In processing data researcher applied five steps, these are; editing this is the process of extracting data in order to discard the inappropriate data and retain relevant data.

Coding refers to the process of aligned the data into a particular system for the purpose of making it more sensible and usable for further use. The method of coding ensures just that and arranges data in a comprehendible format. The process is also known as netting or bucketing. Data entry is another step in Data processing which is done after the data being properly arranged and coded was entered into the software that performs the eventual cross tabulation

Validation Data; validation refers to the process of thoroughly checking the collected data to ensure optimal quality levels. All the accumulated data were double checked in order to ensure that it contains no inconsistencies and is utterly relevant. Tabulation this is the final step in data processing. The final product i.e. the data is tabulated and arranged in a systematic format so that it can be further analyzed.

3.10 Data Analysis

Data Analysis is the process of systematically applying statistical and/or logical techniques to describe and illustrate, condense and recap, and evaluate data. According to Shamoo and Resnik (2003) various analytic procedures "provide a way of drawing inductive inferences from data and distinguishing the signal (the phenomenon of interest) from the noise (statistical fluctuations) present in the data".

While data analysis in qualitative research can include statistical procedures, many times analysis becomes an ongoing iterative process where data is continuously collected and analyzed almost simultaneously. Indeed, researchers generally analyze for patterns in observations through the entire data collection phase (Savenye, Robinson, 2004). The form of the analysis is determined by the specific qualitative approach taken (field study, ethnography content analysis, oral history, biography, unobtrusive research) and the form of the data (field notes, documents, audiotape, and videotape).

An essential component of ensuring data integrity is the accurate and appropriate analysis of research findings. Improper statistical analyses distort scientific findings, mislead casual readers (Shepard, 2002), and may negatively influence the public perception of research. Integrity issues are just as relevant to analysis of non-statistical data as well. The data were finally verified, and then analyzed by using Statistical Package for Social Science (SPSS) version 16.

3.11 Results Presentation

Data can be presented as text, in a table, as a chart, diagram or graph. Graphs are useful for indicating trends and making broad comparisons, or showing relationships. Graphs should be self explanatory without the necessity for the reader to refer to the text. (Charles Strut University, 2000) Tables are better than graphs for giving structured numeric information. The table should be self explanatory. The title should be informative and rows and columns of tables should be clearly labeled. (Charles Strut University, 2000). In the study, the analyzed data were presented by using frequency tables, pie charts and figures.

3.12 Reliability and Validity

Researchers performing analysis on either quantitative or qualitative analyses should be aware of challenges to reliability and validity. For example, in the area of content analysis, Gottschalk (1995) identifies three factors that can affect the reliability of analyzed data: First; Stability, or the tendency for coders to consistently re-code the same data in the same way over a period of time. Secondly, reproducibility, or the tendency for a group of coders to classify categories membership in the same way. Lastly, accuracy, or the extent to which the classification of a text corresponds to a standard or norm statistically. The potential for compromising data integrity arises when researchers cannot consistently demonstrate stability, reproducibility, or accuracy of data analysis

According Gottschalk (1995), the validity of a content analysis study refers to the correspondence of the categories (the classification that raters' assigned to text content) to the conclusions, and the generalizability of results to a theory.

Reliability is concerned with whether the measure used in a research will yield the same results in different occasion (deductive approach) or if it can provide similar observations if done by different researchers on different occasion (inductive approach). According to Bogdan and Biklen, 1992 reliability is essentially about the degree of accuracy and comprehensiveness of coverage, as well as consistency of which repeated measures produce the same results across time and observers. For the purpose of ensuring reliability the researcher had to observe anonymity in all stages of the research. Furthermore, the researcher introduced a high degree of structure so that different respondents did not generate different responses to the same question.

Validity is concerned with whether the instrument used in the study measures what it is intended to measure. In ensuring validity of the data all necessary factors were taken into consideration. It is, therefore, the extent to which scores on a test enables one to make meaningful and appropriate interpretations (Aryl, 2010). This consisted taking into account historical perspective, testing of the response given by the respondents, uses of modern instruments such as tape recorder, digital camera etc, Clearance of causal relationship between variables and generalisability of the case depending as whether it is peculiar or typical.

CHAPTER FOUR

DATA PRESENTATION, ANALYSIS AND DISCUSSION

4.1 Introduction

This chapter serves the purpose of data presentation, analysis and discussion of the research finding. The data obtained for this study was largely analyzed qualitatively. Where necessity dictated otherwise, tables and simple descriptive statistics such as percentage were employed. Data presentation and analysis was guided by the research objectives and questions. Discussion of research findings was informed by the theoretical framework that has already been discussed in Chapter Two. The chapter is divided into two major parts. The first of which is this introduction. The second part is data presentation and analysis where research findings of the study are discussed.

4.2 Data Presentation and Analysis

The present study was set to achieve three specific research objectives. The first one was to examine the beneficiaries' awareness on health insurance scheme following the introduction of NHIF. The second objective was to explore the NHIF beneficiaries' perceptions on the accessibility and quality of health services between patients with health insurance cover and those without. The third objective was to determine the challenge from beneficiaries' perspective facing NHIF towards accessible and quality delivery of health services. To achieve the above research objectives three research questions were devised to guide data collection. The first question was: *To what extent do beneficiaries of health insurance schemes aware of*

the introduction of NHIF services? Secondly, *How do health services been accessible to NHIF beneficiaries?* Thirdly, *what are the challenges facing by NHIF towards accessible and quality delivery of health services?* The data for this study were collected through questionnaires and interviews. Both data collection instruments had questions that were devised in a way that enabled the researcher to collect data that could achieve the objectives of the study. Data was also summarized in tables, pie charts and histograms for clear presentations and interpretation.

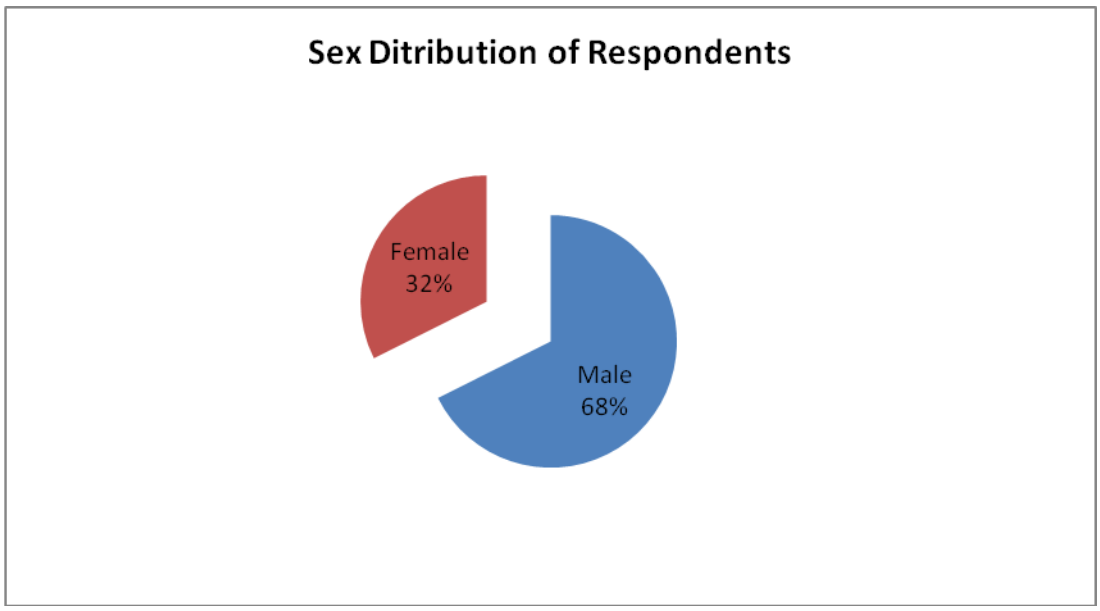
4.3 Profile of Respondents

There were three categories of information which helped to describe profile of respondents involved in the study. These were mainly biographical data of respondent and they were seen to be very important because they helped to get clear understanding regarding the characteristics of the respondents. The three categories of biographical information include sex distribution, age distribution and education pattern of respondents.

4.3.1 Sex Distribution of Respondents

For the purpose of ensuring that both men and women involved in the present study, sex of respondents was used. Data as illustrated in Figure 4 below, the number of male respondents 67.6% (46) was higher than that of female respondents 32.4% (22). This owed to the fact that there were more male respondents than female ones due to historical tendency of men outnumbering women in different institutions be it in public or private organizations. Nevertheless, this did not harm the kind of responses acquired from the study area because there were no gender specific issues that needed specific attention.

Figure 4.1: Sex Distribution of Respondents



Source: Field Data, 2014.

4.3.2 Age Distribution of Respondents

Determining the state of age distribution among respondents involved in this study was very important because the study was set to seek opinions and views from people of different ages hence gain more insight on their experiences. As indicated in table 2 below, data from the study area indicates that the number of respondents at age between 25-30 years was higher than others age group with 44.1%(30) of all 68 respondents involved in the study.

Table 4.1: Age Distribution of Respondents

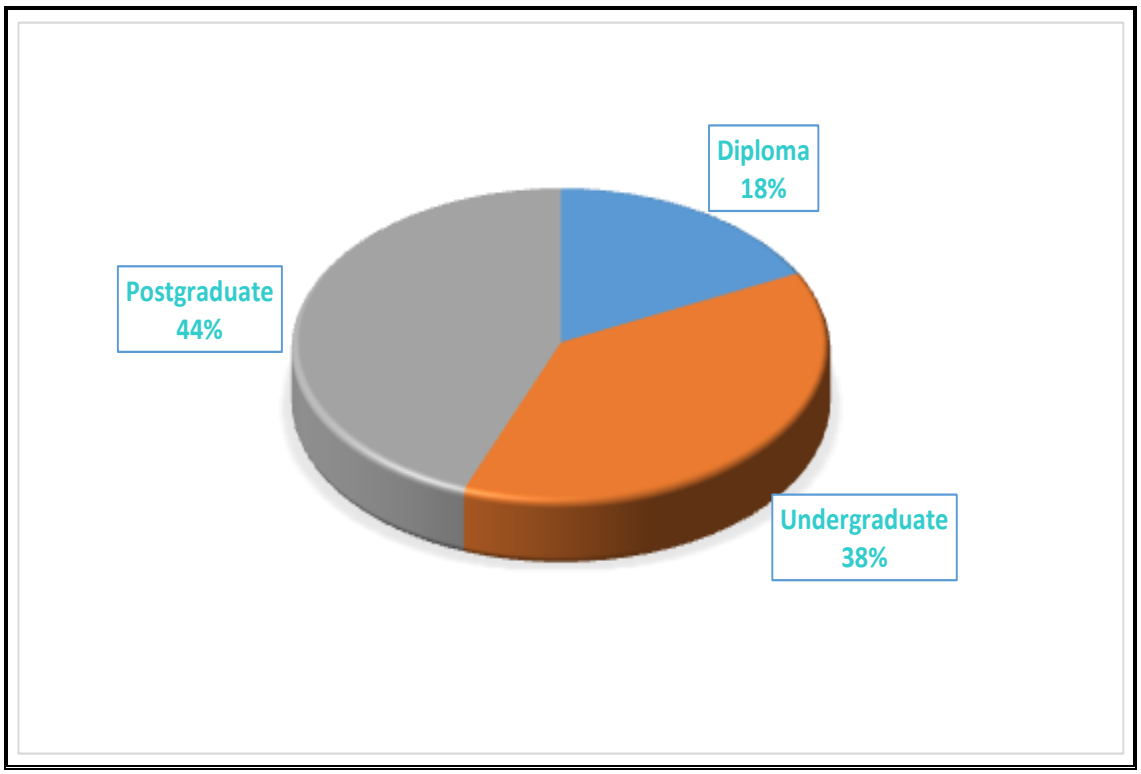
Age of Respondents	Frequencies	Percentage
18-25 years	4	5.9%
25-30 years	30	44.1%
30-40 years	26	38.2%
40-50 years	6	8.8%
Over 50 years	2	2.9%
Total	68	100%

Source: Field Data, 2014.

4.3.3 Education Pattern of Respondents

Data regarding education pattern of respondents were collected in order to help in assessing their responses in relation to how they may perceive the accessibility and quality of health services in different health facilities. As presented in Figure 2 below, respondents with postgraduate level of education were higher with 44% (30) compared to the rest.

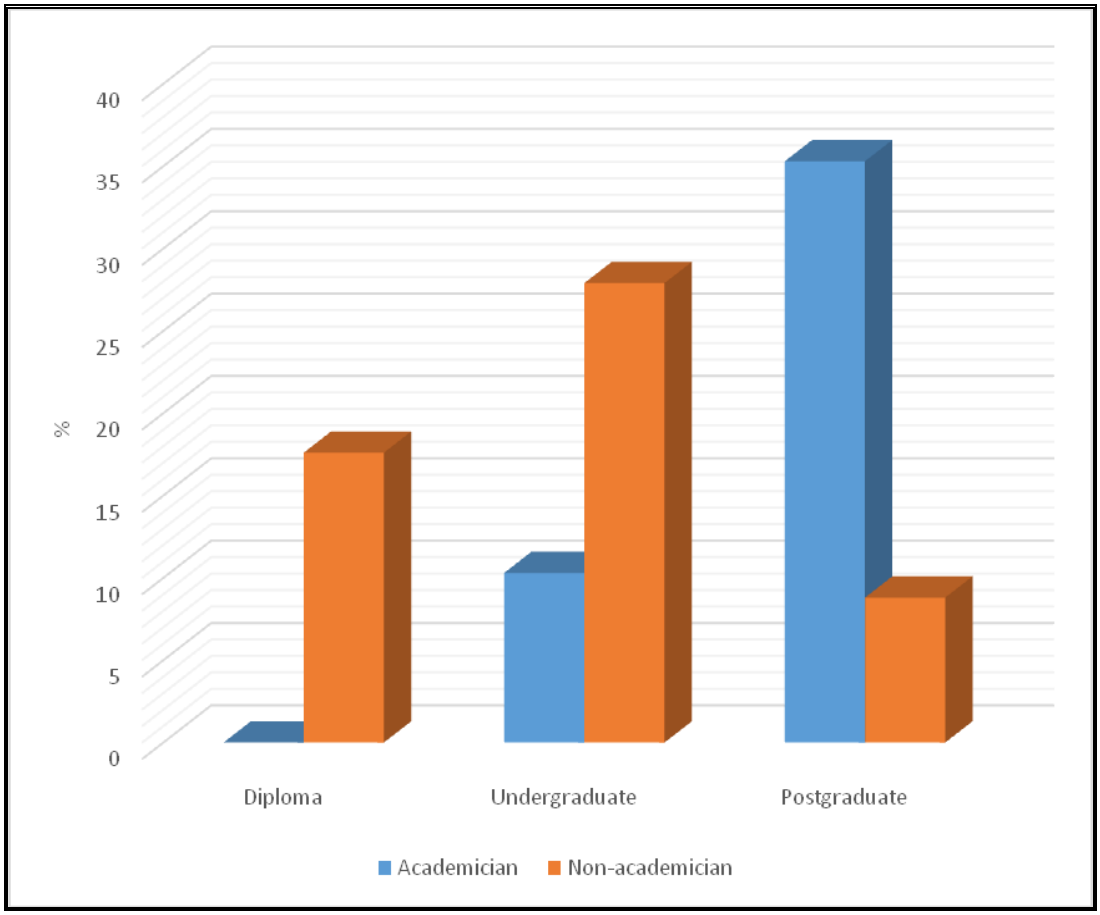
Figure 4.2: Level of Education



Source: Field Data, 2014.

From the data presented in the figures 3 below, it appears that the findings of the present study did comprise responses from respondents with different levels of education which was an important variable for researcher to consider contextual limitations and self awareness of respondents regarding the topic at hand.

Figure 4.3: Level of Education vs Occupation Pattern



Source: Field Data, 2014.

4.4 Analysis of Questionnaires and Interview

The findings obtained from Questionnaires and Interview in this study has been divided into three major categories. These are level and extent of awareness among respondents, Accessibility and Quality of Health services among NHIF beneficiaries and Challenges facing by NHIF towards accessible and quality delivery of health services.

4.4.1 Level and Extent of Awareness among Respondents

Awareness creation is meant to convey the knowledge and skills that will contribute to alleviating poverty, changing livelihoods, improved environment and having a positive effect on the national economy. In conducting this different avenue may be used such as Advocacy, Workshop, Media (press releases and talk shows) and exhibitions. It was the first objective of this study to examine the beneficiaries' awareness on health insurance scheme particularly among higher learning institutions staff in Dodoma region. In assessing awareness it was observed that only 16.2% of all respondents are very knowledgeable about health insurance scheme in Tanzania. This implies that most of beneficiaries of NHIF are not aware about the scheme. In other words there is a need of investing much in providing education to members and other beneficiaries of NHIF. Table 4 below depict cross tabulation of awareness vs number of years in the scheme

Table 4.2: Cross Tabulation of Awareness vs Years in the Scheme

Responses	**1 - 4 years**	**5 - 10 years**	**Above 10 years**	**Total**
Very knowledgeable	2 (2.90%)	6 (8.80%)	3 (4.40%)	11 (16.20%)
Somewhat knowledgeable	15 (22.10%)	5 (7.40%)	3 (4.40%)	23 (33.80%)
Moderate knowledgeable	22 (32.40%)	10 (14.70%)	1 (1.50%)	33 (48.50%)
Poorly knowledgeable	1 (1.50%)	0 (0.00%)	0 (0.00%)	1 (1.50%)
Not Knowledgeable at all	0	0	0	0
Total	**40 (58.80%)**	**21 (30.90%)**	**7 (10.30%)**	**68 (100.00%)**

Source: Field Data, 2014.

Another indicator that was used to assess awareness of health Scheme was to determine preference of type of scheme among staff of higher learning institutions. Data revealed that despite the fact that members are not aware of health insurance they prefer much to be covered under National Health Insurance Fund scheme by (72%). This has been shown clearly in table 5 below.

Table 4.3: Preference of Type of Scheme

Responses	**Frequency**	**Percentages**
NHIF	49	72.1
CHF	1	1.5
AAR	13	19.1
Strategy	1	1.5
Others	4	5.9
Total	**68**	**100.0**

Source: Field Data, 2014.

Due to lack of awareness among NHIF members it was further observed that it took them very long period of time to get membership card. Table 6 below shows that there were only 17.6% respondents who got their membership card within a month. While best practice in NHIF office requires member to be issued with membership card within three weeks from the time of filling application form.

Table 4.4: Period of Time Taken to Get Membership Identification Card

Responses	**Frequency**	**Percent**
Within a month	12	17.6
Within three months	34	50.0
More than three months	22	32.4
Total	**68**	**100.0**

Source: Field Data, 2014.

Furthermore awareness among staff from higher leaning institutions in this study has been measured in terms of extent on which members get updated information regarding NHIF services. Data revealed that only 11.8% of all respondents get regularly information about NHIF. This data also answer the question as to why many members are not knowledgeable about Health insurance Scheme, because they are not informed regularly.

Table 4.5: The Extent of Getting Updated Information Regarding NHIF Services

Responses	**Frequency**	**Percent**
More Regularly	0	0
Regularly	8	11.8
Somewhat regularly	23	33.8
Irregularly	14	20.6
Not at all	23	33.8
Total	**68**	**100.0**

Source: Field Data, 2014.

4.4.2 Accessibility and Quality of Health Services among NHIF Beneficiaries.

It was important to analyse accessibility and quality of Health services among NHIF beneficiaries. This is because one could not talk about how NHIF members perceive the quality of health services without analyzing it thoroughly. Data from the study are obtained through questionnaire denote that it is less than fifty percent of all respondents who use NHIF membership card every time i.e 47.6% .The rest use their card depending on the other factors as shown in Table 8 below. This implies that the access and quality of health services is not good among NHIF beneficiaries.

Table 4.6: The Habitually Uses of Health Insurance Card to Obtain Health Services

Responses	Frequency	Percent
Every time	30	47.6
At referral level facilities	3	4.8
If the cost of health services is high (expensive)	11	17.5
When asked	9	14.3
Never at all	10	15.9
Total	**63**	**100.0**

Source: Field Data, 2014.

The data presented above revealed that more than 50% of respondents use Health insurance card after being influenced with other factor and not the quality of service rendered.

During interview session one administrative officer from one of the higher leaning institutions quoted remarking that " *I am not using NHIF card at all when I am in Dodoma, I always use it when seeking medical service at Dar es salam especially at referral facilities like Muhimbili. Orthopaedic Institute (MOI)*. That is to say the quality of health services rendered through NHIF is not promising to their beneficiaries.

Another question that was used to assess the quality of Health services was how long it takes to acquire health services by using NHIF card. In this area also it was observed that members acquire medical services very delaying by 69.4%. Table 9 below shows in details how NHIF beneficiaries acquire Health services through NHIF card

Table 4.7: Duration Taken to Acquire Health Services Using Health Insurance Card

Responses	Frequency	Percent
Short time	12	19.4
Few minutes	7	11.3
Very delaying	43	69.4
Total	**62**	**100.0**

Source: Field Data, 2014.

It was also obvious to find out that the extent of satisfaction among NHIF beneficiaries was not promising at all. Data obtaining from the study revealed that only one respondent declared that he (she) is highly satisfied with the services provided by NHIF. Many respondents about 60% are satisfied but at low extent, which implies that something must be done to improve the quality of services rendered by NHIF. Table 10 below shows in details the extent to which NHIF beneficiaries satisfied with the services provided by NHIF.

Table 4.8: The Extent of Satisfaction among NHIF Beneficiaries

Responses	Frequency	Percent
Highly satisfied	1	1.5
Somewhat satisfied	21	30.9
Satisfied	21	30.9
Unsatisfactory	18	26.5
Very poor	7	10.3
Total	**68**	**100.0**

Source: Field Data, 2014.

4.4.3 Challenges Facing by NHIF towards Accessible and Quality Delivery of Health Services

From the study it was observed that from beneficiary's perspective NHIF is facing many challenges as far as rendering of services is concerned. The first big challenge is lack of education and awareness among NHIF beneficiaries. This challenge has been already discussed in part 4.4.1 of this report. Furthermore this can be witnessed in table 11 and 12 below which shows number of members who have got training on NHIF and how they rate that training respectively. Table 11 highlighted that there were only 17.6% of all respondents who undergo formal training regarding services offered by NHIF.

Table 4.9: Have You Been Trained on the Services Provided by NHIF Scheme?

Responses	**Frequency**	**Percent**
Yes	12	17.6
No	56	82.4
Total	**68**	**100.0**

Source: Field Data, 2014.

Despite the fact that few members were attending training but many of them were not satisfied with that training. This can be viewed in Table 12 whereby about 25% of respondents rated the training poor and only 35% satisfied with that training.

Table 4.10: Rating of the Training

Responses	Frequency	Percent
Excellent	1	4.2
Very good	2	8.3
Good	7	29.2
Satisfactory	8	33.3
Poor	6	25.0
Total	24	100.0

Source: Field Data, 2014.

The second challenge is deteriorating of the quality of services provided to NHIF beneficiaries in comparison between before and after introduction of NHIF scheme. Data presented in Table 11 below depict the views of respondents regarding deteriorating of health services. From the data obtained there were only 37% of respondents who witnessed that the quality of health service is highly improved and improved. That means more than 60% of all respondents complain that the quality of services is either remained constant or deteriorating.

Table 4.11: Comparison of Quality of Health Services Before and After the Introduction of NHIF

Responses	Frequency	Percent
Very deteriorated	5	7.7
Deteriorated	17	26.2
Remained constant	19	29.2
Highly improved	4	6.2
Improved	20	30.8
Total	**65**	**100.0**

Source: Field Data, 2014.

Another big challenge observed in this study is unsatisfactory deliverance of Health services to NHIF beneficiaries. Through the questionnaire responded by all selected

sample it was revealed that only 44% of respondents pointed out that the services provided are either very good or good. Most of respondents fall in the category of satisfactory which is 35.3%, of which is not promising to the Fund. Table 12 below depicts how respondents rated the services rendered by NHIF.

Table 4.12: Rating of the Services provided by NHIF

Responses	**Frequency**	**Percent**
Very good	7	10.3
Good	23	33.8
Satisfactory	24	35.3
Poor	14	20.6
Very poor	0	0
Total	**68**	**100.0**

Source: Field Data, 2014.

Shortage of Drugs is another big challenge reported by respondents. About 77% of all respondents pointed out that the shortage of Drugs/Medicine is a big challenge in many accredited facilities. Table 15 below shows views of respondents regarding availability of Drugs/Medicine in those facilities accredited by NHIF.

Table 4.13: Availability of Drugs and Medical Supplies

Responses	**Responses**		**Percent of Cases**
	N	**Percent**	
Shortage of drugs and medicine/not reliable	43	76.8	78.2
NHIF members provided with low quality medicine	3	5.4	5.5
In most health facilities drugs and medicine are available	8	14.3	14.5
Supply of medical is bias to NHIF members	2	3.6	3.6
Total	**56**	**100.0**	**101.8**

Source: Field Data, 2014.

4.5 What Can Be Done to Make Establishment of NHIF to Be More Meaningful

With regards to the need to overcome challenges pointed out by respondents, the question was posed to help to grasp the opinion and perception of respondents regarding what can be done so as to make the establishment of NHIF more meaningful. Data from the study area shows that there were multiple responses from respondents whereby issues were divided into two main categories. These are strength to be developed and weakness to overcome. Regarding the strength to be developed about fourteen (14) issues were pointed to be given consideration in the course of helping NHIF to perform more professional.

As presented in Table 16 below out of fourteen (14), five (5) issues were pointed out by more than five (5) respondents which is above 10% .These include the following; To undergo training to acquire more knowledge, Equal treatment (not discriminate NHIF patients), Other family member/dependants be covered in NHIF, Improved health care and Medical supply should be improved. The rest of issues were pointed out by less than five respondents but they are strong because they show importance of investing in education to NHIF members and beneficiaries.

Table 4.14: Strengths to be developed

Responses	Responses		Percent of Cases
	N	Percent	
Include typhoid examination and treatment in the NHIF services	1	1.9	2.2
NHIF representative in hospitals to control situation	3	5.7	6.5
Equal treatment(not discriminate NHIF patients)	8	15.1	17.4
Other family member/dependants be covered in NHIF	8	15.1	17.4
Keep it up/Improved health care	6	11.3	13.0
Membership cards should be available as early as possible	1	1.9	2.2
Medical supply should be improved	5	9.4	10.9
Private hospital are more committed than government	1	1.9	2.2
Improve customer care to patients	4	7.5	8.7
Timely bounded on providing the services to patients	2	3.8	4.3
Evaluation of services provided by patients	1	1.9	2.2
To undergo training to acquire more knowledge	11	20.8	23.9
To establish national standards based upon best practices	1	1.9	2.2
NHIF should make payment on time	1	1.9	2.2
Total	**53**	**100.0**	**115.2**

Source: Field Data, 2014.

Another area which has been addressed by respondents especially through open ended questionnaire is weakness to overcome. Under this fifteen (15) issues were pointed out by respondents as shown in Table 17 below. Out of those fifteen issues, seven (7) issues were pointed by more than six (6) respondents which is more than 10% as far as percent of cases is concerned. These are Improve services/quick services, NHIF beneficiaries and non-beneficiaries should be treated equally,

Improve customer care, More training, Increase services restricted to NHIF and Membership card should be issued timely.

Table4.5: Weakness to be Overcome

Responses	**Responses**		**Percent of Cases**
	N	**Percent**	
NHIF beneficiaries and non-beneficiaries should be treated equally	10	14.1	19.6
Improve services/quick services	12	16.9	23.5
Payment of debit of health services providers on time	3	4.2	5.9
Introduce services to many health facilities	3	4.2	5.9
Increase number of beneficiaries	2	2.8	3.9
Ensure availability of qualified health personnel	2	2.8	3.9
Improve customer care	8	11.3	15.7
Increase services restricted to NHIF	6	8.5	11.8
Transparency especially in drug prices	1	1.4	2.0
More training	7	9.9	13.7
Close supervision/evaluate health facilities	6	8.5	11.8
Availability of medicine and drugs	3	4.2	5.9
Membership card should be issued out timely	6	8.5	11.8
NHIF should own hospitals	1	1.4	2.0
Same services offered from one region to another	1	1.4	2.0
Total	**71**	**100.0**	**139.2**

Source: Field Data, 2014.

It is important to note that three items from each category receive significant attention by majority of respondents as they were pointed by about more than ten percent of the total number of respondents. These issues included the following: To undergo training to acquire more knowledge, Equal treatment (not discriminate NHIF patients) and other family member/dependants be covered in NHIF, for the case of strength to be developed. While for the case of weakness to overcome includes Improve services/quick services, NHIF beneficiaries and non-beneficiaries should be treated equally and Improve customer care.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents the summary of the study, conclusion and recommendations springing from the findings guided by the research objectives and questions. The chapter is divided into five sections; introduction, summary of the study, summary of the findings, conclusion and recommendations which is divided into: policy-based recommendations as well as recommendations on areas for further studies.

5.2 Summary of the Study

The present study was designed to analyses perception of beneficiaries on Health Insurance services offered by NHIF, a case of Higher Learning Institutions Staff in Dodoma Regional. It is important to assess the perception of beneficiaries especially for those who are at higher leaning institutions due to their level of understanding for the purpose of analyzing how Millennium Development Goals are achieved so far, taking into consideration that we are approaching 2015. Furthermore we have to take into account that out of eight Millennium Development Goals three are health related issues.

There were three specific objectives of the study which were set to address the overall objectives stated above. The first task was to examine the beneficiaries' awareness on health insurance scheme following the introduction of NHIF. The second objective was to explore the NHIF beneficiaries' perceptions on the

accessibility and quality of health services between patients with health insurance cover and those without. The third objective was to determine the challenge from beneficiaries' perspective facing NHIF towards accessible and quality delivery of health services.

In addressing the above objectives, three research questions were devised as follows; the first question was: To what extent do beneficiaries of health insurance schemes aware of the introduction of NHIF services? Secondly, how do health services been accessible to NHIF beneficiaries? Thirdly, what are the challenges facing by NHIF towards accessible and quality delivery of health services? Since the study was field based, then the assessment on the perception of beneficiaries on the health insurance services was done in their field work settings. This study was conducted in Dodoma Municipality whereby different staffs from Higher Learning Institution in Dodoma were involved in responding Questionnaires and Interview Guide. The study employed descriptive research design, using semi structured interview, questionnaire survey, observation and focus group discussion as the methods of collecting data from the sampled respondents.

5.3 Summary of the Findings

The study came up with a number of major findings following research tasks as far as the research questions were concerned. The first task was to examine the beneficiaries' awareness on health insurance scheme following the introduction of NHIF. The research question that guided this task was, to what extent does beneficiaries of health insurance schemes aware of the introduction of NHIF services? The findings showed that about 50% of all respondents are not aware on

the introduction of NHIF scheme. Lacking of formal training as well as regularly updating on various issues introduced by NHIF made most of beneficiaries not to understand how NHIF offered services to its members and other beneficiaries, despite the fact that it is in operations for more than ten years now.

How do health services been accessible to NHIF beneficiaries was the second guiding research question that fulfill the need of the researcher on understanding how services are delivered to NHIF beneficiaries by using accredited facilities scattered all over the country. The essence here was to find out accessibility and quality of those services. The study revealed that many beneficiaries receive services very delaying and without satisfying much. It was further revealed that most of NHIF members use their membership card through the influence from other factors, other than the quality of services such as if the cost of health services is high or when asked by service providers.

The third task of the present study was to determine the challenge from beneficiaries' perspective facing NHIF towards accessible and quality delivery of health services. This was done in order to look for chances that need to be worked on towards improvement of services. The study revealed that many challenges can be addressed by the Management of the Fund especially through educating all stakeholders and intervention on the delivery of services in the accredited health facilities. Furthermore aggressive measures should be taken by the management of the Fund to make sure those Drugs/medicines or medical consumables are available all the time in each facility level, taking into consideration that more than 60% of all medical services fall under medicine and consumables.

5.4 Conclusion

From the discussed context of this study, the claim can be made that there has been successfully accomplishment of the research objectives. It can therefore, be concluded that there is lack of awareness in a greater extent among NHIF beneficiaries. Despite the fact that staff from higher learning Institution are in a better position of becoming aware on not only health related issues but even other crucial issues, they are not aware for more than 50%. This poses the need for the management of the Fund to invest much in providing training to its members and service providers.

Empirical data identified that despite the fact that more than 70% of respondents prefer much NHIF scheme compared with other schemes of Insurance and 44% rated NHIF services either very good or good, there was unsatisfactory rendering of NHIF services to beneficiaries. This suggested the need for improving means of delivering those services by addressing or overcoming those challenges which hinder proper provision of Health services.

While we are approaching final year of implementing Millennium Development Goals i.e 2015, the management of NHIF should take serious measures in addressing those challenges pointed out by respondents so as to achieve those goals especially health related, efficiently. Nevertheless, it has been proved in this study that despite of fall in the quality of education countrywide, staff from higher learning institutions remain potential stakeholders for the providing of good advice in eradicating some of problems faced by the Tanzanian citizens.

In this study it has been observed that accessibility of health services under health insurance scheme is slowed down by the following main factor; long time taken to get membership identification card and duration taken to acquire health services using health insurance card. This implies that the access and quality of health services is not good among NHIF beneficiaries. This has been witnessed by habitual uses of health insurance cards, whereby many beneficiaries tend to use their cards by influencing with other factors, other than quality of services, such as expensiveness of the services or when asked by service providers.

5.5 Recommendations

In this study it has been emphasized that government which own more than 80% of all accredited facilities should take corrective measures to eliminate any form of discrimination especially to NHIF beneficiaries so as make more meaningful the introduction of this scheme in the Country. Furthermore the management of NHIF should intervene the provision of Health services for the purpose of improving services and addressing those pointed challenges. This has remained to be the most important credit that can be pointed out for the reasons why staffs from higher leaning institutions are very useful in the struggles to improve health services in Tanzania. For that reason, two types of recommendations are provided as follows;

5.5.1 Policy-Based recommendations

To improve the quality of Health service is among the plans of the Tanzania government through the use of National Health Insurance Fund apart from other institutions. In order to reach the target successfully, the government and the Management of NHIF should consider the followings;

(i) Addressing the challenges that hinder smoothly provisions of Health services within those accredited health facilities.

(ii) Reviewing the Health policy so as to make Community Health Fund to be Compulsory to every citizen who falls under informal sector of employment in order to reach universal coverage.

(iii) NHIF should increase number of dependants through the introduction of membership plus to those members who wish/intend to register more beneficiaries in the scheme.

5.5.2 Recommendations for Further Studies

The study recommends for further studies be conducted to enrich the available literature on the perception of beneficiaries on Health Insurance Services offered by NHIF. The Ares for further studies include:

a) The perception of beneficiaries on Health Insurance Services offered by NHIF for the case of members who are living peripheral area.(Villagers)

b) The influence of political leaders in improving the quality of Health services especially those provided by National Health Insurance Fund.

c) Capacity of local government authorities to monitor or control the provision of Health services in their areas.

REFERENCES

AHRQ, (2007), *"Questions and Answers about Health Insurance": A Consumer Guid*e. August 2007.

Akal, A. and Harvey, R. (2001), "The Role of Health Insurance and Community Financing in Funding Immunization in Developing Countries", *Final Paper*, Geneva, WHO.

Alderson, P. (1998), *The Importance of Theories In Health Care*, British Medical.

Alejandro, P. and William, H. (2005*), The Informal Economy: Willingness to Pay for Community Health Fund Card Handbook of Economic Sociology*, 2nd Edition, Russell Sage Foundation.

Bennet, C. (2004), *Dictionary of Insurance* 2nd ed, London: Prentice Hall.

Bennett, S., A. Kelley, (2004), 21 Questions on CBHF: *An Overview of Community-Based Health Financing*, PHR plus.

Bennett. S, Creese, A. Monasch, R. (1998), *Health Insurance Schemes for People outside Formal Sector Employment.* Geneva: World Health Organization;

Bonu, S., R. Manju, (2003), *"Using Willingness to Pay to Investigate Repressiveness of User Fees in Health Facilities in Tanzania,*" Health Policy and Planning.

Bump, J., Coleman, N., Frost, L., Hozum, D., Michael R., (2010), *The Long Road to Universal Health Coverage*.

Burns, M. and M. Mantel, (2006), *Tanzania Review of Exemptions and Waivers*, Report submitted to the Ministry of Health by the Euro Health Group.

Carrin, G., Mathauer,I., Xu,K and Evans D.B et al. (2008), "Universal Coverage of Health Services: Tailoring Its Implementation." *Bulletin of the World Health Organization*, 86(11): 817–908.

Carrin, G. (2003), *Community Based Health Insurance Schemes in Developing Countries*: Facts, problems and perspectives. Discussion Paper No. 1-2003, Geneva, WHO.

Carrin, G., Waelkens, M. (2005), "*Community-Based Health Insurance in Developing Countries:* A Study of Its Contribution to the Performance of Health Financing Systems," Tropical Medicine and International Health.

Ekman, B. (2004), "Community-Based Health Insurance in Low-Income Countries: a Systematic Review of the Evidence," *Health Policy Plan Journal*, UK.

Hsiao, W. and Shaw, R. P, (2007), *Social Health Insurance for Developing Nations*. Washington: The World Bank; 2007.

Kelley, A. G., F. Diop, E. (2006), Approaches to Scaling up Community-Based Health Financing Schemes. USA, PHR plus.

Laterveer, L., M. Munga and Schwerzel,P.(2004), *Equity Implications of Health Sector User Fees in Tanzania*: Do We Retain the User Fee or Do We Set the User Fee Leusden, Netherlands, ETC Crystal for REPOA.

Lowe, R. (1997), *Consumer Education and Economics*.4th ed, New York, Glencoe

Manzi, F. (2005), *Experience of Exemptions and Waiver Mechanisms in Kilombero District*, Satellite Workshop on Health Insurance, Dar es Salaam, MoHSW.

Mhina, L. G. (2005), *Factors Contributing to High Drop-Out of CHF Members in Nzega District*, University of Dar es Salaam, Master of Public Health.

MDG, (2000), *What has been Achieved*, World Summit, Geneva.

MoH, (1999), *Community Health Fund (CHF) Operations Guidelines*, URT.

MoH, (1999), C*ommunity Health Fund* (CHF), Design, URT.

MoH (1999), *Community Health Fund: District Health Plan Model*, Dar Es Salaam, Ministry of Health.

MoH (2000), *Community Health Fund Design in Urban and Peri-Urban Areas*, Dar es Salaam, MOHSW.

MoH, (2003), *Assessment of CHF in Tanzania: Factors Affecting Enrolment and Coverage*. Second Draft Report.

MoH, (2003), Assessment of CHF in Tanzania: Factors Affecting Enrolment and Coverage. Dar es Salaam.

Mtei, G and Mulligan, J. (2007), *Community health Fund in Tanzania: a Literature Review; Ifakara Health Research and Development Centre*, Morogoro.

Shirima, R. M. (1999), *Community health fund in Tanzania*, MoH, Dar Es Salaam.

NHIF, (2011), *Actuarial and Statistical Bulletin as of 30 June*, 2011.

Preker, A. Carrin, G. Jakab, M. Krishnan, C. (2004), "Review of the Strengths and Weaknesses of Community Financing", In: PrekerA, CarrinG, editors. *Health Financing for Poor People*: Resource Mobilization and Risk Sharing. Washington, DC: World Bank; 2004. p. 53-117.

Preker, A. Carrin, G, (2004), *Health Financing for Poor People: Resource Mobilization and Risk Sharing*, Washington: The World Bank.

Dr. J. S. Baradyana, & Prof. A. M. Ame, (2007), *Business Research Methods*, University of Dar es Salaam Press, Dar es Salaam.

Soors, W.,Devadasan, N., Durairaj,V. and Criel, B. (2010), "Community Health Insurance and Universal Coverage: Multiple Paths, Many Rivers to Cross". *World Health Report (2010) Background Paper, No 48.*

URT, (2001), *Community Health Fund Act, United Republic of Tanzania*.

URT, (2005), *National Strategy for Growth and Reduction of Poverty* (NSGRT) United Republic of Tanzania.

WHO, (2011), *Statistical Information System: Core Health Indicators*, WHO.int. Retrieved on 2011-10-26:10:25 am.

WHO, (2010) National health accounts; March. http://www.who.int/nha/country/en [accessed 26.09.10)

Zweifel, P. (2007), *Theory of Social Health Insurance,* Switzerland

APPENDICES

Appendix I: Questionnaire for Beneficiaries

Dear Respondent,

I am a Master Degree in Business Administration student at the University of Dodoma (UDOM). In partial fulfillment of the course requirements, I am conducting a study **"Perception of Beneficiaries on Health Insurance services offered by National Health Insurance Fund: A case of higher learning institutions staff in Dodoma".**

The purpose of this brief questionnaire is to get your views regarding the perception of staff from higher learning institution towards services offered by NHIF. Your views, apart from being used for academic purpose in this study, will also act as a reference to guide various stakeholders in effectively and efficiently implementing Health Insurance Scheme in Tanzania. Furthermore, it will help the management of the Fund in formulating appropriate and useful policies which will make NHIF to be more sustainable.

Hence, you're kindly requested to respond to the following questions clearly and frankly as we assure you that the information you provide will be treated with great confidentiality. Thus, we appreciate your anonymity in this questionnaire.

Thank you in advance.

Section A: Personal information

1. Sex

Male ( ) Female ( )

2. Age Group

18-25 years ( ) 25-30 years ( ) 30-40 years ( ) 40-50 years ( ) over 50 years ( )

3. Highest level of education

Secondary school ( ) Certificate ( ) Diploma ( ) Undergraduate ( ) Postgraduate ( )

4. In which occupation do you work? (a) Academician……(b) Non Academician…….

5. What is your current job designation? ……..

Section B: To what extent do beneficiaries of health insurance schemes aware of the introduction of NHIF services?

1. How do you rate your awareness regarding NHIF services?

a. Very Knowledgeable
b. Somehow Knowledgeable
c. Moderate Knowledgeable ( )
d. Poorly Knowledgeable
e. Not Knowledgeable at all

2. Which type of the scheme do you prefer much?

a. NHIF
b. CHF
c. AAR ( )
d. Strategy
e. Others

3. For how long have you joined your scheme?

a. 1-4 years

b. 5-10 years ( )

c. Above 10 years

4. How long did it take to get membership Identification Card?

a. Within a month

b. Within three months ( )

c. More than three months

5. How do you get updated information regarding NHIF services?

a. More regularly

b. Regularly

c. Somehow regularly ( )

d. Irregularly

e. Not at all

6. How many beneficiaries do you prefer to be included in NHIF?

a. Four

b. Six ( )

c. More than six

Section C: How do health services been accessible to NHIF beneficiaries?

1. How often do you use health insurance card to obtain health services?

a. Every time

b. At referral level facilities

c. If the cost of health services is High (expensive) ( )

d. When asked

e. Never at all

2. How long does it take you to acquire health services using health insurance card?

a. Short time

b. Few minutes ( )

c. Very delaying

3. To what extents do you satisfied with the services provided by your nearest service providers.

a. Highly satisfied

b. Somehow satisfied

c. Satisfied ( )

d. Unsatisfactory

e. Very Poor

Section D: What is the perception of beneficiaries of NHIF on the quality of health services between patients with social health insurance cover and those without?

1. How do you compare the quality of health services before and after the introduction of NHIF?

a. Very Deteriorated
b. Deteriorated
c. Remained constant ( )
d. Highly Improved
e. Improved

2. How do you rate the services provided by NHIF?

a. Excellent
b. Very Good
c. Good ( )
d. Satisfactory
e. Poor

3. Have you been trained on the services provided by NHIF scheme?

Yes ( ) No ( )

4. How do you rate the training you have acquired?

a. Excellent
b. Very good
c. Good ( )
d. Satisfactory
e. Poor

5. Do you think there is any difference between services provided to NHIF members and non-NHIF members?

Yes ( ) No ( )

6. What do you think about the availability of drugs and medical supplies?

…….

……

……..

…….

……

7. What do think about the performance of the health care professionals?

a) Strengths to be developed

……

……

…….

…….

b) Weakness to be overcome

……

…….

……

……

8. What do you think should be done to improve effective use of health insurance schemes?

i. . ……

ii. ……..

iii. ……

iv. ……

v. ……

Thank you for your Participation

Appendix II: Interview Guidelines

INTERVIEW DUIDELINES FOR ADMINISTRATORS OF HIGHER LEANING INSTITUTION

1. Do you think that your staffs have enough knowledge about NHIF?

2. If the answer is no in Q 1 above, what efforts have you done to make sure that your staffs get appropriate knowledge about NHIF?

3. If it could be voluntary to join NHIF do you think that your institution would be ready to be registered?

4. Which type of Health Scheme do you prefer much?

5. What are the reasons in Q. 4 above?

6. How do you help your staff to get updated information about NHIF?

7. Do you think that number of allowed dependants in NHIF is enough?

8. On average how long does it take to get NHIF card from time of filling application form?

9. Are you using NHIF card most of the time to get medical services?

10. How long does it take you to acquire health services by using NHIF card?

11. Are you satisfied with the services provided by your nearest service provider?

12. Do you think that introduction of NHIF has helped to improve health services in Tanzania?

13. Have you been trained on the services provided by NHIF scheme?

14. Were you satisfied with that training?

15. Do you think that there is any difference between services provided to NHIF members and non-NHIF members?

16. Are drugs and medical supplies available in the accredited facilities?

17. What should be done to improve effective use of health insurance schemes?

Appendix III: Respondents Involved in the Study with Their Designation

Position	Frequency	Percent
Accountant	7	11.1
Casual work employee	1	1.6
Senior Legal Officer	1	1.6
Librarian/Library officer	3	4.8
Human resource/administrative officer	12	19.0
Assistant Lecturer	10	15.9
Planning officer	1	1.6
System administrator	6	9.5
Warden II/Warden officer	2	3.2
Student welfare manager	1	1.6
Janitor	1	1.6
Tutorial Assistant	5	7.9
Laboratory technician	1	1.6
Records officer	1	1.6
Pharmacist	1	1.6
Examination officer	1	1.6
Personal secretary	1	1.6
Admission officer	1	1.6
Lecturer	6	9.5
Legal officer	1	1.6
Total	**63**	**100.0**

Source: Field Data, 2014.