NATIONAL HEALTH INSURANCE FUND (NHIF) IN TANZANIA AS A TOOL FOR IMPROVING UNIVERSAL COVERAGE AND ACCESSIBILITY TO HEALTH CARE SERVICES:

CASE FROM DAR ES SALAAM - TANZANIA
NATIONAL HEALTH INSURANCE FUND (NHIF) IN TANZANIA AS A TOOL FOR IMPROVING UNIVERSAL COVERAGE AND ACCESSIBILITY TO HEALTH CARE SERVICES:

CASES FROM DAR ES SALAAM - TANZANIA

By

Paschal Nathan KUMBURU

A Dissertation Submitted to the School of Public Administration and Management in Partial/fulfilment of the Academic Requirements for the Award of Master Degree in Health System Management (MHSM) of Mzumbe University

2015
CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a Dissertation entitled National Health Insurance Fund (NHIF) in Tanzania as a tool for improving universal coverage and accessibility to health care services; Cases from Dar es Salaam, in Partial/fulfilment of the requirement for the award of the Master Degree in Health Systems Management (MHSM) of Mzumbe University.

Signature

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Major Supervisor

Signature

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Internal Examiner

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External Examiner

Accepted for the School Board, SOPAM of MU

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DEAN/CHAIRPERSON
DECLARATION

I, Paschal Nathan KUMBURU declare that this is my own 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.

Signature: ________________________________

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DEDICATION

This dissertation is dedicated to my beloved parents; the late Mr. and Mrs. Kumburu, May the Almighty God give them a rest in peace. Special dedication goes to my beloved wife Josephine, my beloved sons and daughters for their prayers, patience and tolerance throughout my study. This work also is dedicated to Ndunguru, I. A, without forgetting my friends specifically Ms. Ombati, H. W, and my relatives who in one way or another gave me an encouragement and moral support during the preparation of this dissertation report. “May God bless them all.”
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<table>
<thead>
<tr>
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<th>Description</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>CHF</td>
<td>Community Health Fund</td>
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<tr>
<td>FGD</td>
<td>Focus Group Discussions</td>
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<td>HIV</td>
<td>Human Immune Deficiency Virus</td>
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<td>HoD</td>
<td>Head of Department</td>
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<tr>
<td>IMF</td>
<td>International Monetary Fund</td>
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<td>MMOH</td>
<td>Municipal Medical Officer of Health</td>
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<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>NHIF</td>
<td>National Health Insurance Fund</td>
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<td>NSSF</td>
<td>National Social Security Fund</td>
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<tr>
<td>PHQ</td>
<td>Police Headquarters</td>
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<tr>
<td>SAP</td>
<td>Structural Adjustment Policy</td>
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<tr>
<td>SHIB</td>
<td>Social Health Insurance Benefit</td>
</tr>
<tr>
<td>SOPAM</td>
<td>School of Public Administration and Management</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Sciences</td>
</tr>
<tr>
<td>SSRA</td>
<td>Social Security Regulatory Authority</td>
</tr>
<tr>
<td>SWAP</td>
<td>Sector Wide Approach</td>
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<tr>
<td>THE</td>
<td>Total Health Expenditure</td>
</tr>
<tr>
<td>TIKA</td>
<td>Tiba kwa Kadi (Treatment by Health Card)</td>
</tr>
<tr>
<td>TIRA</td>
<td>Tanzania Insurance Regulatory Authority</td>
</tr>
<tr>
<td>TZS</td>
<td>Tanzanian shillings</td>
</tr>
<tr>
<td>UC</td>
<td>Universal Coverage</td>
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<tr>
<td>UHC</td>
<td>Universal Health Coverage</td>
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<tr>
<td>URT</td>
<td>United Republic of Tanzania</td>
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<td>WHO</td>
<td>World Health Organization</td>
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ABSTRACT

Introduction: This study examines National Health Insurance Fund (NHIF) in Tanzania as a tool for improving universal coverage and accessibility to health care services was conducted in Dar es Salaam City. The main objective was to explore factors affecting accessibility to health care services and challenges in health care delivery by NHIF in Tanzania.

Methodology: A multiple case cross-sectional design was employed and a sample of 58 respondents were selected using purposively and snowballing techniques in nine (9) NHIF accredited health facilities and NHIF head Office. A combination of qualitative and quantitative approaches was used in studying a phenomenon. Data were collected using documentary reviews, interview guides, focus group discussions (FGD) and questionnaires. Quantitative data from the questionnaires were analysed by using Statistical Package for Social Sciences (SPSS) and Microsoft Excel Spread Sheet, while qualitative data from interview guides and Focus Group Discussion were analysed descriptively using content analysis procedure.

Findings: Although NHIF help to improved health care financing system in Tanzania, and provide capacity building to its staff, health facility administrators, NHIF focal persons as well as raises public awareness. The findings revealed that the reimbursement of NHIF bills to health care providers take long time contrary to NHIF reimbursement policy (within 60 working days) from when complains were tabled. Some of the NHIF benefits and packages services which are supposed to be provided to NHIF members are not provided. The results showed that among challenges faced by the NHIF members include; poor quality health services delivered, prolonged registration process, and most of health facilities favour much to the people who pay cash rather than the NHIF members.

Recommendations: The study recommends that efforts should be made to improve quality of health services in the NHIF accredited health facilities. NHIF and health facilities providers must ensure that there is equal treatment between NHIF members and those who pay by cash. There is also a need for reviewing benefit and packages services and mechanism of reimbursement of NHIF bills.
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CHAPTER ONE

INTRODUCTION AND BACKGROUND

1.1 Introduction

Quality of health care is determined by effective and efficient health care financing system that an organization has. However, the world is facing challenges in financing and providing health care. Documentary evidence revealed billions of poor people especially those who live in low and middle income countries lack access to effective and affordable health interventions largely because of the weaknesses in financing and health care delivery (World Bank; 1997, World Bank; 1993, The World Health Report 2000). The World Health Organization health financing policy emphasizes that the health system as a financing strategy is a key determinant to population health and well-being. This is particularly true in the poorest countries where the level of health spending is still insufficient to ensure equitable and universal access to needed health services and interventions (WHO, 2003). Tanzania, like many countries in sub-Saharan Africa, share the similar to the tight public health care budget and the need to improve access to health services, especially for the poor and those working in the rural areas and/or the informal sector (Quijada & Comfort 2002).

Provision of health care services in Tanzania is through the public and private sector, with the central government through the Ministry of Health and Social Welfare being the largest provider. In Tanzania health care is available depending on one's income and accessibility. People in urban areas have better access medical facilities. For a patient admitted to hospitals within Tanzania they are expected to pay 10,000 Tanzanian Shillings, the equivalent to £4 approximately in the UK currency. Most families are trying to buy their own medication as the policy within the hospitals means that if the government is not supplying medicine to these hospitals, the patients will not get them. So many patients’ views are that, medication should be available within the hospitals so that they can buy them to guarantee receiving them rather than have the potential go without them. Understandably, this is a luxury some families simply cannot afford (WHO 2010; Mtei & Mulligan, 2007; MASCOT, 2012).
1.2 The evolution of health care financing in Tanzania

In Tanzania, after independence and before 1990, health services were fully funded by the government through taxation, and provided without charge for all Tanzanians. The Arusha Declaration of 1967 initiated by president Julius Nyerere, outlining the principles of Ujamaa (Nyerere vision of social and economic policies) to develop the national economy in which social service programmes came to have a high profile. It marked the start of a series of health sector reforms with the intention of increasing universal access to social services to the poor and those living in marginalized rural areas (Hyden, 1980). Followed by the Government banning private-for-profit medical practice in 1977 and took on the task of providing health services free of charge (Kolstad & Lindkvist 2013).

However, the strain of providing free health care for all became evident in the face of rising health care costs and a struggling economy due to implementation of Structural Adjustment Policy (SAP) of 1980s (IMF & World Bank, 2000). In early 1990s, the government adopted health sector reforms that changed the financing system from free services to mixed financing mechanisms including cost sharing policies. The cost sharing programme for health services in the form of user charges was introduced with the Health Sector Reform Plan in 1993 (MoHSW, 2003). It was implemented in four phases; the first phase covered grade one and grade two patients and the second phase also grade three patients in the referral and some services in regional hospitals. The third phase concerned grade three in and out-patients in district hospitals. The implementation of the fourth phase, which concerned village dispensaries and rural health centres, was delayed and had not yet been implemented in June 1995.

Even the hospitals which were permitted to charge were directed to exempt Maternal and Child Health services with an affirming directive by the Minister of Health in June 1996. Thus exempted groups were pregnant mothers until delivery, children under five years, and in addition, patients with epidemic diseases such as AIDS, meningitis, cholera, and dysentery as well as patients with diabetes (MoHSW, 2003).
1.2.1 Health spending in Tanzania

Current data in Tanzania shows that there has been an increase in health budget over the years: Total Health Expenditure (THE) increased from US$734 million in 2002/2003 to US$1.75 billion in 2009/2010 as indicated in the National Health Accounts 2010 report (MoHSW, 2011). However donors have been the main financier of health, despite the decrease in their share of health expenditure from 44 percent in 2005/2006 to 40 percent in 2009/2010. Overall, the government allocation to health spending has remained almost constant at about 7 percent since 2002/2003, far away from reaching the Abuja declaration target of 15% of total government expenditure. The increase in donor funding is attributed to the commencement of financing for HIV and AIDS by the Global Fund in 2001 and the commencement of health financing through Sector wide Approach (SWAP) in early 2000 (Mcintyre. 2008).

1.2.2 Concept of Health insurance

In this study health insurance is defined as insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. According to the Health Insurance Association of America, health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury. Includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment" (Caxton, 2002)

Health insurance originated in the Blue Cross system that was developed between hospitals and schoolteachers in Dallas in 1929. Blue Cross covered a pre-set amount of hospitalization costs for a flat monthly premium and set its rates according to a "community rating" system: Single people paid one flat rate, families another flat rate, and the economic risk of high hospitalization bills was spread throughout the whole employee group (Caxton, 2002).
1.2.3 Health insurance in Tanzania

Health insurance is defined as insurance against the risk of incurring medical expenses among individuals. According to MoHSW (2003) health insurance policy has a relatively longer history in Tanzania (since 1993) than other health financing schemes currently running in the country, NHIF was established by the Act of Parliament No. 8 of 1999 and began its operations in June 2001. The scheme was initially intended to cover public servants but recently there have been provisions which allow private membership. The public formal sector employees pay a mandatory contribution of 3% of their monthly salary and the government as an employer matches the same. This scheme covers the principal member, spouse and up to four below 18 years legal dependants. There has been a steady increase in coverage from 2.0% of the total population in 2001/2002 to 7.1% in 2011(NHIF, 2013).

On the other hand, there has been a commitment to expand the insurance coverage in the country; however the insurance schemes are highly fragmented. There are four health insurance schemes which are publicly owned, namely National Health Insurance Fund (NHIF), Social Health Insurance Benefit (SHIB) established as a benefit under the National Social Security Fund (NSSF) and the Community Health Fund (CHF) and Tiba Kwa Kadi (TIKA). Recent statistics shows that there were about 7 private firms as indicated in the Tanzania Insurance Regulatory authority (TIRA) which were providing health insurance per se, while a few of other general insurance firms combine health insurance benefit under life insurance (NHIF, 2010).

1.3 Statement of the problem

Apart from few documents’ evidence regarding NHIF in Tanzania, very little is known about NHIF as a tool for improving accessibility to health services and financing health care. Despite, NHIF scheme being in operation in all regions and districts in Tanzania mainland and Zanzibar (for union government staff found in Zanzibar), its coverage is still low in Tanzania (NHIF 2013). Reports show that NHIF is estimated to cover about 6.6% of the population based on 2012 Census. The beneficiaries of this scheme include the contributing members, spouse and up to four legal dependants.
Low health insurance coverage can lead to overreliance on direct payment at the point of use of health care, which is among the fundamental problem that restrains the move towards universal health coverage in many developing countries including Tanzania, hence direct payment can lead to high level of inequity, and in most cases denying the poorest access to needed health care (NHIF, 2013).

Recently, NHIF provides comprehensive portable benefits packages such as diagnostic tests, out-patient services, in-patient service care at fixed rates per day, minor and major surgery, in- and out-patient specialized services, physiotherapy, dental services, glasses, prostheses and also offers services for retirees (NHIF, 2013). These services are provided by the accredited health facilities and pharmacies. However, there are some promised service packages, which are not fully provided. As per planning, NHIF anticipate by 2015 to be able to offer all promised services appropriately; in addition to that there is an expectation of extending access to East Africa in case a member is on official duties within the region (NHIF, 2013).

The benefit packages are now and then being improved and reimbursement prices enhanced often and this is overseen to improve more when cost studies will be undertaken especially at the facility level so as to relinquish all leakages and unfaithfulness which in turn lead to embezzlement spoor (NHIF, 2013), but this could be undermined by the essence that current NHIF services have a wide gap to bridge considering current emerging diseases which in fact few are included in the service packages, there has been asymmetrical know-what about the pro-poor financing policies made and implemented under the umbrella of the NHIF including the Community Health Fund (CHF). Even those who are physically, mentally and economically well need to be included in the policy implementation. However, the regulations suggest that all those who are able to contribute to NHIF/CHF should contribute to the programs so as to reduce dependences and create a strong pool to subsidize or finance the pro-poor (NHIF, 2013).
For years, NHIF has been stable and uniform 6% of the employee’s monthly salary as a premium (shares equally by employer and employee). With this income of related amount contributed per month, there still is a controversy on the number of dependants attached to a contributing client, the relationship between the dependant and the client, and other many unlimited challenges (NHIF, 2013).

Evidently, NHIF was built on several initial thoughts that hold the operation of the scheme and assures sustainability of the fund and these are enrolment, management, equity and sustainability and comprehensive coverage (Mtei & Mulligan, 2007). It was not intended to be prescriptive, but rather stimulate debate. For many areas it was clear that further targeted research and evaluation was urgently required. Not only that awareness was the problem, but the NHIF and other key stakeholders had to work hand in hand looking for solutions with regards to accessibility in terms of quality services such as, waiting time, and availability of medicines for its members so as to lessen dissatisfaction and complaints which usually result from poor services provided (Mtei & Mulligan, 2007).

Notwithstanding the above criticized scenarios, there were a couple of successes recorded by the NHIF, these include assurance of access to health services at all times (however not all services are of acceptable quality), contribution to the Health Sector Development as a component in Health financing, attitude changes (from free services to contributions, from cash payments to use of Cards, from laisser-faire to ownership by members and so forth), use of Cards have reduced bribery tendencies, sustainable system outside the Government general taxation system, brings services closer to members (Zones), its setting has been model to most interested countries (Mtei & Mulligan, 2007).

Nevertheless, NHIF coverage in Tanzania is still low as compared to other East African countries such as Rwanda 91%, and Kenya 21% (NHIF Director General speech in 2010). What specifically should the fund cover, in terms of benefits package and improvement of quality assurance to remain in the hands of decision makers and answers to this has been addressed in this study’s findings.
1.4 General objective

To explore factors affecting accessibility to health care services and challenges in health care delivery by NHIF in Tanzania

1.4.1 Specific objectives

1. To establish a profile of the main factors that affects accessibility to health care by NHIF members
2. To analyse efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing
3. To establish a profile of the main challenges that NHIF face in the course of ensuring accessibility to health care/medical services

1.5 Research questions

1. What are the main factors that affect accessibility to health care by NHIF members?
2. What is the level of efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing?
3. What are the main challenges that NHIF face in the course of ensuring accessibility to health care/medical services?

1.6 Significance of the study

This study was designed to explore factors affecting accessibility to health care services as well as challenges in health care delivery by NHIF in Tanzania. The findings from the study would assist policy and decision makers in Tanzania on how to improve the performance of NHIF scheme in Tanzania. This study adds on the knowledge on the effects of existence of NHIF scheme. The findings shed some light on what can be done to increase the performance of NHIF scheme hence improve the quality of care provided at the health facilities.
Evidence based policy decisions could be made based on the study findings and may help to strengthen the NHIF scheme in Tanzania. This study is part of partial fulfilment of the award of Master Degree in Health System Management

1.7 Limitation of the study

Since the study was conducted in one region (Dar es Salaam), this is not a representative of Tanzania. However, many areas in Tanzania have similar problems regarding NHIF scheme.

1.8 Scope of the study

This study was designed and conducted in Dar es Salaam (the main trade city in Tanzania) where as various NHIF accredited health facilities within the city were visited as well as some NHIF offices. The NHIF members/beneficiaries as well as official staffs were interviewed in order to get different information. Since the study employed both quantitative and qualitative data, hence findings has been generalized to help address similar problems especially in the same country.

1.9 Organization of Dissertation

The study comprises with six chapters, Chapter one is made up with an introduction, problem statement, objectives, research questions, Significance of the study for the study, limitations and scope of the study as well as organization of the study. Chapter two reviews literature in the study field both theoretical and empirical point of views. Chapter three looks on the methodological applied in the research; while chapter four dealt with presentation and analysis of study findings; chapter five comprises of discussion of the findings; and lastly chapter six covers conclusions based on the results, study recommendations, suggestions for further research and the policy implications (see figure 1.1).
Figure 1.1 Organization of Dissertation

1. INTRODUCTION

2. LITERATURE REVIEW

3. STUDY METHODOLOGY

4. PRESENTATIONS AND ANALYSIS OF THE STUDY FINDINGS

5. DISCUSSION OF THE FINDINGS

6. SUMMARY, CONCLUSIONS AND POLICY IMPLICATIONS

Source: Researcher’s Construct 2015
1.10 Conceptual Framework

Figure: 1.2 Conceptual Framework

Theoretically, the more the National Health Insurance Fund (Independent variable) improves its services the better accessibility to the health care and health care financing is achieved (Dependent variables).

Since health care is very vital as well as expensive, it requires high investment in terms of budget expenditure to cover medical care, medical equipment and medical supplies expenses. Customers/clients on the other hand, should also invest in their health through National Health Insurance scheme so that they can access to health care services.

Using insurance scheme a patient is subsidized in accessibility to health need. However, the fund gains premiums from other members who may not consume as still money/fund is collected.

Source: Researcher own construction 2015
CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

Researcher review on literatures key variables as factors affecting accessibility to health care services as well as challenges in health care delivery by NHIF in Tanzania. Finally the researcher establishes appropriate base of information and services that will contribute to enhancing comprehensive accessibility to health care service through NHIF. Several concepts were analysed and the case studies cited in connection to the variables. Both research questions and objectives formed the basis of review in this section.

2.2 Theoretical literature review

2.2.1 Definition of key terms

Insurance
Hornby and Wehmeier (1995) defines insurance as an arrangement by which a company or the state undertakes to provide a guarantee of compensation for specified loss, damage, illness, or death in return for payment of a specified premium.

Health Insurance
A type of insurance coverage that pays for medical and surgical expenses that are incurred by the insured. Health insurance can either reimburse the insured for expenses incurred from illness or injury or pay the care provider directly. Health insurance is often included in employer benefit packages as a means of enticing quality employees (DeNavas-Walt, 2010).

Universal Coverage
Universal coverage (UC), or universal health coverage (UHC), is defined as ensuring that all people can use the promotive, preventive, curative, rehabilitative and palliative
health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

This definition of UC embodies three related objectives which are: equity in access to health services - those who need the services should get them, not only those who can pay for them; that the quality of health services is good enough to improve the health of those receiving services; and financial-risk protection - ensuring that the cost of using care does not put people at risk of financial hardship (Victora et all 2004).

**Accessibility**
Accessibility refers to the quality of being available when needed. You like the accessibility of the company's customer service because you don't have to wait endlessly on hold in hopes of reaching a human being (Jones et al, 1998).

### 2.2.2 Policies overview

**National Health policy**
The National Health Policy of 2007 aims at implementing national and international commitments. These are summarized through policy vision, mission, objectives and strategies. The health policy vision is to have a community which will contribute effectively to an individual development and the country as a whole. The mission is to facilitate provision of basic quality health services, which are proportional in standard, equitable, affordable, acceptable and sustainable (MoHSW 2007).

**Health care financing policy**
In this study health care financing is regarded as among the key component of a functional health system. According to WHO (2000); health care financing involves three aspects, namely revenue collection, risk pooling, and purchasing. In recent years, there has been a growing demand for access to high-quality and affordable care for all, thus the government is committed to respond with a process of developing health financing strategy (Hyden, 1980).

Proper health care financing ensures the population not only has access to health care but also use the health services when they need them.
A well-functioning health financing system also determines whether the health care services exist (Carrin & Chris, 2005). Out of this recognition, in 2005 member States of the World Health Organization (WHO) committed to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them. Achieving this goal is in effect a move towards universal health coverage (WHO, 2010).

There are several methods that can be used to support health services. They include the general systems of taxation used to finance government expenditures and the ministries of health; donor assistance that is specifically earmarked for health projects; charitable donations targeted to private voluntary health providers, such as church missions; user fees; and health insurance.

Faced with budget constraints and at the same time trying to reduce government dependency as in budgeting on provision of health services, many countries introduced or raised the user fee at public facilities (World Health Report, 2000). User fee was an essential policy response to health care financing crisis. It could have improved the quality of health services at public services and thus benefit the poor who mainly use them. Furthermore the user fees could have enabled the government to redirect the funds to other essential programs like cost-effective preventive services.

Social security schemes
Social security schemes are schemes imposed and controlled by government units for the purpose of providing social benefits to members of the community as a whole, or of particular sections of the community (Bultman et al, 2012). In human life, there are various social situations that cause the livelihood to be categorically in some of the life manners, in this regard, social security schemes and other social welfare matters are very much important at aiming good and quality livelihood, so in the country there are various means of gaining benefits accordingly to the needy of the individuals thus there are the social security schemes (Batman et al, 2012).
Health insurance policy in Tanzania

In Tanzania health insurance and related legislations are technically sound, the various enactments and their respective regulations adequately covering the different forms of health insurance and health service delivery in the country. However, as in any other dynamic country, principal laws and their more detailed regulations need to be adjusted to changing policies, taking into account developments in society, new or evolving international treaties and jurisprudence (Bultman et al, 2012). Laws developed over time, sometimes without reference to one another, and dealing with particular issues such as, health financing and health insurance, can easily devolve into a regulatory patchwork that may no longer reflect the actual policy objectives of a national Government. Current legislation codifies existing policies, as it should, but if policies change, legislation needs to change with them, reflecting current policy objectives (Bultman et al, 2012).

Health insurance policy was also introduced in Tanzania in the year 1993 (MoHSW 2007) hence the National Health Insurance Fund as a Public institution was established by the Act No.8 of 1999 (CAP 395 R.E 2002). The main objective of NHIF is ensuring health care services to; employees in the public, private, other groups as available, accessible and affordable to contributing members and their respective legal dependants. NHIF is the largest alternative health financing option (scheme) that commenced its operations in July 2001 as a driving force towards implementation of the Health Sector Reform Policy (1993/4). The coverage of National Health Insurance Fund (NHIF) in Tanzania as at July 2013 was about 6.6% (NHIF 2013). This health financing mechanism requires monthly subscription premiums. However, these formal health funding mechanisms do not solve the challenge on how to finance health services to over 70% of Tanzanians residing in rural areas who are also involved mainly in the informal economic sector (NHIF 2013).
2.3 Empirical literature review

i. Challenges facing NHIF in its operations as a health financing tool in Tanzania

General perception at early days (mainly negative): this isn’t something new in the sight of most beneficiaries since you must need to be new in order to be old. Within this financing scheme, it is always found too hard to first register and second to accept on terms and conditions pertaining to be member. Until someone is extremely ill that he is required to spend more on their health care, they will never adhere to what health insurance demands. It has been always seen as people’s loop holes of fetching clients’ money.

Some stakeholders are yet to fulfil their roles: insurance schemes involve different kinds of stakeholders including service provision like hospitals, and other health facilities, fund providers, development partners, and many others. All these stakeholders have their specific roles to fulfil and stipulated tasks to be accomplished in attaining high quality services in all places and areas of coverage throughout the country.

Medicines shortages: Absence of infrastructures for instance part one pharmacy in most parts of the countries is now alarming. Stock out has been a major problem in health care servicing under this financing scheme. Having a card isn’t a sufficient and necessary condition for acquiring quality services in all NHIF designated hospitals all over the country. Clients are ever given referrals to private pharmacies and medicines selling shops to purchase prescribed medicines. This has cast a couple of complains to the scheme and has made people regret of joining the fund but no way out they should be involuntarily enrolled.

Emergence of fraudulent tendencies: corruption is now in people’s finger tips. Everyone possessing an office despite being highly paid still fetches a lot of money and directs it to corruptible activities, invalid schedules are now and then emerged in offices which make them no longer trust worthy or even degrade the scheme.
Furthermore, there are numerous challenges still hindering smooth operations of NHIF scheme in Tanzania. Problems related to the health system and infrastructure itself has negative impacts on the funds’ operations; limited scope of coverage; operating in un-regulated environment; low awareness by the public on how these different schemes operate; preference on cash payments against cards; absence of set basic package by Health and Social Welfare; non adherence by some health service providers on the standards set by Ministry of Health and Social Welfare and the fraud to mention but a few.

**Challenges due to NHIF enrolment and coverage**

One of the biggest challenges to the NHIF and CHF was that of enrolment, however to the latter was more intense than the former. There were two important issues to take into consideration when assessing these two building blocks strongly holding these health insurance schemes especially in Tanzania. First, the identification of the contributing population; and the second was how to collect the contributions. How much to collect from each member could be the main point here but usually ignored. It was possible to identify the contributing population and could even be simpler to fetch funds from them but to what extent that was where it started to become a problem. With most expensive standards of living especially when catering basic requirements-food, shelter, children’s education, clothes and other related to these NHIF contributing members, thinking of the amount to collect from each one would be great (NHIF, 2010; NHIF, 2013).

For members to join a national or community scheme there was a need to involve them from the beginning of the formulation of the scheme in order to make them feel as part of the scheme. If members were more involved, the potential for membership fees to be set at an affordable rate is much higher, the benefit package would be clear to all members and this avoids the possibility of over expectations of the benefits package. This would work out if and only if members’ views and suggestions were included in the implementation (MASCOT, 2012).

Mtei & Mulligan (2007) evidenced and stresses the importance of being strategic when sensitizing for the establishment of a national and community health scheme such like
NHIF and CHF. It was important that community members were integrated at the beginning. To ensure that a large number of the community members are involved in the CHF (because it is voluntary and depends on someone’s discretion) and NHIF (many will join because it is compulsory), it may be useful to link with and learn from existing national and community schemes either internal or external. Furthermore, Mtei & Mulligan (2007) recommends that Institutions, sectors and councils could consider consolidating the community health fund with existing community initiatives and leave the control of the scheme to the existing management or encourage group membership, as was the case of Rungwe CHF. This would promote transparency, accountability, and tackling issues of technicalities in simple measures. For instance, the scheme could be decentralized and delegated to local administrative authorities and be regulated and monitored often to ensure quality and effectiveness. This would bring out willingness and likelihood of high desire to join these schemes, hence solve existing problems.

Moreover, it was also important to address the issue of how to set the contribution rate. Ideally the CHF and NHIF premium should be based on community willingness and ability to pay so as to enhance community participation and improve enrolment rates and not only deciding on behalf of the person (the case of NHIF to workers at large). This will allow perfect understanding, negotiation and if possible alternative measure of insuring themselves because we also have private insurance schemes charging differently depending on services and type of client dealing with. Having flexibility in membership fee, payment timing and rate of contribution is also important. In addition to the traditional annual payment councils could consider two payments per annum; monthly payments or seasonal payments, this will allow every client decide what is the best alternative for him or her to continue being a member. The community needs to agree on the rate of contribution and the CHF managers should give them the opportunity to choose the most convenient mode of contribution (Mtei & Mulligan, 2007).

Currently, the CHF has been introduced in 69 district councils and NHIF works in all places in the country. In 2003 the MOHSW undertook a study of factors affecting enrolment and coverage and suggested a number of possible explanations behind the
slow roll out. At the regional level reasons included: lack of commitment by some regional and district officials; inadequate follow-up from the Ministry of Health and Social Welfare; lack of capital for initiation of the scheme; lack of uniformity on premiums, inadequate mechanisms for continuation of membership and unclear referral mechanisms (MoHSW, 2011).

ii. National Health Insurance: A relatively wide reach, but limited to public workers, questions on quality, demand-side indications

Health insurance single biggest insurance usage category
According to NHIF Director General speech in 2010, NHIF coverage in Tanzania is still low as compared to other East African countries such as Rwanda 91%, and Kenya 21% (NHIF, 2010). Only 5.6% of the adult population have health insurances, amounting to nearly 1.2 million individuals in Tanzania by 2011. Though this was still only a small percentage of adults, it made the health insurance the single biggest insurance category according to the number of users (88.9% of those with insurance).

Health risks utmost in people’s minds
Health insurance is by far the best known and most desired but also the most criticized. The bulk of the population regards health expenses as the biggest threat to their income which, to most them, is the most uncertain and urgent cost facing it and that is paying for medical services. Hougaard et al (2012) survey results show that the bulk of the population regards health expenses as the biggest threat to their income. This is confirmed by the focus group research: respondents indicated that the most frequent, and at the same time most uncertain and urgent cost facing them, is paying for medical service.

Variety of coping mechanisms
Given the high cost and unexpected nature of illness and accidents, various financing mechanisms are used to pay for healthcare. These include contributions from relatives, loans, the sale of livestock and financial support from rotating savings schemes/merry-go-rounds and VICOBAs.
Therefore, the sense of urgency people feel in getting money together for health care financing is terrible through whatever means to cover healthcare expenses. Most strategies used include asking for help from your relatives and close friends, another strategy is that in case one does not have relatives or close friends to look to, selling valuable possessions becomes the last resort or otherwise use that valuable item as collateral to borrow money from several sources, thus “You have to help yourself” is the common say among non-insurers (Hougaard, et al., 2012).

**Caters for civil servants**

As per NHIF consultation (2012) the NHIF was set up in 2001 in recognition of the need to use social insurance as a financing tool to achieve effective cross-subsidization towards the goal of universal coverage. It was compulsory for public sector workers only, though there was a plan to extend coverage to the full formally employed market and even the informally employed market in future.

Premiums are equal to 6% of a member’s salary 3% is deducted from a member’s salary and remitted to the NHIF, and the remaining 3% is contributed by the member’s employer, i.e. the government. Healthcare providers are remunerated on a fee for services basis and members must be treated at one of the 5,500 accredited healthcare providers in the NHIF’s network in the country through (Hougaard, et al., 2012).

Despite inequalities in beneficiaries salaries or rather monthly incomes, prons of NHIF have been merited, as Hougaard et al (2012) in their report on the focus groups conducted some accredited NHIF as “It has benefits. Instead of using cash you get the service without paying - they will deduct from your salary. For example I delivered my first child in a private hospital and I didn’t pay anything, so the benefits are there” While other groups discredited NHIF as “Let me say the majority has health insurance because we are forced by the institution that we are working for because it is being deducted from our salaries. If it were voluntary to sign up probably some of us wouldn’t be there, so it’s compulsory, you must sign up.
2.4 Research gap

The literature reviewed on NHIF related studies has indicated that no any researches which have been conducted on “NHIF in Tanzania as a tool for improving universal coverage and accessibility to health service care in Tanzania” It was after consideration of this inadequacy, the researcher decided to face this challenge head on by conducting this study to bridge the gap using cases and examples from Tanzania.
CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This section explains the research methodology that was used in collection and analysing data. The section starts by presenting the research design and then proceeds to describe the setting where the research was carried out. After that description methods that applied in collection of data followed.

3.2 Study design

Multiple cases cross sectional design were used in this study. A total of nine (9) health facilities and NHIF office were purposefully selected and involved. Selected health facilities were suitable in this study simply because they met the criteria of being accredited by NHIF and providing services through NHIF scheme within Dar es Salaam City. Moreover, this design was favourable due to its time constraint (Varkervisser, 2002; Bowman, 2004; Adam & Kamuzora, 2008).

3.3 Study area

3.3.1 Dar es Salaam in Brief and Geographical Location

Dar es Salaam region is one of Tanzania's 30 administrative regions. The regional capital is the city of Dar es Salaam, which comprises three Municipalities namely; Temeke, Kinondoni and Ilala. According to the 2012 national census, the region had a population of 4,364,541, which was much higher than the pre-census projection of 3,270,255. For 2002-2012, the region's 5.6 percent average annual population growth rate was the highest in the country. Also the most densely populated region with 3,133 people per square kilometre.

The City, (region) of Dar es Salaam lies between 6° 45' Latitude and 39° 18’ Longitude, E and 7.10' on the West Indian Ocean coastline, stretching about 100 kms between Mpiji River to the north, and beyond Mzinga River in the south, enclosing some 1350
sq. kms of land with 8 offshore islands. Whilst national in character, the city's immediate sphere of influence extends from Bagamoyo in the north, beyond the Ruvu River in the west, as far south as Kisiju, with surrounding villages and towns focusing on Dar es Salaam as the market for their produce and the source of supplies and consumer goods.

Historical
Dar es Salaam historically means: "Haven of Peace" was founded by Sultan Sayyid Majid of Zanzibar, who in 1862 wanted to move his capital Bagamoyo to a small port of Mzizima later to be known as Dar es Salaam, reflecting a relaxed and informal atmosphere of its "Cityite’s".

3.3.2 Social Economic Activities
The Dar es Salaam region consists of heterogeneous type of people from different parts of the country as well as outside the country with different cultures and traditions, although the main habitants were Wazaramo. Most of the residents are businessmen, employees of Government, Private Sectors, NGO’s though there are few peasants, fishermen and livestock-keepers, petty traders where most of them are vendors (Wamachinga) and street food vendors not forgetting those who were jobless makes a day population of City to become higher than right population.

3.3.3 Health care delivery system
The health care delivery system in Dar es Salaam region is organized like in other regions in Tanzania through administrative, planning and programming coordination. The service channelled through curative, preventive and primitive health services provided by one public National Hospital (Muhimbili), three public regional referral hospitals (Amana Hospital in Ilala, Temekte Hospital in Temekte and Mwananyamala Hospital in Kinondoni).

Also, several public and private hospitals, health centres and dispensaries are distributed all over the city including Military and Police health facilities. The health care delivery system is direct supervised by Ministry of Health and Social Welfare and the
region/Council/District health management team as part of its management activities does the same in respective area of jurisdiction.

The study area was purposefully selected due to the fact that, Dar es Salaam is a commercial city and represents typical semi urban and urban areas; as well as the presence of both large number of NHIF accredited health facilities and NHIF members in the Tanzania.

3.4 Variables

The list of both dependent and independent variables were considered and used to explore factors affecting accessibility to health care services as well as challenges in health care delivery by NHIF in Tanzania.

3.4.1 Dependent variables are:

These variables includes accessibility to health and financing health care

3.4.2 Independent variables are:

The variables involve Health care delivery through NHIF

Table 1/Table 3.1: Description of main study variables

<table>
<thead>
<tr>
<th>Variables</th>
<th>Definition</th>
<th>Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care delivery through NHIF</td>
<td>A largest Government alternative health care financing mechanisms scheme in Tanzania operates through its members monthly contributions.</td>
<td>Better accessibility and affordable health care services to contributing NHIF members and their legal dependents</td>
</tr>
<tr>
<td>Accessibility to health</td>
<td>Ensure availability and uses of health care services</td>
<td>Determine whether health care service exists</td>
</tr>
<tr>
<td>Financing health care</td>
<td>A key component of a functional health system which involved revenue collection, risk pooling, and purchasing</td>
<td>Proper financing health care</td>
</tr>
</tbody>
</table>

Source: Researcher own construction 2015
3.5 Sample size and sampling method

The targeted study population was NHIF members/beneficiaries. Available data showed that coverage of NHIF in Tanzania was 6.6% (NHIF 2013)

3.5.1 Sample size

3.5.2 Study population

NHIF members were included in all over the study period; NHIF personnel and other administrative staff or NHIF focal person from the health facilities were also involved for updates and evidences.

3.5.3 Source Population

**Inclusion criteria:** The main inclusion criteria for a subject involved in this study, must be either an NHIF Members/beneficiaries, administrators from NHIF offices and administrators/NHIF focal person from health facilities were consulted for assistance and provision of reliable information as per tools administered.

**Exclusion criteria:** Non NHIF Members/beneficiaries, administrators from NHIF offices and administrators/NHIF focal Person from health facilities were excluded from the study.

3.5.4 Sampling frame

A total of 58 respondents from the study population were included in the study. Among those respondents, 36 respondents who were NHIF Members/beneficiaries attending services at the NHIF accredited health facilities, 18 (Administrators/NHIF focal persons) from NHIF accredited health facilities; two (2) respondents from each studied health facilities and four (4) NHIF official from NHIF Quality Assurance office at one hand or another be incorporated in this pool.
Table 3.2: Distribution of respondents

<table>
<thead>
<tr>
<th>Sample frame</th>
<th>Ilala</th>
<th>Temeke</th>
<th>Kinondoni</th>
<th>NHIF HQ</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHIF Members/Beneficiaries</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>-</td>
<td>36</td>
<td>62%</td>
</tr>
<tr>
<td>Administrators/NHIF focal person in partner health facilities</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
<td>18</td>
<td>31%</td>
</tr>
<tr>
<td>NHIF official administrators</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td></td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>18</td>
<td>18</td>
<td>4</td>
<td>58</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data Survey (2015)

3.5.5 Sample strategy and technique

This study applied two major types of sampling techniques, namely purposive and snowball techniques.

3.5.5.1 Purposive Sampling

This is the type of sampling used when particular people, events or settings are chosen because they are known to provide important information that could not be gained from other sampling designs. The researcher opted for purposive sampling because of its associated advantages as stated by Creswell and Clark (2007), Bowling (2014) and Neutens and Rubinson (2010) that purposive sampling give a researcher better cross-section of information, it prevents unnecessary and irrelevant items entering into the sample per chance. Bowling (2014) adds that purposive is the only viable sampling technique in obtaining information from a very specific group of people. Creswell (2014) emphasises that can be used to reach a targeted sample quickly. In applying this sampling technique the researcher started with purposive sampling which enabled him to get information rich respondent for this study. The purposively selected respondent referred the researcher to other similar respondents (snowballing).

3.5.5.2 Snowball Technique

Snowball sampling is a non-probability sampling technique (also known as chain referral sampling) which is used by researchers to identify potential subjects in studies where subjects are hard to locate.
In this study the researcher used the first respondent obtained through purposive then to nominated respondent and continues in the same way until he obtaining sufficient number of respondents for this study. The reasons for using this technique area: snowballing/chain referral process allows the researcher to reach populations that are difficult to sample when using other sampling methods; snowballing process is cheap, simple and cost-efficient and the fact that this sampling technique needs little planning and fewer workforce compared to other (Creswell & Clark, 2007).

Table 3.3 Distribution of studied health facilities according to level

<table>
<thead>
<tr>
<th>Facility level</th>
<th>Ilala</th>
<th>Temeke</th>
<th>Kinondoni</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Level</td>
<td>Regency</td>
<td>Kilwa Road</td>
<td>Mwananyamala</td>
<td>3</td>
</tr>
<tr>
<td>Health Centre Level</td>
<td>Buguruni</td>
<td>Kigamboni</td>
<td>Magomeni</td>
<td>3</td>
</tr>
<tr>
<td>Dispensary level</td>
<td>Pugu</td>
<td>SDA</td>
<td>Bweni</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Field data Survey (2015)

3.5.6 Data Sources and Data Collection Technique

Various data sources were employed to aid widened data pool and cross checked of the data collection, thus triangulation. The nature of research questions was fostered the use of extreme sources such as primary and secondary sources. Primary sources of data (questionnaire and interviews method) are those data which are collected afresh and for the first time, and thus happen to be original in character (Kothari 2004). According to White (2002), a questionnaire is a series of questions; each one providing a number of alternative answers from which the respondents can choose. In this study open ended and close ended questions were constructed and distributed to different NHIF Members/beneficiaries during health facility visit in order to have comprehensive and unbiased representation of results. To liaise with the questionnaire; interview was conducted to NHIF official workers and two (2) focus group discussions (each group comprised nine (9) respondents)were conducted with a specific administrators and NHIF focal people from studied health facilities.
More so, secondary source was used; these are second hand information and include both raw data and published one’s (Saunders et al, 2007). In this study the researcher dealt with various documents related to Health Insurance and NHIF from official statistical publication report, various literature books, previous conducted studies in the same area to help a comparative aspect and hence strengthen triangulation.

3.5.7 Quality control

Before data collection, one research assistant was recruited and trained for one day, on data collection. Thus ensured accuracy and validity of the data collection, and the process includes two days for pre-testing, the pre-test of data collection tools and methodology was done in two facilities and one office that was not included in the study. The aim was to see the applicability of the questionnaire and study methodology. The pre-testing exercise was also served as a means of training the research assistant for data collection. All necessary correction was done before starting the actual study.

All activities regarding data collection was done under the monitoring and supervision of the principal investigator. Either, research team was met every evening after data collections to review the collected data and to cross check the filled questionnaires for correctness and completeness.

3.5.8 Data management and analysis

Data was managed at highly standardized procedures to ensure quality results. Coding, recording, cleaning, processing, finally analysis and outputting of the results was conducted depending on the available software standards. Qualitative data entry was done through appropriate software where analysis will follow suit. Quantitative data from the questionnaires were analysed by using Statistical Package for Social Sciences (SPSS) and Microsoft Excel Spread Sheet, while qualitative data from interview guides and Focus Group Discussion were analysed descriptively using content analysis procedure. The research findings are presented in tables and others are narrated.
3.5.9 Ethics, consent and approval

Prior to conducting the study, a letter for requesting to do so, from Mzumbe University was sent to the respective authorities. Correspondence was also sent to all offices proposed which were included in the study. Before data collection the purpose of the study was explained to the respondents.

Acceptance was also sought from all individuals involved in the study. During data processing, numbers were used instead of names to ensure that confidentiality is observed.

3.5.10 Dissemination of results

The results of this study were submitted and presented to the examination panel of the School of Public Administration and Management in Partial/Fulfilment of the Academic Requirements for the Award of the Master Degree in Health System Management [MHSM] of MZUMBE UNIVERSITY.
CHAPTER FOUR

ANALYSIS AND PRESENTATION OF RESULTS

4.1 Introduction

This chapter summarizes findings of the field work. The researcher reviewed and put into analysis some of collected data whereas; MS Excel and SPSS version 20 method of data analysis was applied. The rest of the data was presented through content analysis method because it was concerned with interview and FGD. The findings are presented in three different groups that are results from NHIF members/beneficiaries who were clients after getting services in NHIF accredited health facilities, results from NHIF officials, and results from FGD conducted to administrators and their NHIF focal person in studied health facilities. The study had three main research questions.

4.2 Factors that affect accessibility to health care by NHIF members

4.2.1 Knowledge on NHIF

The researcher aimed at exploring different information from NHIF Members/Beneficiaries concerning NHIF and the health services that is received from health facilities through NHIF. The information was gathered from questionnaires that were distributed to 36 respondents (NHIF members/beneficiaries) getting health care service in health facilities. The findings were obtained from all respondents. See the following sub-section results. This information had the aim of knowing if the respondents knew anything about NHIF. (See table 4.1)

Table 4.1: Respondents knowledge on NHIF

<table>
<thead>
<tr>
<th>Responses</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data survey, (2015)
Findings from table 4.1 above show that all of the respondents 36 (100%) had the knowledge of the NHIF, which implies that the information that was obtained was gathered from people who know something about NHIF.

4.1.2 Benefits and Packages provided by NHIF

This information had the aim of knowing whether respondents knew all benefits and packages provided by NHIF to its members. Basically NHIF benefits and packages include registration & consultation fees, Medical cost, Investigation fees, Inpatient Care Services, Surgical Services, Dental Services, Optical Services, Physiotherapy, Health Care for Retirees, Medical/Orthopaedic appliances and others. (See table 4.2).

Table 4.2: Responses on benefits and packages provided by NHIF

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31</td>
<td>86%</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data Survey (2015)

The study found out that the majority of the respondents 31 (86.11%) knew all benefits and packages provided by NHIF while only 5 (13.89%) of the respondents do not know.

4.1.3 Time Spent in the health facility

This information was basically aimed to know if the NHIF members attended/got services on time in Health facilities. (See table 4.3)

Table 4.3: Time spent by NHIF Members in the facility

<table>
<thead>
<tr>
<th>Time Spend</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than three hours</td>
<td>22</td>
<td>61.11%</td>
</tr>
<tr>
<td>Three hours</td>
<td>5</td>
<td>13.89%</td>
</tr>
<tr>
<td>Two hours</td>
<td>6</td>
<td>16.67%</td>
</tr>
<tr>
<td>Less than one hour</td>
<td>1</td>
<td>2.78%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data survey (2015)
The findings show that 22 (61.11%) of all respondents spend more than three hours in the facilities from the arriving time, 6 (16.67%) spend two hours, while 5 (13.89%) spend three hours and 1 (2.78%) spends less than one hour respectively. This finding implies that the majority of the respondents spend more than three hours in the facilities from the arriving time.

4.1.4 Availability of Medicine

The researcher aims at knowing if the respondents are normally getting all medicines doctors prescribed under NHIF. (See table 4.4).

Table 4.4: Availability of medicine

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>25%</td>
</tr>
<tr>
<td>No</td>
<td>27</td>
<td>75%</td>
</tr>
<tr>
<td>Total</td>
<td>36</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data survey, (2015)

The result shows that the majority of the respondents, 27 (75%) did not get all medicines as prescribed under NHIF with different reasons while only 9 (25%) indicated that they got.

Table 4.5: Reasons of unavailability of medicines as prescribed under NHIF

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out of Stock</td>
<td>12</td>
<td>44.44%</td>
</tr>
<tr>
<td>Medicine not under NHIF</td>
<td>6</td>
<td>22.22%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>9</td>
<td>33.33%</td>
</tr>
<tr>
<td>Total</td>
<td>27</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data survey (2015)

Table 4.5 above shows that the majority of the responses 12 (44%) medicines were Out of Stock, 6 (22%) wouldn’t get medicines listed under NHIF, while 9 (33%) don’t know. This result implies that NHIF members are not satisfied with the services provided under NHIF scheme.
4.1.5 Diagnostic Services

The researcher aims to know if the respondents were normally getting all diagnostic/laboratory services prescribed under NHIF. This service includes laboratory test, radiology, cardiology, MRI and so on. (See table 4.6)

Table 4.6: Diagnostic Services

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>83%</td>
</tr>
</tbody>
</table>

Total 36 100%

Source: Field data survey (2015)

Majority of the respondents 30 (83.33%) they did not get all diagnostic services as prescribed under NHIF, while only 6 (16.67%) they got. The following were respondent’s reasons. (See table 4.7)

Table 4.7: Respondent’s reasons of not getting diagnostic services

<table>
<thead>
<tr>
<th>Diagnostic Services</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>No diagnostic equipment</td>
<td>6</td>
<td>20%</td>
</tr>
<tr>
<td>Lack of reagents</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Lack of Laboratory Technician</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Equipment broken</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>3</td>
<td>10%</td>
</tr>
</tbody>
</table>

Total 30 100%


Table 4.7 above depicted that 6 (20%) no diagnostic equipment, 9 (30%) lack of reagents, 9 (30%) lack of laboratory technician while 3 (10%) equipment was broken and 3 (10%) don’t know.
4.1.6 Findings from Focus group Discussion

Focus Group Discussion is a group discussion of approximately 6 - 12 people guided by a facilitator, during which group members talk freely and spontaneously about a certain topic. FGD is a qualitative method (Varkevisser et al, 2003).

Its purpose was to obtain in-depth information on concepts, perceptions and ideas of a group. In this study the researcher aimed to explore different information concerning NHIF and the services that it offers to its Members from its health facility administrators as well as NHIF focal persons from Dispensaries, Health Centres and Hospitals. A total of two Focus Group Discussions were conducted which involved a total number of eighteen (18); A group of nine (9) was composed of administrative staff from studied health facilities and the other nine (9) respondents were NHIF focal persons at studied health facilities. Convenient sampling method was employed to get all of FGD members

Discussions were based on the following themes:

- Factors/variables that affect accessibility to health care by NHIF members
- Efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing
- Challenges that NHIF face in the course of ensuring accessibility to health care/medical services
- Suggestions for improving

The findings were obtained from all respondents. See the following sub-section results

Through discussion the majority of the respondents especially from hospitals and health centres level pointed in Swahili that “Wagonjwa wanalalamikia usumbufu usio wa lazima kwa baadhi ya vipimo (mfano; MRI na CT Scan) kuhitaji uthibitisho kutoka ofisi za mfuko wa bima ya afya kabla ya kupata huduma” meaning that clients complain about the inconveniences caused by NHIF for some of items like MRI and CT Scan which need approval from NHIF
Few respondents, especially from health centres and dispensaries added in Swahili that “Wateja wanalalamika kutokuwepo kwa baadhi ya dawa na huduma katika ngazi za zahanati na vituo vya afya na hivyo kulazamika kununua kwenye maduka ya dawa” meaning that clients complain regarding unavailability of facilities like medicines and others especially in health centres and dispensaries. This result depicts that NHIF clients are not satisfied with some NHIF services packages, terms and conditions.

4.2 Efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing

4.2.1 Role of studied office

The researcher aimed to explore different information from NHIF official concerning NHIF and the services that NHIF offer to its members. In-depth interview was conducted to four (4) Quality Assurance Officers at the NHIF headquarters and two focus group discussions was conducted to 18 respondents (health facility administrators and NHIF focal persons). See the following sub-section results (See table 4.8)

<table>
<thead>
<tr>
<th>Table 4.8: Role of the office n=4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response</td>
</tr>
<tr>
<td>Registration of Health facilities and pharmacies</td>
</tr>
<tr>
<td>Sorting all claims</td>
</tr>
<tr>
<td>Review and setting Benefits packages</td>
</tr>
<tr>
<td><strong>Total</strong></td>
</tr>
</tbody>
</table>

Source: Field data survey 2015

Table 4.8 above shows some of the roles of NHIF Quality Assurance office

4.2.2 Training of NHIF staff

The researcher aimed to know if NHIF staff attended or participated in any NHIF training (Job training) related to their job position a better efficiency and effectiveness to their respectful positions. (See table 4.9)
Table 4.9: On job training

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source: Field data survey 2015

Findings from Table 4.9 shows that 3 (75%) of the respondents had attended NHIF training workshop related to job or position in office while 1 (25%) had not attended any training related to his job position. The result implies that NHIF management provides training to the administrators so as to gain new knowledge and skills that can lead to increasing the efficiency and effectiveness of the daily work.

4.2.3 Awareness Campaign to Clients/NHIF Members and public

The research aimed to know from NHIF administrators about the last campaign awareness to the clients/NHIF Members. All of the respondents 4 (100%) said several campaigns were conducted in different ways such as mass campaign, public and private organization and the last campaign was at Temeke primary school. However, they did not remember the exact date/month of the last NHIF awareness campaign to the clients as the result of increasing membership. The result implies that NHIF conducted different awareness campaigns to its clients as well as public at large.

4.2.4 NHIF payment system and reimbursement mechanism

The researcher aimed to explore the information about reimbursement mechanism and period/time of NHIF bills to NHIF accredited Health providers. Also to know if health facility claims settled on time. The study revealed that reimbursement mechanism of NHIF bills to NHIF accredited Health providers took up to three months/or more which was not reasonable and against NHIF policy (within 60 working days). This finding implies that there was poor reimbursement mechanism of NHIF bills.
4.2.5 NHIF staff working experiences with other NHIF stakeholders

The researcher aimed to know the working experience with other NHIF stakeholders. All of the respondents 4 (100%) said that there was a good relationship with other public and private organizations in improving accessibility to health and health care financing system to the other NHIF stakeholders. The result implies that good relationship between NHIF and other private and public organization can lead to improvement of efficiency and effectiveness of daily working to NHIF services.

4.2.6 Importance of NHIF

The researcher aims to know different views from respondents concerning the importance of the NHIF services. Also, he wants to explore the quality of health service at facilities, accessibility of health services to the individuals and assurance of the health services when one NHIF beneficiaries get sick. 2 (50%) respondents agree that NHIF services helps to improve the quality of health services at facilities, 2 (50%) were unsure of whether or not do NHIF services increase the accessibility of health services to the members and 2 (50%) agreed that NHIF services provide assurance of health services when member get sick. (See table 4.10)

Table 4.10: Responses regarding Importance of NHIF

<table>
<thead>
<tr>
<th>NHIF Importance</th>
<th>Strong Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strong Disagree</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helps to improve the quality of health services at facilities</td>
<td>1(25%)</td>
<td>2(50%)</td>
<td>0</td>
<td>1(25%)</td>
<td>0</td>
<td>4(100%)</td>
</tr>
<tr>
<td>Increase accessibility of health services to the individuals</td>
<td>1(25%)</td>
<td>1(25%)</td>
<td>2(50%)</td>
<td>0</td>
<td>0</td>
<td>4(100%)</td>
</tr>
<tr>
<td>Provides assurance of health services when member gets sick</td>
<td>1 (25%)</td>
<td>2(50%)</td>
<td>0</td>
<td>1(25%)</td>
<td>0</td>
<td>4(100%)</td>
</tr>
</tbody>
</table>

*Note: There were multiple-choice responses
Source: Field data 2015

The finding above shows that NHIF has much importance to its members although it needs some improvement to meet the NHIF service package and conditions to clients.
4.2.7 Findings from Focus Group Discussion

The researcher’s targeted aim to explore different information from health facility administrators and NHIF focal persons if the health facilities provide in the office space for NHIF related matters, can be used by focal persons to provide services to the NHIF Members, keeping and store NHIF information. Different answers were given by respondents however, that the majority of respondents 18 (100%) answered in Swahili language “ofisi hii inashughulikia kazi za Bima ya Afya tu” meaning that the office which they were using was 100% responsible for NHIF related matters only!

As discussion continued one respondent one focal person said in Swahili “siku hizi tofauti na zamani kuhakiki uhalali wa kadi za wanachama wa bima kabla ya kutoa huduma pamoja na kuandaa madai ya Bima vinashughulikiwa kituoni kabla ya kuwasilisha madai katika ofisi ya Mfuko wa Bima ya Afya” meaning that their office is now able to scrutinize membership card verifications and preparation of NHIF claims.

The researcher also wanted to know if NHIF focal persons attended or participated in any NHIF training (on job training) related to their job position for better efficiency and effectiveness to the respected area of specialization.

Half of the respondents participated in FGD were attended training (on job training) relating to their job position organised by NHIF. One administrator answered in swahili “tunahudhuria mafunzo kazini mara kwa mara yanayohusiana na kazi za bima ya afya” meaning that they attended regular NHIF workshops related to the job or position in the office. Another NHIF focal person from Kinondoni said in Swahili “hajawahi kuhudhuria mafunzo yoyote yanayohusiana na kazi za bima ya afya na anafanya kwa uzoefu tu” meaning that he did not attend any NHIF workshop training related to the job or his position in the office.

Regarding awareness campaign all respondents agreed in Swahili that “Kampeni zinafanyika mfano ni kampeni ya kuhakiki vitambulisho vya uanachama wa bimaya afya inayofanyika kupitia Redio, Magazeti na Televisheni ingawa hatukumbuki kwa mara ya mwisho ilikuwa ni lini” meaning that awareness campaigns were conducted like the current membership verification campaign cast over the Radio, Magazine and TV.
although they did not remember exactly date the or month. The result implies that NHIF conducted public awareness campaign.

This result implies that all studied health facilities provide equipment and office for the NHIF service and NHIF provides training to some of the health facility administrators and their NHIF focal persons so as to gain new knowledge and skills in their tasks. Also, NHIF conducts regular public awareness campaigns which can lead to the special care, efficiency and effectiveness of the services to the NHIF members.

The researcher also wanted to know if the NHIF was promoting equitable and universal access to health care services in Tanzania. As the discussion continued, the majority of the respondents 13 (72.22%) said in Swahili that “Bima ya afya inaweka usawa kwa watu wote kwenye huduma za afya kwani wengu kikubwa na kidogo wote wanapata huduma za afya sawa” meaning that low and high NHIF contributors are treated equally.

A few respondents 5 (27.78%) said in Swahili that “Ipo tofauti kubwa katika huduma za Bima kwa wengu kikubwa na wengu kidogo, wengu kadi za kijani ndio wengu kikubwa na ndio wanaopata huduma bora zaidi kuliko wengu kadi nyingine” meaning that some NHIF beneficiaries especially those with green cards get better access to quality services than the others.

The result implies that the majority of the respondents agreed that NHIF services promote equitable and universal accessibility to health care services in Tanzania.

4.3 Profile establishment of the main challenges that NHIF faces in the course of ensuring accessibility to health care/medical services

4.3.1 Challenges facing NHIF member/beneficiary

The researcher aims to know if the respondents are normally facing any challenges when they need health services in health facilities using their NHIF membership card. Since the researcher knows that most of the services provided to any members have
some challenges. In this study, the respondents had the following responses regarding the quality health services provided to them (See table 4.12)

Table 4.12: Challenges face by NHIF member/beneficiary

<table>
<thead>
<tr>
<th>NHIF Challenges</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strong Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor quality health services</td>
<td>3(8.33%)</td>
<td>12(33.33%)</td>
<td>15(41.67%)</td>
<td>6(16.67%)</td>
<td>0</td>
</tr>
<tr>
<td>Poor referral mechanisms</td>
<td>6(16.67%)</td>
<td>15(41.67%)</td>
<td>9(25%)</td>
<td>6(16.67%)</td>
<td>0</td>
</tr>
<tr>
<td>Take long to get Registered</td>
<td>6(16.67%)</td>
<td>12(33.33%)</td>
<td>9(25%)</td>
<td>9(25%)</td>
<td>0</td>
</tr>
<tr>
<td>Poor leadership</td>
<td>6(16.67%)</td>
<td>15(41.67%)</td>
<td>9(25%)</td>
<td>6(16.67%)</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note: There were multiple-choice responses

Source: Field Survey 2015

Table 4.12 above shows responses from the respondents 15 (41.67%) were not sure about the quality of service provided to them under NHIF, 15 (41.67%) agreed there was poor referral mechanisms, 12 (33.33%) also agree that they took long time to be registered while 15 (41.67%) agree that there is poor leadership.

4.3.2 Equitability and universal access to health through NHIF

The researcher aimed to know if the NHIF promotes equitable and universal access to health care services in Tanzania. (See table 4.13)

Table 4.13: Equitability and universal accessibility

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>3</td>
<td>75%</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: Field data survey 2015

The majority of the respondents 3 (75%) said NHIF promotes equitable and universal access to health care in Tanzania with the reason that low and high NHIF contributors are treated the same, while only 1 (25%) said NHIF doesn’t promote equitable and universal access to health care services in Tanzania, with the reason that some
beneficiaries get more access than others. The result implies that majority of the respondents agree that NHIF services promote equitable and universal accessibility to health care services in Tanzania.

4.3.3 Responses regarding NHIF packages and services

The researcher aimed to know the responses from health facilities and clients about NHIF packages and services. All respondents 4 (100%) said that the majority of their clients complain regarding NHIF service packages, conditions and other items (See table 4.14)

**Table 4.14: NHIF Packages and Services**

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Satisfied with services packages offered</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Some of the drugs are not listed under NHIF</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Some investigations like MRI and CT Scan needs approval from</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>NHIF</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Source: Field data survey 2015*

The result from the table 4.14 above shows that NHIF management still receives complains from clients (NHIF members) regarding NHIF services, packages, terms and conditions.

4.3.4 Challenges/ difficulties encountered by NHIIF staff during their daily work

The researchers aimed to know if there were any challenges that NHIF administrators got in NHIF daily working. All of the respondents 4 (100%) said that during NHIF daily working they had challenges, although they differ from one another. 2 (50%) of respondents facing the challenge of low salary and motivation among staff while 1 (25%) faced one with increased workload due to the increase of stakeholders and 1 (25%) faced a challenge of staff insufficiency. (See table 4.16)

**Table 4.15: Daily NHIF challenges/difficulties**

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insufficient staff</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td>Low salary and motivation among staff</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Increase work load due to the increase of stakeholders</td>
<td>1</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>4</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*Source: Field data 2015*
The finding above implies that NHIF administrators had different challenges in the NHIF daily working.

4.3.5 Perception of NHIF Beneficiaries on people who pay cash

The researchers aimed to explore the information about perceptions of NHIF members/beneficiaries on the services provided to non-members who pay by cash at the different facilities. Also to know the relationships with health care, access to services, time spent and perceptions attitudes on NHIF members compared to the non-members who get the health services with direct cash payments.

The findings show that 26 (72.22%) NHIF members strongly agree that Non members who pay cash directly are attended first before them while only 10 (27.22%) responded that they are not sure if the ones who pay directly by cash get the first attended before them 23 (63.89%) respondents strongly agree that there is better relationship between non members of NHIF and health care providers and 13 (36.11%) just agree that there are always better relationship between Non members and health care providers. Also, all 36 (100%) respondents, strongly agree that there is better access to health services to Non members of NHIF than NHIF members, 29 (80.56%) respondents strongly agree that people paying the cash directly perceive a better attitude from health care providers than NHIF members while 7(19.44%) said that they are not sure if non-members perceive the attitude of health care workers as well as NHIF members, 24 (66.67%) strongly agree that people paying cash directly wait for a shorter time to be attended by the health care workers compared to NHIF members, 6(16.67%) just agree that people paying cash wait shorter to be attended by the health care workers while the other members 6 (16.67%) responded that they disagree that people paying cash wait shorter to be attended by the health care workers and the majority of the respondents 36 (100%) strongly agree that people paying cash are more satisfied with the care given compared to NHIF members. (see table 4.16)
Table 4.16: Perception of NHIF Beneficiaries over people who pay cash  

<table>
<thead>
<tr>
<th>Pay by Cash</th>
<th>Strong Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strong Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>First attended before NHIF members</td>
<td>26 (72%)</td>
<td>0</td>
<td>10 (28%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Better relationship with health care providers</td>
<td>23 (64%)</td>
<td>13 (36%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Better access to health services</td>
<td>36 (100%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Perceive the attitude of health care workers as good</td>
<td>29 (81%)</td>
<td>0</td>
<td>7 (19%)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Waiting time to attend health care</td>
<td>24 (67%)</td>
<td>6 (17%)</td>
<td>0</td>
<td>6 (17%)</td>
<td>0</td>
</tr>
<tr>
<td>Satisfied with the care given</td>
<td>36 (100%)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Note: There were multiple-choice responses

Source: Field data survey 2015

These finding from table 4.16 above shows that the NHIF members complain a lot of things which NHIF Board is supposed to address so as to come out with good solutions to the NHIF members and being treated equally to Non NHIF Members (People pay by cash) when attending health care facilities since all of them pay cash but by different ways.

The table above depicts that the studied NHIF offices were responsible for NHIF 1 (25%) is used for review and setting benefit packages while 2 (50%) used for sorting claims and 1 (25%) used for health facilities and pharmacies registration. The result implies that all studied offices are used for NHIF related matters.

4.3.6 Findings from Focus Group Discussion

Most of the respondents involved in FGD answered differently regarding NHIF facing challenges when coming to accessibility to health care service. On top of that one man, a health administrator from Kilwa Road Hospital said in Swahili “malipo yanachukua muda mrefu sana tangu kuwasilisha madai katika ofisi ya mfuko wa Bima hadi madai kulipwa, wakati mwingine inachukua zaidi ya miezi mitatu” meaning that the NHIF claims take as long as three months before settlement.

Another health administrator answered in Swahili that ‘watumishi wetu wote ni wanachama wa mfuko wa bima ya Afya na wakati huo huo vituo tiba vyetu vinatoa
huduma za afya kupitia Bima ya Afya lakini idadi ya wafanyakazi walio katika orodha ya makato ya bima na idadi halisi tuliyonayo havilingani” meaning that there is some overlapping of NHIF memberships records in NHIF Offices.

One respondent added in Swahili that “Mbali na malipo ya madai kuchelewa wakati mwingine malipo yanakataliwa kulipwa kwa sababu ambazo hazieleweki” meaning that leave alone NHIF delayed payment and claims, sometimes the NHIF refuses to even pay claims without any valid reasons”

This finding implies that payments of NHIF claims take too long a time and the majority of health care facilities management are not satisfied with the NHIF payment system. There are some overlapping of NHIF memberships records this can result to poor efficiency and effectiveness of health care facilities vague-frame it better provide services which is cost fully as well as service provision to NHIF members

4.3.6.1 Suggestions for improving NHIF scheme

Different suggestions were given from both members of FGD; a number of suggestions was given. Through discussion on that themes majority of respondents were appreciable and they commended in swahili that “Huduma za afya kupitia mfuko wa bima ya afya zimesaidia kuboresha huduma za afya, nchini na zinarahisisha upatikanaji wahuduma za afya na pia zinatoka uhakika wa huduma za afya wakati wote ingawa kuna changamoto zinazotakiwa kutatuliwa” Meaning that NHIF helps to improve the quality of health services, increase accessibility of health services to the individuals and provides assurance of health services when a member gets sick”.

Suggestions given by the majority of respondents were like the following;

- “Juhudi za makusudi zifanyike kuboresha huduma za bima kwa kuwapatia wafanyakazi mafunzo ya mara kwa mara pamoja na kuboresha ofisi na vitendea kazi”,
- “Orodha ya mafao ya bima kwa wanachama ipitiwe upya ili kuingiza dawa, vipimo pamoja na huduma za magonjwa ya moyo"
The finding shows that NHIF has much importance to its members but also needs some improvement to meet the NHIF service package and conditions and if possible effort should be made especially to all health facilities and NHIF offices in terms of the capacity building of both in and up country on-job training including to provide modern office equipment.
CHAPTER FIVE

DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter explains the summary of the findings obtained from the study and it moreover evaluates the results with facts found in the study, also the chapter gives the summary, discussion, conclusion and recommendations based on the findings of the study on National Health Insurance Fund (NHIF) as a tool for improving universal coverage in accessibility to health and financing of health care services. In addition, it provides some policy recommendations to address the issues that have been raised here. Furthermore areas for further study on the National Health Insurance Fund (NHIF)

5.2 Discussion

Profile establishment of the main factors/variables that affect accessibility to health care by NHIF Members

Findings from table above show that all of the contacted respondents (NHIF Member and their dependants) by the number 36 (100%) had the knowledge of the NHIF benefits and packages provided by this scheme, these include registration & consultation fees, Medical cost, Investigation fees, Inpatient Care Services, Surgical Services, Dental Services, Optical Services, Physiotherapy, Health Care for Retirees, Medical/Orthopaedic appliances and others which implies that the information that was obtained was gathered from people who know something about NHIF.

The findings of this study show that time spent by NHIF members at health care facilities when accessing health care facilities was one of the factors that affect NHIF members to access health care services, since the majority of the respondents spend more than three hours at health care facilities when accessing care services. 22 (61.11%) spend more than three hours in the facilities from the arriving time, 6 (16.67%) spend
two hours, while 5 (13.89%) spend three hours and 1 (2.78%) spend less than one hour respectively.

This study also identified that unavailability of some services provided through NHIF was another factor that affects accessibility to health care services to NHIF members since not all package services as prescribed under NHIF were in place so as the members could be free to access them when needed and sometime some of the medicines are not available at the health care facilities. The findings show that the majority of the respondents, 27(75%) said that they do not get all medicines as prescribed under NHIF with different reasons like out of stock or they don’t know

The NHIF members accessing some of the diagnostic/investigations in the health care facilities, this is another factor which was identified in the study since the majority of the respondents 30 (83.33%) they did not get all diagnostic services as prescribed under NHIF.

The study established that 6 (20%) of the respondents said that there were no diagnostic equipment, 9 (30%) lack of reagents, 9 (30%) lack of laboratory technician while 3 (10%) equipment broken and this implies that majority of NHIF members were not satisfied with the diagnostic/investigation services prescribed by NHIF.

This was also observed in the FGD where as a majority of 12 (66.67%) from FGD topped by said in Swahili “Baadhi ya dawa na vipimo muhimu vinavyoandikwa na madaktari havipo kwenye orodha ya malipo ya bima ya afya” meaning that some of the drugs and investigation are not listed in the NHIF package.

Furthermore, the majority from FGD especially from hospital level pointed in swahili that “Wagonjwa wanalalamikia usumbufu usio wa lazima kwa baadhi ya vipimo (mfano; MRI na CT Scan) kuhitaji uthibitisho kutoka ofisi za mfuko wa bima ya afya kabla ya kupata huduma” meaning that clients complains about inconveniences which caused by NHIF for some of facilities like MRI and CT Scan needs approval from NHIF
Also few respondents especially from health centres and dispensaries added in swahili that “Wateja wengi wanalalamika kutokuwepo kwa baadhi ya dawa na huduma hasa katika ngazi za zahanati na vituo vya afya na hivyo kulazamika kununua kwenye maduka ya dawa” meaning that clients claims regarding unavailability of services like drugs and some of the investigation equipment in the health centres and dispensaries.

**Efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing**

The study finding shows that the efficiency and effectiveness is high in practice of NHIF in the course of provision and improvement of accessibility to medical services through health services since the study finding depicted that NHIF staff had attended NHIF training workshop (on job training) relating to their job position and being able to work with ability and knowledge to the respected area of specialization. Furthermore, and all the office under study was used for review and setting benefit packages, claim sorting and registrations of NHIF health facilities and pharmacies.

The study come with finding that NHIF management provides training to its staff and other health facility staff which leads to gaining new knowledge and skills in their tasks resulting in increasing the efficiency and effectiveness of daily work.

The findings from this study shows that there was good efficiency and effectiveness to the NHIF focal person and administrators since all the studied health care facilities which provide office for the NHIF staff which they can make good service provided to its NHIF members. 18 (100%) said that the offices which were using are 100% responsible for NHIF related matters, *ofisi hii inashughulikia masuala ya Bima ya Afya tu*” meaning that the facilities used in this study they provide office for the NHIF service. Furthermore, one focal person said in Swahili “*siku hizi tofauti na zamani kuhakiki uhalali wa kadi za wanachama wa bima kabla ya kutoa huduma pamoja na kuandaa madai ya Bima vinashughulikiwa kituoni kabla ya kuwasilisha madai katika ofisi Mfuko wa Bima ya Afya*” meaning that their office is now able to make membership card verifications and preparation of NHIF claims.
This result implies that majority of the respondents agree that the NHIF scheme promote equitable and universal accessibility to health care services in Tanzania.

This was also observed in the FGD where as half of respondents 9 (50%) appreciate in swahili “tunahudhuria mafunzo kazini mara kwa mara yanayohusiana na kazi za mfuko wa bima ya Afya” meaning that they attended regular NHIF workshop training related to the job or position in the office, meaning that they attended NHIF training workshops related to the job or position in the office.

This result implies that all studied NHIF office and health facilities provide equipment and office for the NHIF service and provides training to NHIF staff and some of the health facility administrators and their NHIF focal person so as to gain new knowledge and skills in their tasks.

In this study it was identified that there was efficiency and effectiveness improvement in NHIF stakeholder’s in practice of NHIF in the course of the provision and improvement of accessibility to medical services through health care financing since NHIF staff 4 (100%) said that the working experience with other NHIF stakeholders was improving time after time especially in health care financing. This finding implies that majority of NHIF focal personnel and health facilities administrators realize that there was financing system improvement in working with NHIF and other NHIF stakeholders.

However, the study findings also depicted that there was poor mechanism of reimbursement of NHIF bills to NHIF accredited health providers and the bills from health providers took up to three months/or more, which was not reasonable time as the providers has already incurred costs. The NHIF policy stated reimbursement should be within 60 working days. This finding implies that there was poor reimbursement mechanism of NHIF bills.

The result obtained from FGD shows respondents 18 (100%) said in swahili that “Mahuiano ni mazuri baina ya mfuko wa bima ya afya na taasisi zingine zinazotoa huduma za afya za serikali na binafsi na hili linachangia kuboresha huduma za afya” meaning that there was good relationship between NHIF and other public and private
organizations which led to improved financing of health service. This result showed that there was good relationship between NHIF and other private and public organizations which lead to improvement of efficiency and effectiveness of daily working.

Furthermore, the findings from this study showed that there was efficiency and effective awareness campaign regarding NHIF services since NHIF administrators majority of respondents agreed that there were several NHIF awareness campaigns conducted in different ways such as mass campaign, public and private organization and last campaign was at Temekе primary school which led to effective involvement of the registration of new members.

This finding was consistency with finding from FGD where by 18 (100%) respondents answered in Swahili “that “Kampeni zinafanyika mfano ni kampeni ya kuhakiki vitambulisho vya uanachama wa bima ya afya inayofanyika kupitia Redio, Magazeti na Televisheni ingawa hatukumbuki mara ya mwisho ilikuwa ni lini” meaning that awareness campaigns were conducted like currently membership verification campaign using different ways such as Radio, Magazine and TV although they did not remember exactly date or month. The result implies that NHIF conducts public awareness campaign.

This result implies that NHIF conducts regular public awareness campaigns, which can lead to the special care, efficiency and effectiveness of the services to the NHIF members.

However, this study argues that health services are provided faster to people who pay by cash (non NHIF members) than the NHIF members. The findings showed that 26 (72.22%) NHIF members were strongly agreed that non NHIF members who pay by cash directly are attended first in studied health facility before NHIF members even if the arrived before or at the same time. 23 (63.89%) respondents strongly agreed that there is a better relationship between non members of NHIF and health care providers and 36 (100%) respondents, strongly agreed that there was better access to health services to Non members of NHIF than NHIF members while 29 (80.56%) respondents strongly agree that people paying cash directly perceive the good attitude of health care
providers than NHIF members. 24 (66.67%) of respondents strongly agreed that people paying cash directly wait for a shorter time to be attended by the health care workers compared to NHIF Members and 36 (100%) strongly agree that people paying cash are more satisfied with the care given compared to NHIF members.

The study pointed out that there was an efficient improvement in promotion of equitable and universal access to health care services in Tanzania since majority of the respondents by 13 (72.22%) said in Swahili that “Bima ya afya inaweke usawa kwa watu wote kwenye huduma za afya kwani wenyi kipato kikubwa na kipato kidogo wote wanapata huduma za afya sawa” meaning that low and high contributors are treated the same. However, few respondents 5 (27.78%) said in Swahili that “Ipo tofauti kubwa katika huduma za Bima kwa wenyi kipato kikubwa na walio na kipato kidogo, wenyi kadi za kijani ndio wenyi kipato kikubwa na ndio wanaopata huduma bora zaidi kuliko wenyi kadi nyingine ambao ndio wenyi kipato kidogo” meaning that some NHIF beneficiaries especially those with green card get better access to quality services than others.

The result implies that a majority of the respondents agreed that NHIF services promote equitable and universal accessibility to health care services in Tanzania.

**Profile of the main challenges that NHIF faces in the course of ensuring accessibility to health care/medical services**

In this study the results showed that time spend by NHIF members in the health care facilities was one of the challenge that NHIF face in the course of ensuring accessibility to health care or medical services since majority of the respondents 33 (91.67%) spend more than two hours at the health care facilities from the arriving time, therefore NHIF management with collaboration of health care service facilities they need to address this challenge so as to reduce tie spend by NHIF members when access health care services.

Also shortage of some medicines and diagnostics services as prescribed by NHIF was another challenge which was identified in this study, majority of the respondents, 27 (75%) of NHIF members did not get all medicines as prescribed by NHIF with different
reasons like being out of stock while 30 (83.33%) they did not get all diagnostic services as prescribed under NHIF and this implies that NHIF members did not get satisfied with the medicines and diagnostic services provided by NHIF in health care facilities also 12 (66.67%) of NHIF focal personnel added this challenge by saying in swahili “Baadhi ya dawa na vipimo mahimu vilivyoadikwa na madaktari havipo kwenye orodha ya malipo ya bima ya afya” meaning that some of the drugs and investigation are not listed in the NHIF package.

The finding shows that NHIF administrators 4 (100%) agreed that there was a complaint from NHIF members against NHIF service packages, conditions and other items. Furthermore 15 (41.67%) of NHIF members mentioned that there was poor referral mechanisms and poor leadership which was also identified in this study as a challenge that NHIF face in the course of ensuring accessibility to health care/medical services

In this study it was identified that perception of NHIF members on the services provided to Non members who pay by cash at the different facilities which NHIF management and health care service supposed to address this challenge since the findings from NHIF members showed that 26 (72.22%) NHIF members strongly agree that non members who pay cash directly are attended first, 23 (63.89%) respondents strongly agree that there are better relationships between non members of NHIF and health care providers and 13 (36.11%) just agreed that there was always a better relationship between non members and health care providers. 36 (100%) respondents, strongly agreed that there is better access to health services to Non members of NHIF than NHIF members, 29 (80.56%) respondents strongly agreed that people paying the cash directly perceive the good attitude of health care providers than NHIF members, 24 (66.67%) strongly agreed that people paying cash directly wait for a shorter time to be attended by the health care workers compared to NHIF Members and 36 (100%) strongly agreed that people paying cash are more satisfied with the care given compared to NHIF members. The NHIF management and health care services facilities are supposed to address this challenge so as to come with good solutions to the NHIF members and being treated equally like non NHIF members (people pay cash directly) when attended to health care facilities since all of them pay cash but by different ways.
Also, it was identified that NHIF administrators had challenges in their daily working, although they differ one another. 2 (50%) of respondents facing the challenge of low salary and motivation among staff while 1 (25%) faced with increase work load due to the increase of customers and 1 (25%) was faced with insufficient staff.

Another challenge, which was identified in this study, was long time taken for payments of NHIF claims since majority of respondents involved in FGD answered differently in relation of the NHIF facing challenges when it comes to accessibility to health care service. As one man, a health administrator from Kilwa Road Hospital said in Swahili “watumishi wetu wote ni wanachama wa mfuko wa bima ya Afya na wakati huo huo vituo tiba vyetu vinatoa huduma za afya kupitia Bima ya Afya lakini idadi ya wafanyakazi walio katika orodha ya makato ya bima na idadi halisi tuliyonayo hazilingani” meaning that there was an overlap of NHIF memberships records in NHIF Offices.

Another health administrator answered in Swahili that “malipo yanachukua muda mrefu sana tangu kuwasilisha madai katika ofisi mfuko wa Bima ya Afya hadi madai kulipwa, wakati mwingine inachukua zaidi ya miezimi tatu” meaning that the NHIF claims take long before payment even more than three months. One respondent added in Swahili that “Mbali na malipo ya madai kuchelewa wakati mwingine malipo yanakataliwa kulipwa kwa sababu ambazo hazieleweki” meaning that Out of NHIF delay in payment of claims, sometimes the NHIF refuses to pay claims without any valid reasons”

This finding implies that payments of NHIF claims took long a time and the majority of health care facilities management were not satisfied with the NHIF payment system, this can result to poor efficiency and effectiveness of health care facilities as already do provides services which is costly as well as service provision to NHIF members Therefore NHIF management needs to address this challenge so as to make payment soon after receiving claims so as to increase efficiency and effectiveness of health care facilities as they are providing services which have been paid for.
Responses from clients about NHIF services packages and other terms and conditions was another challenge which was identified in this study such as majority of the respondents especially from hospital and health centre; pointed in swahili that “Wagonjwa wanalalamikia usumbufu usio wa lazima kwa baadhi ya vipimo (mfano; MRI na CT Scan) kuhitaji uthibitisho kutoka ofisi za mfuko wa bima ya afya kabla ya kupata huduma” meaning that clients complain about inconveniences which were caused by NHIF for investigations like MRI and CT Scan needs approval from NHIF. Furthermore, other respondents especially from health centres and dispensaries added in Swahili that “Wateja wengine wanalalamika kutokuwepo kwa baadhi ya dawa na huduma katika ngazi za zahanati na vitu vya afya na hivyo kulazamika kununua kwenyi maduka ya dawa ” meaning that clients claim regarding unavailability of services like medicines and some of the investigation equipment in health centres and dispensaries.

This result depicts that NHIF management needs to address this challenge so as to get good responses from clients regarding NHIF services packages, terms and conditions.
CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Introduction

This chapter summarizes all findings reported in chapter four and discussions made in chapter five according to the study questions, later on draw conclusions and recommendation as well as suggested in some areas for further studies.

6.2 Summary

The study was conducted in Dar es Salaam city in three Municipalities namely; Kinondoni, Temeke and Ilala where health care facilities such as dispensaries, health centres and hospitals were visited. A sample of 58 respondents was used to capture the information and the respondents involved in this study were NHIF Members/Beneficiaries, NHIF focal persons and administrators the health facilities and NHIF official staff. The study aimed to explore factors affecting accessibility to health care services and challenges in health care delivery by NHIF members. Furthermore, the study had specific objectives which include, first to establish a profile of the main factors that affects accessibility to health care by NHIF members, secondly to analyse the efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing and lastly to establish a profile of the main challenges that NHIF face in the course of ensuring accessibility to health care/medical services. To examine the specific objectives of the study mentioned above, questionnaires and interview guide were developed and conducted respective. Based on the data collected each specific objective of the study was examined, purposively sampling and snowballing techniques were used to select a sample of 58 respondents from the study population. Data were analysed by using Microsoft Excel and Statistical Package for Social Science (SPSS) version 20.
6.3 Conclusions

The study aimed to explore factors affecting accessibility to health care services and challenges in health care delivery by NHIF in Tanzania. The results of the study indicate that the NHIF scheme has many impacts on NHIF members.

The researcher was guided by the research questions, which were drawn from the research objectives to find the answer of the question to the respondents who were willing to cooperate. So, on the basis of the findings obtained from the field study a number of conclusions can be drawn as follows:

i. There is an improvement in health care financing system through NHIF scheme.

ii. NHIF management provides training to the NHIF staff, NHIF focal persons and health facility administrators so as to improve efficiency and effectiveness of the services to their clients.

iii. The NHIF scheme helps to improve the quality of health services and increase accessibility of health services in Tanzania since the NHIF members can get health care services at any time.

iv. The reimbursement of NHIF bills to NHIF accredited health providers took up to three months/or more which was contrary to NHIF reimbursement policy (within 60 working days).

v. Majority of the respondents said that benefits and packages services that are supposed to be provided by NHIF are not provided.

vi. NHIF accredited health facilities favour much more on the people who pay cash directly rather than the NHIF members whose payments are based on monthly contributions and had no direct impact to the health facility workers. For example, time to deliver the health care services.

vii. Challenges facing the NHIF members include; poor quality health services and prolonged registration process
6.4 Recommendations

Based on the major findings of this study, the following policy measures are recommended in order to improve the implementation of the NHIF scheme.

i. Efforts should be made to improve the quality of health services in the public and private NHIF accredited health facilities for NHIF members. This will increase efficiency and effectiveness of the health care services.

ii. It must be ensured that health care facilities provide equal treatment between NHIF members and people who pay by cash.

iii. The study recommends that health care services providers should improve the availability of medicines and diagnostic services in the health facilities so as to balance the situation of non members and NHIF members.

iv. There is a need of reviewing benefit and packages services offered to the NHIF clients and mechanism of reimbursement of NHIF bills.

6.5 Areas for further Research

In the light of the findings in chapter four and literature review in chapter two, the study recommended area for further study that would help to improve the accessibility of health care services delivered by NHIF members.

i. There is a need for other researchers with similar title to explore factors affecting accessibility to health care services and challenges in health care delivery by NHIF members outside Dar es Salaam so as to get the other views from rural areas.

ii. Further studies can be done on how the government is committed in providing health services in the health facilities.
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Appendix 1: Consent form (English)

INFORMED CONSENT FORM

ID NO: …………………………………………………..

Greetings,

My name is Paschal N. KUMBURU, I’m a resident studying Masters of Health System Management at School of Public Administration and Management in MZUMBE UNIVERSITY, Morogoro. I am doing research on explore factors affecting accessibility to health care services as well as challenges in health care delivery by NHIF in Tanzania

Purpose of the study

The purpose of the study is to find out factors affecting accessibility to health care services as well as challenges in health care delivery by NHIF in Tanzania

If you agree to participate in the study you will be interviewed to answer questions related to the NHIF scheme and NHIF related information.

Confidentiality

Your information will be treated with great confidential and it will be used for study purpose only. Identification number will be used instead of names.

Risks

It is not expected that any harm may happen to you because of your participation in this study.

Right to withdraw and alternatives

To participate in this study is completely voluntary. You can freely choose not to participate in this study and even if you have already accepted to participate in this study
you can quit at any time if it is necessary. No penalty or loss will be encountered upon refusal to participate or withdraw from the study

**Benefits**

If you choose to participate in this study you will provide your views and contribution that will be useful in improving NHIF scheme for the betterment of your family and the nation at large.

**Who to consult**

If you ever have questions about this study, you should contact the study coordinator or the Principal Investigator; Paschal N. Kumburu, MZUMBE UNIVERSITY, (MU), Main Campus P.O. Box 1, Morogoro Tel:0782-921065

If you have questions which need further clarification you have the right to call Mr Richard Ngowi, MZUMBE UNIVERSITY, (MU), Main Campus P.O. Box 1, Morogoro Tel: 0768277567

Signature ………………………………………

**Do you agree?**

Participant agrees……………………………..Participant does not agree………………

I…………………………………………………… have read the content in this form, my questions have been answered; I agree to participate in this study

Signature of Participant …………………………………………………………………………

Signature of Researcher …………………………………………………………………………

Date of signed consent …………………………………………………………………………
Appendix 2: Consent form (Kiswahili)

FOMU Y A RIDHAA

NAMBA YA USAJILI……………………………………..

Habari?

Naitwa Paschal N. Kumburu, mwanafunzi wa shahada ya pili (uzamili) ya afya ya sayansi ya Utawala wa Mfumo wa Afya katika chuo Kikuu Mzumbe kampasi ya Morogoro.

Nafanya utafiti kuhusu sababu zinazochangia kwemplo huduma za afya hafifu kwa wanachama wa Mfuko wa Taifa wa Bima ya Afya wanapoenda kutibiwa katika hospitali pamoja na changamoto zinazochangia katika ujumbe wa afya hafifu kwa bima ya afya Tanzania.

Madhumuni ya utafiti

Utafiti huu unalenga kugundua visababishi vinavyochangia huduma hafifu katika vitu tiba kwa wanachama wa Mfuko wa Taifa wa Bima ya Afya pamoja na changamoto zake kwa mfuko tofauti na matarajio.

Nini kinahitajika ili kushiriki

Ukikubali kushiriki kwenye utafiti huu utajibu maswali toka kwenye dodoso kadiri utakavyoulezwa na mtafiti.

Usiri

Taarifa zitakazokusanywa kupitia dodoso hili zitakuasiri na hakuna mtu yeyote atakayembeza ulichoema. Taarifa zitaingizwa kwenye ngamizi kwa kutumia namba za utambulisho

Tahadhari

Hakuna hatari yeyote itakayotokea kwako kutoka nanaushiriki wako kwenye utafiti huu.
Haki ya kujitoa au vinginevyo

Ushiriki katika utafiti huu ni wa hiari. Kutokushiriki au kujitoa kutoka kwenye utafiti hakutakua na adhabu yeye na hutapoteza stahili zako zozote endapo utaona ni vema kufanya hivyo.

Faida

Kama utakubali kushiriki kwenye utafiti huu utapata fursa ya kutoa mchango wako kuhusu maboresho ya utendeshaji wa mfuko wa afya ya bima kwa manufaa yako.

Endapo utapata madhara au la

Hatutegemei kupata madhara yoyote kutokana na ushiriki wako katika utafiti huu.

Nani wa kuwasiliana naye

Kama kuna swali kuwasiliana na utafiti huu unaweza kuwasiliana na mhusikaMkuu Paschal N. Kumburuwa Chuo Kikuu MZUMBE P.O. Box 1, Morogoro.Tel:0782-921065.

Ikiwa unamaswali zaidi unaweza kuwasiliana na msimamizi wa utafiti huuMr Richard Ngowi, wa Chuo Kikuu MZUMBE P.O. Box 1, Morogoro.Tel: 0768277567

Je, Umekubali?

Mshiriki amekubali…………………………. Mshiriki hajakubali . ……………………..

Mimi…………………………………………………… nimesoma maelezo kwenye fomu hii, maswali yangu yamejibiwa nanimeridhika. Nakubali kushiriki katika utafiti huu.

Sahihi ya Mshiriki…………………………….. …

Sahihi ya mtafiti ……………………..
Appendix 3: QUESTIONNAIRE FOR NHIF MEMBER/BENEFICIARY (English Version)

IDENTIFICATION

Questionnaire Number………………

Name (health facility for exit questionnaire)……………………

Date ………..Month……….Year……………..

SECTION A: PERSONAL CHARACTERISTICS

1. Sex

(a) Male [    ] (b) Female[    ]

2. What is the age of the respondent?

(a) 15-25 [  ] (b) 26-35[  ] (c) 36-45[  ] (d) 46 and above [ ]

3. What is your highest level of education you attained?

(a) None [  ] (b) Primary education [  ] (c) Secondary education [  ]

(d) Certificate/ College (Diploma) [  ] (f) University level [  ]

4. What is your occupation?

(a) Public employee [  ] (b) Private employee [  ]

(c) Dependent [    ] (d) Retired [    ] (e) Others

(specify)……………………………………………….
SECTION B: ACCESSIBILITY TO HEALTH CARE SERVICES

5. Do you know anything about NHIF?

(a) Yes [ ] (b) No [ ]

6. Are you aware of all benefits and package provided by NHIF? (a) Yes [ ] (b) No [ ]

6.1 If yes, Mention *Tick as much as he/she mention type of benefits and packages below*

1. Registration and Consultation [ ]
2. Medical Cost [ ]
3. Investigation Fees [ ]
4. Inpatient Care Services [ ]
5. Surgical Services [ ]
6. Dental Services [ ]
7. Optical Services [ ]
8. Spectacles (for principal members only) [ ]
9. Physiotherapy [ ]
10. Health Care for Retirees [ ]
11. Medical/Orthopaedic Appliances [ ]
12. Others (specify)…………………………………………………………………………

7. What time do you spend in this facility from the time you arrived in reception?

(a) One hour[ ] (b) Two hours [ ] (c) Three hours [ ] (d) More than three hours [ ]

8. Is this the facility that you usually attend when confronted with an illness episode?

(a) Yes[ ] (b) No [ ]
9. Do you normally get all medicines as prescribed under NHIF?

(a) Yes [ ] (b) No [ ]

9.1: If No, why? *Tick appropriate

1. Out of stock [ ]

2. Medicines not under NHIF [ ]

3. Don’t know [ ]

4. Other specify ………..

10. Do you normally get all diagnostic services (laboratory/any investigation) as prescribed under NHIF?

(a) Yes [ ] (b) No [ ]

10.1: If No, why? *Tick appropriate

1. No diagnostic equipment [ ]

2. Lack of reagents [ ]

3. Lack of laboratory Technician [ ]

4. Equipment broken [ ]

5. Don’t know [ ]

6. Other specify ……………

11. Have you ever bought medicine prescribed under NHIF out of pocket because they are not available or out of stock?

(a) Yes [ ] (b) No [ ]
12. **Tick that mostly applies to you**

<table>
<thead>
<tr>
<th>NHIF challenges</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor quality health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor referral mechanisms</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Takes long to get Registered</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poor leadership</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expensive</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SECTION C: PERCEPTION OF NHIF BENEFICIARIES ON THE SERVICES PROVIDED TO NON NHIF MEMBERS WHO PAY BY CASH

13.

<table>
<thead>
<tr>
<th>Pay by cash</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>People paying cash are attended first before NHIF members</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People paying cash have better relationship with health care providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People paying cash have better access to health services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People paying cash perceive the attitude of health care workers as good</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People paying cash wait shorter to be attended by the health care workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>People paying cash are more satisfied with the care given</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SECTION D: ADVICE/OPINION

14. In your view, what should be done to improve services provided by NHIF?

........................................................................................................................................................................

........................................................................................................................................................................

THANK YOU FOR YOUR PARTICIPATION!
Appendix 4: Dodoso la mteja (Kiswahili version)

UTAMBULISHO

Namba ya dodoso………………

Jina la Kituo alichohojiwa Mshiriki……………………

Tarehe………………

SEHEMU YA KWANZA: TAARIFA BINAFSI

1. Jinsia

(a) Mme [ ] (b) Mke [ ]

2. Umri wa mshiriki?

(a) 15-25 [ ] (b) 26-35[ ] (c) 36-45 [ ] (d) 46 ya zaidi [ ]

3. Kiwango cha elimu ya mshiriki?

(a) hajasoma[ ] (b) elimu ya msingi [ ] (c) elimu ya sekondari [ ]

(d) elimu ya ufundi [ ] (e) Chuo (Stashahada) [ ] (f) Elimu ya juu[ ]

4. Kazi?

(a) Ameajiri wa serikalini [ ] (b) amejiriba binafsi [ ]

(c) Tegemezi [ ] (d) Mstaafu [ ] (e) Nyingine (Taja)…………………………
**SEHEMU YA PILI: UPATIKANAJI WA HUDUMA ZA AFYA**

5. Je unafahamu mfuko wa bima ya Afya?

(a) Ndio [ ] (b) Hapana [ ]

6. Je unafahamu mafao yanayotolewa na Mfuko wa bima ya afya? (a) Ndio [ ] (b) Hapana [ ]

6.1 Kama ndio, Taja "*Weka alama ya vema kila anapotaja*

1. Uandikishaji na kumuonadaktari [ ]

2. Gharama za tiba [ ]

3. Gharama za vipimo [ ]

4. huduma za kulazwa [ ]

5. huduma za upasuaji [ ]

6. huduma za meno [ ]

7. huduma za macho [ ]

8. miwani (kwa mchangiaji tu) [ ]

9. huduma za kuzoeza viungo [ ]

10. huduma kwa wasataafu [ ]

11. huduma za Tiba/Mifupa [ ]

12. nyingine (taja)…………………………………………………………………………………………

7. Umechukua muda gani tangu kuandikishwa hadi kupata huduma?

(a) Saa moja [ ] (b) masaa mawili [ ] (c) Masaa matatu [ ] (d) Zaidi ya masaa matatu [ ]
8. Je, ni kituo hiki ndicho unachopata matibabu kila unapouguu?

(a) Ndio [ ] (b) Hapana [ ]

9. Je, huwa unapata dawa kupitia Bima kila unapoandikiwa na daktari?

(a) Ndio [ ] (b) Hapana [ ]

9.1: kama hapana, kwanini? *Weka alama ya vema katika alilotaja

1. Hakuna dawa[ ]

2. Dawa iliyoandikwa haipo katika Bima[ ]

3. Hajui [ ]

4. Jibu lingine (taja)…………..

10. Je, umefanyiwa vipimo kama ilivyoandikwa na daktari?

(a) Ndio [ ] (b) Hapana [ ]

10.1: Kama Hapana, kwanini? *Weka alama ya vema katika jibu  alilotoa

1. Hakuna vifaa [ ]

2. Hakuna vitendanishi [ ]

3. Hakuna mtaalamu [ ]

4. Ubovu wa vifaa [ ]

5. Hajui [ ]

6. jibu lingine (taja) ..................

11. Je, umeshawahi kununua dawa ulizoandikiwa kupitia bima?

(a) Ndio[ ] (b) Hapana [ ]
12. Je, unafikiri kuna kuna changamoto gani katika huduma kupitia Bima ya Afya?
Weka alama ya vema katika chumba kulingana na unavyoona

<table>
<thead>
<tr>
<th>Changamoto</th>
<th>Nakubalianakabisa</th>
<th>Nakubaliana</th>
<th>Sinahakika</th>
<th>Sikubaliani</th>
<th>Sikubalianikabisa</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Huduma haziridhishi na sio nzuri</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Utaratibu mbaya wa rafaa</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Inachukua muda mrefu hadi kuandikishwa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Uongozi mbovu</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ni gharama kubwa</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
SEHEMU YA TATU: MTIZAMO WA MWANACHAMA WA BIMA YA AFYA JUU YA HUDUMA ZA AFYA KWA WALE WASIO WANACHAMA WA BIMA (WANAOLIPIA HUDUMA)

13.

<table>
<thead>
<tr>
<th>Mtizamo</th>
<th>Nakubali ana kabisa</th>
<th>Nakubali ana Sina hakika</th>
<th>Sikubali ani</th>
<th>Sikubali ani kabisa</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanaolipa wanahudumi wa mapema zaidi</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanaolipa wana mahusiano mazuri na watoa huduma</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>Wanaolipa wanawapata huduma zote na wanahudumiwa vizuri zaidi</td>
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<td></td>
</tr>
<tr>
<td>Wanaolipa wanaonekana ni watu bora zaidi kwa watoa huduma</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanaolipa wanahudumiwa kwa muda mfupi</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wanaolipa wanaridhika zaidi na huduma wanazopata</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

SEHEMU D: MAONI/USHAURI

14. Kwa jinsi unavyoona, unafikiri nini kifanyike kuboresha huduma za Bima ya Afya?

........................................................................................................................................................................

........................................................................................................................................................................

AHASANTE KWA KUTUMIA MUDA WAKO KUSHIRIKI!
Appendix 3: INTERVIEW GUIDE FOR NHIF KEY INFORMANTS

<table>
<thead>
<tr>
<th>Date (dd/mm/yy)</th>
<th>Initials</th>
<th>Office Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I am ____________________________ from _______________________________

☐ Describe the general purpose of the study

☐ Explain why the participant’s involvement in the study is important

☐ Explain what will happen with the information collected through the interview, making note of confidentiality

☐ Ask the participant if he/she has any questions

☐ Request written consent from the participant, using a witness if the participant is illiterate

1. What is the role of this office?

2. Does the NHIF facing challenges when comes to accessibility to health care service? (a) Yes (b) No

2.1 If yes, mention……………………………………………………………………………………………………

3. Have you attended any training (on job training) relating to your job/position (a) Yes (b) No

4. Does the NHIF promoting equitable/universal access to health in Tanzania? (a) Yes (b) No

4.1 Explain

5. What time will take from preparation of NHIF claims after health services provision and receiving payment of claims?

6. Did you satisfy with mechanism of reimbursement of NHIF bills?
7. What response do you receive from clients regarding NHIF service packages and other terms and conditions?

8. When was the last awareness campaign to your clients/NHIF Members?

9. What was clients’ response to this campaign?

10. What challenges/difficulties did you encounter during your NHIF daily work?

11. What is your working experience with other NHIF stakeholders?

12. Tick that mostly applies

<table>
<thead>
<tr>
<th>NHIF importance</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Unsure</th>
<th>Disagree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helps to improve the quality of health services at facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increase accessibility of health services to the individuals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provides assurance of health services when one gets sick</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 4: FOCUS GROUP DISCUSSION (FGD) GUIDE

PART ONE

I am ____________________________ from _______________________________

☐ Describe the general purpose of the study
☐ Describe the aims of the interview
☐ Mention the expected duration of the interview
☐ Explain why the participant’s involvement in the study is important
☐ Explain what will happen with the information collected through the interview, making note of confidentiality
☐ Ask the participant if he/she has any questions
☐ Request written consent from the participant, using a witness if the participant is illiterate

PART TWO

Discussions based on the following themes:

- Factors/variables that affect accessibility to health care by NHIF members
- Efficiency and effectiveness in practice of NHIF in the course of provision and improvement of accessibility to medical services through health care financing
- Challenges that NHIF face in the course of ensuring accessibility to health care/medical services
- Suggestions for improving

PART THREE

Closing

Ask participant if there is anything else that he/she thinks is important in the NHIF that you have not yet talked about.

☐ Summarize the interview
☐ Thank the participant for his/her time
☐ Answer any questions he/she may have and provide your contact information to the participant
### Appendix 5: BUDGET PLAN

<table>
<thead>
<tr>
<th>COST TYPE</th>
<th>COST IN TANZANIA SHILLINGS (TSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials and equipment for research</td>
<td>500,000/=</td>
</tr>
<tr>
<td>Secretarial services photocopy and binding costs</td>
<td>500,000/=</td>
</tr>
<tr>
<td>Consumable materials</td>
<td>1,000,000/=</td>
</tr>
<tr>
<td>Data entry, analysis, and interpretation of data</td>
<td>1,000,000/=</td>
</tr>
<tr>
<td>Report writing and presentation</td>
<td>500,000/=</td>
</tr>
<tr>
<td>Travel and transport cost</td>
<td>500,000/=</td>
</tr>
<tr>
<td>Daily cost</td>
<td>2,300,000/=</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>TSH. 6,300,000/=</strong></td>
</tr>
</tbody>
</table>
APPENDIX 6: RESEARCH TIME PLAN

The Proposed Time of Activities for Nine Months

<table>
<thead>
<tr>
<th>S/N</th>
<th>ACTIVITY</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Search background information and developing research tools</td>
<td>1 month</td>
</tr>
<tr>
<td>2</td>
<td>Study conduct to test the research tools</td>
<td>1 month</td>
</tr>
<tr>
<td>3</td>
<td>Data collection</td>
<td>2 months</td>
</tr>
<tr>
<td>4</td>
<td>Data analysis</td>
<td>1 month</td>
</tr>
<tr>
<td>5</td>
<td>Report writing and presentation</td>
<td>2 months</td>
</tr>
<tr>
<td>6</td>
<td>Integrate comments &amp; research report publication</td>
<td>2 months</td>
</tr>
<tr>
<td>7</td>
<td>TOTAL</td>
<td>9 months</td>
</tr>
</tbody>
</table>
Ref.No. MU/SOPAM/ DHSM/VOL.I/106

18th February, 2015

NHIF,
Headquator,
P. O. Box ..........
DAR - ES - SALAAM.

RE: DATA COLLECTION FOR KUMBURU, PASCHAL NATHAN

The above named is a student of this University in the School of Public Administration and Management pursuing Master of Science Health System Management (MSc. MHSIM) Mr. Kumburu has finished Semester II of his studies which ended in July, 2014.

As a partial fulfillment of the requirement for the award of Masters Degree every graduate student is required to undertake dissertation on a topic relevant to her area of specialization. The candidate has opted to conduct a study on the topic entitled:

National Health Insurance Fund (NHIF) in Tanzania as a tool for Improving Universal Coverage/Accessibility to and Financing Health Care Services: Case Studies from Dar es Salaam - Tanzania.

The study (research) is expected to take only six months and thereafter Mr. Kumburu will be required to submit the thesis to the School of Public Administration and Management as per the University regulations.

We kindly request your office to accord the student with all necessary assistance, particularly in accessing official data necessary for accomplishment of his study and also getting permission to interview various people in your organization as indicated in his research proposal.

Thank you in advance for your Cooperation.

Dr. Orest Masue
For Dean SOPAM

cc: Mr. Kumburu
TEMEKE MUNICIPAL COUNCIL
[All letters should be addressed to the Municipal Director]

Tell: +255 22 2851054
Fax: +255 22 2850640
E-mail: temekemunispea@tmc.go.tz
website: www.tmc.go.tz

Ref. No. TMC/MDU U:21/30

Date: 02/16/2015

Research

RE: RESEARCH PERMIT

Please refer to the heading above

This is to inform you that permission is granted to the above mentioned student/researcher from Mzumbe University to conduct research on the impact of traditional medicine in malaria and HIV/AIDS study of... This permit will effect from the date of this letter.

Please give with necessary assistance.

For: MUNICIPAL DIRECTOR
TEMKE

Copy to: Student/researcher

From Mzumbe University

OFISI YA HANGA MKUU
IMEPOKELEWA
0 2 MAR 2015

81
ILALA MUNICIPAL COUNCIL

ALL COMMUNICATIONS TO BE ADDRESSED TO THE MUNICIPAL DIRECTOR

P.O. BOX 20950
PHONE NO: 2128800
2128805
FAX NO: 2121486

MUNICIPAL OFFICE
ILALA

Date: 12/03/2015

Medical officer in-charge

ILALA MUNICIPALITY

RE: PERMISSION TO CONDUCT RESEARCH

Reference is made to the above heading.

Paschal N. Kumburu is a 2nd year student undertaking Master of Health system management (MHSM) at Mzumbe University.

He requested to conduct a study titled: “National Health Insurance in Tanzania as a tool for improving universal challenge in accessibility to health and Financial Health care services in Dar es Salaam”. After going through his proposal, MMOH office has given him a permission to conduct study within the Municipal.

Your facility is among the facilities earmarked for the above study.

I hereby request your assistance to the candidate during the intervention period at your facility.

Dr. Yusuph A. Nangeda

For: MMOH – ILALA MUNICIPAL
Copy: Researcher
KINONDONI MUNICIPAL COUNCIL
ALL CORRESPONDENCES TO BE ADDRESSED TO THE MUNICIPAL DIRECTOR

Tel: 2170173
Fax: 2172606

In reply please quote:
Ref. No. PF/K/14 Vol.VI/

MUNICIPAL MEDICAL OFFICER OF HEALTH,
KINONDONI MUNICIPAL COUNCIL
S. L. P. 61665,
DAR ES SALAAM.

Date: 20/06/2015

Health Facility I/C,
MINYAMA HOSPITAL, MASHAVU HIC, AND ALBION HIC
Kinondoni Municipal.

REF: RESEARCH PERMIT

Refer to the above heading.

DMO office is pleased to inform your health facility that KUNBUKURU, PASCAL NATHAN which is from MEdicine UNIVERSITY
has been given a permit to perform the research work in your facility stating from 23rd JUNE 2015 to 23rd AUGUST 2015 the research is titled NATIONAL HEALTH INSURANCE FUND (NHIF) IN TANZANIA AS A TOOL FOR IMPROVING UNIVERSAL COVERAGE AND ACCESSIBILITY TO AND FINANCING HEALTH CARE SERVICES, CASE STUDIES FROM DARES-SALAAM, TANZANIA

Kindly receive & provide the necessary assistance in order to enable the student/organization to fulfill the activities comfortably.

Best wishes,

[Signature]
Research Coordinator,
Kinondoni Municipal Council

NB: Please share research report with MMOH Office at the end of your study
Map of Dar Es Salaam City Council Showing Municipalities