

**MZUMBE UNIVERSITY**

**FACTORS INFLUENCING COVERAGE OF HEALTH INSURANCE IN  
TANZANIA: A CASE OF BUGANDO MEDICAL CENTER**

**Andrew Luhanga**

**A Research Report Submitted to School Of Business in Partial Fulfillment of the  
Requirement for an Award of Master's Degree in Business Administration  
(Corporate Management) Of Mzumbe University**

**October, 2015.**

**CERTIFICATION**

We, the undersigned, certifies that he has read and hereby recommend for acceptance by Mzumbe University – Mwanza Campus a research entitled: “**Factors Influencing Health Insurance Service: A Case of Bugando Medical Center**” in Partial Fulfillment of the Requirement for the Master of Business Administration of Mzumbe University - Mwanza Campus.

Supervisor, Dr. Daud Mollel

Signature: \_\_\_\_\_

Name : \_\_\_\_\_

Signature: \_\_\_\_\_

Internal Examiner

Accepted for the Board of

\_\_\_\_\_

Signature

\_\_\_\_\_  
DEAN/DIRECTOR  
FACULTY/DIRECTORSATE/SCHOOL BOARD

## **DECLARATION**

I, Andrew Luhanga, declare that, this research study is my own original work and it has not been presented and will not be presented to any other university for a similar or any degree award.

Signature

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## **DEDICATION**

I dedicate this work to my family and much of this goes to Almighty God, for protection and guidance during the entire course and throughout my life.

## **ACKNOWLEDGEMENT**

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## **ABBREVIATIONS**

CHIS Community Based Insurance Scheme  
CUHAS Cathiloc University of Health and Allied Sciences  
HIV Human Immunodeficiency Virus  
KCMC Kilimanjaro Christian Medical Center  
LDC's Least Developed Countries  
MGDS Millennium Development Goals  
MOHSW Ministry of Health and Social Welfare  
NGO'S Non-Government Organization  
NHI National Health Insurance  
NSSF National Social Security Fund  
Oop Out of pocket Payment  
SAUT Saint Augustine University of Tanzania  
TANESCO Tanzania Electric Corporation  
TB Tuberculosis  
UNICEF United Nations children's fund  
WHO World Health Organization

## **ABSTRACT**

The study aim was to assess the Factors Influencing Health Insurance Service: A Case of Bugando Medical Center. The research design was adopted case study as research design. In this study the population consisted of all registered and non-registered respondents in the health insurance scheme. The researcher used randomly and cluster sampling technique and the sample size of the population was 100 respondents that researcher decided to work with. This will included 50 registered members in the health insurance scheme and 50 non-registered member of health insurance scheme. The study used different method of data collection such as; Semi-structured Questionnaire and document review. The researcher used both qualitative and quantitative research type in the data collection and analysis. The research result found that there is Insurance coverage to people attending BMC is very low contributing by 24.70% of health financing methods. Based to our results and supported by different literatures in both developing and developed countries the major factors for non-enrollment are financial status and poor general knowledge towards insurance on how it operates. Awareness of existence of this newer health's financing method is another reason for non-enrollment. Perceived poor quality of services at accredited facilities, inadequate benefit packages are other factors for non-enrollment to the schemes. The research recommends that Effort should made by government an NGOs to raise public awareness of importance of health insurance as well as how these people can join schemes as many citizens think that health insurance is only for those people who are employed.

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## CHAPTER ONE

### 1.1 Introduction

This chapter includes the background of the problem, significance of the study, statement of the problem, objectives of the study, limitation of the study and definition of key terms.

### 1.2 Background of the Problem

Health insurance is the cover for the cost of being treated from either in the public hospitals or private hospital. Before health insurance programs were introduced, people paid most of the physician and hospital services they used. Under this type of system, wealthier citizens were able to access these services, while poorer citizens often relied on charitable organization (Krishnaprosad 2008). Everyone has the same right to equal treatments as well as access to essential health care when in need and seeking it. In fact 'health for all' has been a goal yet to be attained since it was adopted in 1981 both on global level and on a national level in a number of countries (Wang 2011). Access to health care is major health and development issues, most government declare that their citizens should enjoy universal and equitable access to good quality care. However even within the developed world, this goal is difficult to archive and there are no internationally recognized standards on how to define and measure equitable access, (Mashinda et al 2007)

Historians debate the many reasons why national health insurance (NHI) purposes have failed, including the complexity of the issues, ideological differences, the lobbying strength of special interest group, a weakened presidency and the decentralization of congressional power. Over the years the American public as measured in opinion polls as far back as the 1930's has generally been supportive of the goals of governmental assess the health care and health insurance for all as well as government role in health financing (Henry 2009).

At national level, many countries are experiences severe crises in the public sector funding of health services and as decline in the availability of low cost, high quality services, particularly for the poor (Standing 2002). There are two very different

approaches to the problem of ensuring that people have adequate access to health care` and approach is for the government to attempt to gradually nationalize all health care services, ultimately ending with fully taxpayer found state- owned health services. The other approach is to establish a health – care environment in which private care funds and provision can rapidly, serving an increasing percentage of the population to the point where all health services are privately provided (Biesmann 2006).

In Tanzania national health insurance officially started in 2001, it is compulsory for the formal sector workers. Employer pays 6% of the employee’s salary (3% Employer and 3% Employee shared equally) to the scheme. It covers the spouse of the employee and up to four other legal dependents. The benefit package includes inpatient and outpatient care of a fixed predetermined amount. The insurance system as it operates in Tanzania effectively limits coverage to formal sector workers and their dependents, a minority of the population (Lem 2009). Good health is an important element for national development, poverty alleviation and other health development gains needed by all Tanzanian. To achieve this Government has since independence emphasized on delivery of equitable and quality preventive, primitive, curative and rehabilitative health services at all level (Abdallah 2003).

The health service at the district level has been devolved to local Authorities to increase their mandate in health service provision. Under this arrangement, the health units including the district hospitals will provide services under the supervision of the council health service Board and Health Facility committees. Apart from NHIF, Tanzania government also established the community health fund earlier. This was planned and implemented to involve the communities in paying for their health care needs through risk pooling schemes at the district level.

Africa has the highest burden of disease in the world. According to WHO (2005) 100 million people every year are driven into poverty due to catastrophic health expenditure. Health insurance can be a solution to improve access to health care. Risk sharing mechanisms are particularly important in Sub-Saharan Africa where most countries dedicate insufficient resources to health care and most health care, including medicines, is financed out-of-pocket. Out-of-pocket payments create financial barriers that prevent millions of people each year from seeking and receiving needed health

services In addition, many of those who do seek and pay for health services are confronted with financial catastrophe and impoverishment (Hjortsberg, 2002 and Xu, Evans et al 2003). People who do not use health services at all, or who suffer financial catastrophe are the extreme. Many others might forego only some services, or suffer less severe financial consequences imposed by user charges, but people everywhere, at all income levels, seek protection from the financial risks associated with ill health (Wagstaff and Doorslaer, 2003). Recognizing this, in 2005 the Member States of WHO adopted a resolution encouraging countries to develop health financing systems aimed at providing universal coverage.

Many types of national, social, private, and community- based health insurance schemes are emerging and expanding in Sub-Saharan Africa. Most Sub-Saharan African countries have been trying to implement Bismarckian social health insurance systems that cover mostly formal sector employees with joint contributions by the employee and employer. To extend insurance coverage to the self-employed and informal sectors, private and community-based health insurance schemes (CHIS) have emerged, currently comprising over 600 community-based health insurance schemes in 11 West African countries. For example, in Ivory Coast the number of functional CHIS grew from 9 in 1997 to 47 in 2006 covering more than half a million beneficiaries . In Ghana, the number of CHIS grew from 2 in 1995 to 78 in 2004. Health insurance coverage can increase access to care.

In line with the principle of universal access to health services, all public health facilities have been providing services health free of charge since independence in 1961.As in many developing counties, Majority of Tanzanians and particularly Lake zone population is of low socio-economic status so introduction of cost sharing from free health service could had impact on health services delivery. This is likely to have effects on attendance, quality and people's health seeking behavior. Introduction of other funding mechanisms in Health care delivery like National Health Insurance Fund (NHIF), National Social Security Fund (NSSF), Community Health Funds (CHF),Micro-health Insurance Schemes, Government and Local Governments,Basket Funding NGOs, Private Financing etc. was aimed at increasing access and equity to health services to the citizens. But these also have the challenges as still many of the

citizen have no formal employment and majority are of low social economic status ,this make them not easy accessible to the schemes.

Many studied in the world have described the factors which may influence insurance coverage

This includes level of income and the rate of economic growth of any country which is likely to enhance capacity of the citizens and the government to prepay.

Structure country's economy is another factor that may influence coverage .Countries which have predominantly formal sector tend to have more insurance coverage than ones with informal ones especially in developing countries because so many people do not have a formal income.

Distribution of the population is yet another factor highly populated areas are likely to access easier than dispersed rural population.

A fourth factor is the country's ability to administer this includes skilled labor force which will be working in the process of enrollment education etc. This well managed in countries with well-organized administration and political will.

A society with a higher level of solidarity is interpreted here as being one where individuals are more willing to support other individuals. Policymakers can, at times, impose solidarity, but a sufficient degree of innate solidarity in society is needed in order to implement and sustain the cross-subsidization inherent within SHI.

Government's stewardship to launch and guide a process that leads to compulsory health insurance for all. Open political debate and availability of financial information help the population to gain trust in government and other agencies involved in SHI implementation. It is therefore warranted that the contributors to SHI, the providers and the population (for example through

All factors above factors have direct or indirect influence on Quality of care from the different schemes and health providers, employment rate to the society, knowledge and awareness towards the health insurance, education status of individuals of the society which have been shown to influence health insurance coverage in many studies other studies.(Mulupi, et al ,Boateng et al 2013,Robert Basaza et al ,De Allegri Met al)

### **1.3 Statement of the Problem**

Tanzania is among the Least Developed Countries (LDCs) with a total population of about 35 million and per capita income (US\$ 310 in 2004). Tanzania subscribes fully to the global efforts of eradicating poverty and alleviating the social conditions of the poor in terms of health, education, good governance, gender balance and environmental preservation and other aspects. Due to poverty Most of Tanzanians have poor access to health insurance which were thought to these be the solution to increase coverage of health services in this era of cost sharing in health services. Many studies have been done elsewhere in the world to find factors that may affect Health insurance coverage, recently identified includes, income and the rate of economic growth of any country, economic structure, population distribution of a given society, administrative ability of the Government, solidarity of a society concerned and Government's stewardship in relation to insurance coverage. Perceived quality of health insurance, awareness education status are also other factors that have been explained by other studies .It's not well known what is the recent of coverage of these schemes in our referral hospitals as the number of schemes have emerged; formerly Tanzania had only one scheme as provider of insurance services i.e. NHIF. It's not well known on what are attitudes people of BMC and towards the tendency of having health insurance coverage especially in tertiary centers like BMC.

### **1.4 Objective of the study**

The study objectives are divided into main and specific objectives

#### **1.4.1 Main Objective**

The main Objective of the study is to assess the factors influencing health Insurance at Bugando Medical Center.

#### **1.4.2 Specific Objective**

- i. To assess the sources of Health care financing among clients attending BMC
- ii. To assess magnitude of population accessing the Health insurance at Bugando medical center.
- iii. To compare coverage of different insurance schemes.

- iv. To assess factors affecting health insurance enrollment of people attending BMC.

### **1.5 Research Questions**

- i. What are the sources of Health care financing among clients attending BMC?
- ii. What is magnitude of population accessing the Health insurance at Bugando medical center?
- iii. What are comparisons among the coverage of different insurance schemes?
- iv. What are factors that affect health insurance coverage in patients attending BMC for treatment?

### **1.6 Significance of the study**

This paper aimed at assessing magnitude of population accessing the Health insurance at Bugando medical center. Factors affecting Health insurance schemes coverage .There is no any research done in Hospital setting regarding this topic in Tanzania and in many developing countries as well, many researches of this kind have been done in communities and to note all Health providing centers in communities tend to refer patients to referral hospitals for further care. To be practical on how these patients are getting their treatments in referral hospitals it's better to assess the health financing methods that are commonly used in these settings and the way people perceive them.

### **1.7. Scope of Research**

The sample of respondents in this study was drawn from the population of all people that are attending treatment at Bugando medical center. Other data was drawn from a well-equipped medical record department .Being largest Consultant Hospital in Lake Zone and the second largest Hospital in Tanzania, the data collected are likely to reflect the scheme situation of major consultant Public hospitals of Tanzania like Muhimbili National Hospital, KCMC in Moshi and Mbeya referral Hospital.

### **1.8. Limitations of Research**

The study was be conducted at one center only and is the consultant hospital and not from the general population as in some other studies, the study population could have better being larger than this. Results may not reflect the small hospitals, health centers and the dispensaries and general population. This was due to financial constrains

duration of study allowed by the University to conduct this study and the real purpose of the study to be limited to

### **1.9. Summary of the chapter**

Access to health care is major health and development issues, most government declare that their citizens should enjoy universal and equitable access to good quality care. At national level, many countries are experiencing severe crises in the public sector funding of health services and as decline in the availability of low cost, high quality services, particularly for the poor. Health insurance can be a solution to improve access to health care. Risk sharing mechanisms are particularly important in Sub-Saharan Africa where most countries dedicate insufficient resources to health care and most health care, including medicines, is financed out-of-pocket. Although Health insurance coverage can increase access to care there are challenges that face the process. Many studied in the world have described the factors which may influence insurance coverage these include; income and the rate of economic growth of any country, economic structure , population distribution of a given society, administrative ability of the Government ,solidarity of a society concerned and Government's stewardship in relation to insurance coverage. These factors have direct or indirect influence on Quality of care from the different schemes and health providers, employment rate to the society, knowledge and awareness towards the health insurance, education status of individuals of the society which have been shown to influence health insurance coverage in many studies other studies . It was not well known on what was coverage and factors affecting coverage of health insurance BMC towards the tendency of having health insurance coverage especially in tertiary centers like BMC. This study aimed at finding out the answers of these questions.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter describes the different review done by various researchers, books, newspaper, journal and other written material who talked about the factors influencing health insurance services. This chapter included review of the related literature, empirical literature review, theoretical framework and conceptual framework.

#### **2.2 Theoretical Framework**

##### **2.2.1 National Health Insurance**

National health insurance (sometimes called statutory health insurance) is health insurance that insures a national population for the costs of health care and usually is instituted as a program of healthcare reform. It is enforced by law. It may be administered by the public sector, the private sector, or a combination of both. Funding mechanisms vary with the particular program and country. National or Statutory health insurance does not equate to government run or government financed health care, but is usually established by national legislation. In some countries, such as Australia's Medicare system or the UK's NHS, contributions to the NHI or SHI system are made via taxation and therefore are not optional even though membership of the health scheme it finances is. In practice of course, most people paying for NHI will join the insurance scheme. Where the NHI scheme involves a choice of multiple insurance funds, the rates of contributions may vary and the person has to choose which insurance fund to belong to. In the United States, the Patient Protection and Affordable Care Act includes a "health insurance mandate" that produces the same effect as NHI or SHI, though relies more heavily on the private market than their public sector (Medicare, Medicaid, and S-CHIP) than most countries (WHO, 2010).

##### **2.2.2 National Health Insurance Scheme in Tanzania**

According to NHIF (2010), The National Health Insurance Fund is a statutory health insurance scheme which was established by Parliamentary Act No.8 of 1999, in order

to facilitate access to health services by the principal members and their dependents. The main objective for the establishment of the fund was to administer the scheme and to formulate and promulgate policies for sound administration of the scheme. The management of the Fund is visited in the Board of Directors However, the day to day operation of the fund are executed by the Director General on behalf of the Board of Director. Generally, employees in the public sector are obliged by the Law to register themselves and contribute to the Fund a total of six percent of employee's salary, equally shared between employer and employee, except uniformed service men, whose contribution is 6.25% and where paid by Government. The membership size of the Fund has increase from 164,708 in 2001 to 586,386 by March 2014; an increase caused rising of number of beneficiaries of the Fund. The beneficiaries have been increasing gradually from 691,774 in 2001 to 3,236,757 as of March 2014. Extension of member coverage has been made possible through the amendments of the National Health Insurance Fund Act, which extended the coverage to include all public servants instead of the previous Central Government employees. The following groups were taken on board namely public servants councilors, and members of the Police, Immigrations, Fire and Rescue as well as other groups of persons.

As the scope of membership and beneficiaries increase, the Scheme is expected to ultimately assume its national role as the major universal social health insurance provider The Fund's benefits package comprising of Registration and Consultation Fees, Outpatient Service, Medicines, Diagnostic Test, Inpatient Services, Surgical Services, Physiotherapy and Optical Service. An important inclusion and enhancement in the package was the introduction of the Retirees benefits for the rest of their live, a great stride in the Scheme's milestone. The service are provided to beneficiaries through the Fund's accredited health facilities which include Government Faith Based and Private facilities that are located throughout the country. During the first two years of operation, the scheme encountered various challenges which hindered its smooth operation. In order to tackle the challenges, the focus was mainly on awareness creation to key stakeholders to ensure that they understand the scheme and package offered by National Health Insurance Fund. Now than ever before, stakeholders to ensure that they understand the concept of social health insurance which has led to increased applications of the excluded groups requesting to join the Fund.

### **2.2.3 Health Service Delivery in Tanzania.**

During the 1990s, Tanzania responded to the WHO's "health for all" declaration by attempting to decentralize the health system through the devolution of central power from the Ministry of health and social welfare and Social Welfare (MoHSW) to Local District Government Authorities. Following the political, administrative, and financial decentralization, the District Councils were given responsibilities of managing clinics and health centers and the generation of local funds for buying medicine and equipment. The MoHSW headquarters was responsible for making and monitoring health policies, guidelines and reforms (URT, 1994). Following the reform, every District or Council need to form a Council Health Management Team (CHMT) whose composition is as follows District/Council Medical Officer, District Nursing Officer, District Pharmacist, District Laboratory Technician, District Health Officer, Health Secretary, Social Affairs Officer and District Dental Officer. These are the core members of the team. Others are co-opted members including District coordinators of various health interventions including HIV/AIDS coordinator, TB/HIV coordinator, TB and Leprosy coordinator, Reproductive and Child Health coordinator, Home based care coordinator, Malaria coordinator and Cold chain coordinator. The District Medical Officer is the head of the team.

The CHMT is responsible for the supervision, management, and monitoring of all district based health services. Furthermore, each health facility is supposed to have a health committee consisting of community representatives to discuss community health problems and needs. It is also responsible for supervising, coordinating and supporting the Primary Health Care, comprised of health centers and dispensaries/clinics. Patients whose condition demands resources not available at the Primary Health Care level are transferred to the district hospital. In collaboration with the Local Government, the CHMT plans and budgets for the activities needed to manage, control, coordinate, and support health services in the district on a quarterly basis. The quarterly reports gathered from each health facility include details of health services offered, efficiencies and deficiencies of the health facility, for example the number of staff present and missing, and infrastructure constraints.

Although CHMT have multiple roles, more often, they lack sufficient capacity both in terms of quantity and quality, to take greater responsibility for health services

management, including of supervision of curative services. However, their work is often interfered with by central government and donor funded parallel systems such that sometime they are ordered to implement directives from higher level authorities, such as attending centrally planned seminars and workshops, participating in centrally driven projects, attending requests for reports, and conducting supervision of health services as per MoHSW schedule (Kimaro and Sahay, 2007).

Following advice from World Health Organization and as an attempt to delegate some of the activities of CHMT, hospitals (health facilities) were supposed to form a Medicine and Therapeutic Committee (MTC). This body is a technical organ that will provide a forum for various disciplines to work together in developing strategies for improving medicines and therapeutics management, such as developing and using medicines formularies, managing medicine safety, information and education activities, and investigating utilization of medicines in health facilities. Also it makes sure that adequate copies of STG are available and the health workers are well informed.

#### **2.2.4 Health care financing**

Health care financing is mobilization of funds for health care , allocation of funds to the regions and population groups and for specific types of health care, mechanisms for paying health care (Hsaio, W and Liu, Y, 2001). There are several mechanisms which can be employed in Health financing ,these includes General revenue or earmarked taxes, Social insurance contributions, Private insurance premiums, Community financing, direct out of pocket payments, Each method distributes the financial burdens and benefits differently ,each method affects who will have access to health care financial protection .

#### **2.2.5 Social insurance contributions**

It is compulsory. Everyone in the eligible group must enroll and pay a specific premium contribution in exchange for a set of benefits. Social insurance premiums and benefits are described in social compacts established through legislation. Premiums or benefits can be altered only through a formal political process.

### **2.2.6 Private insurance**

In this mechanism private contract offered by an insurer to exchange a set of benefits for a payment of a specified premium .Marketed either by nonprofit or for profit insurance companies consumers voluntarily choose to purchase an insurance package that best matches their preference offered on individual and group basis. Under individual insurance the premium is based on that individuals risk characteristics. Major concern in private insurance is buyer's adverse selection .Under group insurance; the premium is calculated on a group basis, risk is pooled across age, gender and health status.

### **2.2.7 Microfinance insurance scheme.**

This can be broadly defined as systems based on voluntary engagement and the principles of solidarity and reciprocity. Members usually have to meet certain obligations, e.g. payment if premiums and are bound together by a common objective and a strong local affiliation. Many times, these schemes evolve out of traditional systems or form as a response to the low coverage provided by formal systems.” (Ziemek and Jutting 2000)

Refers to schemes are based on three principles: community cooperation, local self-reliance and pre-payment ;Several factors are responsible for success of community financing these include, Technical strength and institutional capacity of the local group, Financial control as part of the broader strategy in local management and control of health care services. Support received from outside organizations and individuals, Links with other local organizations, Diversity of funding, Responding to other (non-health) development needs of the community, Ability to adapt to a changing environment.

### **2.2.8 Direct out of pocket.**

In this case payments are made by patients to private providers at the time a service is rendered. User fees refer to fees the patients have to pay to public hospitals, clinics, and health posts not to private sector providers. Proponents of user fees believe that the fee can increase revenue to improve the quality of public health services and expand coverage, major objection raised against user fees had been on equity grounds. Inability to access health services, catastrophic expenditure and impoverishment are

strongly associated with the extent to which countries rely on out-of-pocket payments as a means of financing their health systems. These payments generally take the form of fees for services (levied by public and/or private sector providers), co-payments where insurance does not cover the full cost of care, or direct expenditure for self-treatment often for pharmaceuticals. A major challenge, therefore, to the achievement of universal coverage is finding ways to move away from out-of-pocket payments towards some form of prepayment. Solutions are complex, and countries' economic, social and political contexts differ, moderating the nature and speed of development of prepayment mechanisms (Mills A. et al 2007)

Medicine benefits through health insurance programs have the potential to improve access to and promote more effective use of affordable, high quality medicines. Health insurance is intended to reduce the financial burden of purchasing health care by pooling funds and sharing the risk of unexpected health events.

### **2.2.9 Importance of health insurance**

There are number of reasons of why several countries have made effort to establish Health insurance schemes, these include, Assurance of access to health services at all times, 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 *laissez-faire* to ownership by Members 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

### **2.2.10 Challenges facing Health insurance sector**

The challenge behind the Health insurance globally and developing countries like Tanzania are costs of insurance, economy of these countries as most of them the rate of unemployment is very high .A part of poverty there are other non-financial reasons on why these people have no enough coverage Insurance schemes in some of them are as follows; General perception at early days (mainly negative),Drug shortages by the insurance agents or the service provider, Absence of infrastructures Example pharmacies ,Emergence of fraudulent tendencies, Problems related to the health system and infrastructure itself have negative impacts on the funds' operations Limited

scope of coverage, Operates in un-regulated environment, Low awareness by the public on how these different schemes operates, Preference on cash payments vs card, Absence of set basic package , Non adherence by some health service providers on the standards set by insurance agents or Ministry of health in a given country non acceptance of some new members by different schemes due to other reasons example presence of chronic disease to a joining member. Low quality and unequal distribution of health services play an important, discouraging role in the patients' willingness to pay for any type of health insurance. Also, societal characteristics influence the success rate of a national health insurance. Since rich inhabitants will pay higher premiums than the poor and usually suffer from fewer diseases, the wealthy share of the population partly subsidizes the health care for the poor population.

## **2.3 Empirical Literature review**

### **2.3.1. International evidence about user charges**

A first important observation is that many of the world's 1.3 billion people on very low incomes still do not have access to effective and affordable drugs, surgeries and other interventions because of weaknesses in the health financing system. The last decade numerous proposals for and actual studies on user fees among other cost-sharing mechanisms in developing countries' sectors have been placed. Essentially, cost-sharing systems are intended to augment the inadequate government budgets allocated for service health s by involving the general or selected members of the public to pay partially for their medical service needs.(Boetang et al )

In the 1980s, most sub-Saharan African governments had experienced fiscal difficulties, leading to government failure to continue financing health services alone. As one of the agendas for economic reforms, the World Bank recommended increased cost-recovery systems to finance publicly-provided health services. This was envisioned to relieve the public health services from chronic shortage of recurrent inputs such as drugs and other medical supplies. Increased cost-recovery revenues were also suggested as a means for improving the quality, effectiveness and coverage of health services and to contribute to people's ownership and sustainability in-service health provision.

Mixed evidence about the effect of user charges on people's attendance at facilities health has continued to be documented, the majority of literature pointing out negative effects on the poor and marginalized population groups. There is an assertion that user charges have a reduction effect on the demand for services health especially among the poorest population groups, although the extent to which this is the case depends on the level of the charge. A study in Kenya found a drop in patient attendances in the first nine months after user fee introduction and a reverse in the trend of attendance after the government waived such fees.

Similar observations on user fees discouraging patient attendances were made by Yoder in Swaziland. Moreover, the World Health Organization through the Special Program for Research and Training in Tropical Diseases made an evaluation on the impact of user fees on disease control in several tropical countries and found that a fee introduction or increase leads to a drop in the overall demand for care for diseases, including malaria. Gilson identifies that payment of user fees out of the pocket of a patient at the service counter enforces the poor delaying health contacting facilities. Meanwhile, the introduction of any cost-sharing system without having in place mechanisms to protect those who cannot afford to pay could be more risky than free health service provision, although it is not easy to identify the inability to pay. Nevertheless, a positive impact of user fees on quality of service and increased Services Health Management Research patient attendance has been observed in West African countries such as Cameroon and Niger. This evidence supports an argument that under-utilization of modern medical services might be contributed to by consumer disappointments with quality of service rather than the user fee introduction. Of course, there is the question of which period of cost sharing policies should be evaluated to judge their impacts.

### **2.3.2 Effect of cost sharing in access to Health services**

Many studies have shown that Cost of health services presents a major barrier to adequate health care not only in developing but also in developed world. After the introduction of user fees in the 1990s, Tanzania determined that certain services should be provided free of charge, including certain preventive and maternal and child health services. This cost exemption, however, is not uniformly applied across health

facilities, and varies whether a patient is visiting a private, government-run, or faith-based medical facility.

Consequently, equitable health care distribution is not simply an issue left to the government to decide. While the Tanzanian government owns about 64% of all total health facilities, other major players control the remaining facilities. These players are made up of both private-not-for-profit and private-for-profit organizations, and the private providers rely largely on government financing.

### **2.3.3 Insurance schemes in Africa**

In many African countries registered members under any of the schemes, get a card which he/she can use to seek treatment in any hospital in the country. When members visit a health facility with the card, they are treated and offered the services they have signed for without them having to pay for anything – unless they ask for an extra service, like a private ward. The bills are then sent to the scheme provider which then pays the money to the hospital. They can also use the card to buy prescribed drugs at accredited pharmacies or licensed chemical shops without paying at the point of delivery – the pharmacy will contact their service provider to take its money.

At least, that's how the system is supposed to work on paper. But there have been reports of some hospitals and pharmacies turning patients away, complaining that the public health insurance schemes owes them huge amounts of money. Some of the big hospitals in the Africa have often been compelled to issue public statements warning that their operations could grind to a halt if the Health Insurance doesn't speed up the payment of their claims.

Whatever form of health insurance schemes in many African countries you sign up to entitles you to some minimum services example in Ghana (NHIS) these are: Out-patient services – general and specialist consultations reviews, general and specialist diagnostic testing including, laboratory investigation, X-rays, ultrasound scanning, medicines on the NHIS Medicines list, surgical operations such as hernia repair and physiotherapy. In-patient services – General and specialist in patient care, diagnostic tests, medication-prescribed medicines on the NHIS medicines list, blood and blood products, surgical operations, in patient physiotherapy, accommodation in the general ward and feeding (where available). Excluded Services Ghana schemes include.

Health insurance does not entitle any member to all medical procedures and health services. If they require any of the following that they may need to pay more: Appliance and prostheses including optical aids, heart aids, orthopedic aids, dentures etc. ,Cosmetic surgeries and aesthetic treatment, Anti-retroviral drugs for HIV, Assisted Reproduction (e.g. artificial insemination) and gynecological hormone replacement therapy, Echocardiography ,Photography, Angiography, Dialysis for chronic renal (kidney) failure, Organ transplants, All drugs that are not listed on the NHIS list, Heart and Brain Surgery other than those resulting from accidents, Cancer treatment other than breast and cervical, Mortuary Services Diagnosis and treatment abroad, Medical examinations for purposes other than treatment in accredited health facilities (e.g. Visa application, Education, Institutional, Driving license etc),VIP ward (accommodation),Oral health – pain relief (tooth extraction, temporary incision and drainage), dental restoration (simple amalgam filling, temporary dressing),Maternity care – antenatal care, deliveries (normal and assisted), Caesarean section, post-natal care. Emergencies – these refer to crises in health situations that demand urgent attention such as medical emergencies, surgical emergencies, pediatric emergencies, obstetric and gynecological emergencies and road traffic accidents. These kind of services varies from one country to the other or one scheme to another in the same country, for example contrally to Ghana Tanzania and Kenya, All insurance companies including private ones Echocardiogram services is covered by the scheme.

#### **2.3.4 Patient Health Care Financing Sources in Tanzania**

There are several sources of Health financing strategies in Tanzania the includes,National Health Insurance Fund (NHIF),National Social Security Fund (NSSF),Community Health Funds (CHF),Micro-health Insurance Schemes (MHIS),Other Funding sources include Government and Local Governments,Basket Funding,NGOs,Private Financing,Community Financing,Donor Funding.

#### **2.3.5 National owned insurance schemes In Tanzania (NHIF)**

The National Health Insurance Fund (NHIF) was established in 2001, with the basic objective of providing health insurance to civil servants. Since then, the NHIF has increased coverage by extending its membership to private, informal and semi-formal sectors. In 2009, the NHIF was mandated by the Government to manage the

Community Health Funds (CHF) which were initially managed by the local authorities. The main objective of being given this task was to bring about the growth of the CHF scheme in terms of coverage, number of members and quality of health services accessible to its beneficiaries. In fulfilling this task, the NHIF used several innovative approaches and strategies, including the preparation of the three year implementation plan, training its employees, and conducting several sensitization and motivation campaigns. Also the NHIF has taken several steps to conduct monitoring and evaluation on matters pertaining to the scheme. Through the management of the CHF, the NHIF has learnt several practical lessons about the CHF and social insurance schemes in general. The application of these lessons can be extended to similar schemes in the sub-Saharan region.

### **2.3.6. Private Financing in Tanzania**

Comprise of Direct individual (out of pocket) payments as well as private health insurance schemes. To-date Tanzanian households provide the greatest proportion of health care financing, Out-of-pocket payments are gradually becoming less popular in urban centers, as people are now enrolling in Insurance schemes. i.e. moving from cash payments to card payments (at the point of receiving health service) Cash payments are tricky modes especially for the poor.

### **2.3.7. Private Health Insurance in Tanzania**

Private health Insurance schemes are relatively recent modes of health care financing in Tanzania; these are such as AAR, MEDEX and Strategies are voluntary and cover mostly salaried workers on an individual basis or as employees of a registered employer. Benefit package is rated i.e. each member has a specific benefit package depending on the premium he/she paid. Operates on an individual equivalency (no pooling of risks). There is adverse selection of risk. Premiums are calculated according to the anticipated risk e.g. age, sex, risk exposure-medical family history, medical individual history etc. In Tanzania PHI schemes mostly operate in urban areas and with private health provider.

### **2.3.8. Factors affecting insurance coverage**

There are number of factors can in principle affect insurance coverage. First, there is the general level of income and the rate of economic growth. A greater amount of income per capita is apt to increase the capacity of enterprises and citizens to prepay insurance contributions. In addition, tax revenues are likely to increase with income, facilitating the subsequent channeling of any government subsidies into insurance schemes. Steady economic growth, therefore, is likely to enhance this capacity to prepay.

Second, the structure of the economy also matters. Many developing countries do have important agricultural, manufacturing and service sectors where a notable part of employment is informal. Such countries then are likely to face administrative difficulties in assessing incomes and collecting contributions because so many workers do not receive a formal salary. This may hamper provision of health protection for the informal segment of the population, especially when an SHI scheme would rely significantly on household contributions.

Third, administrative costs may be influenced further by the distribution of the population one intends to cover. The population in urban areas, where there is likely to be at least a minimum quality of infrastructure and communications, and high population density, is likely to be easier to serve with an SHI system than a widely dispersed rural population.

A fourth factor is the country's ability to administer. The establishment of insurance schemes requires a sufficiently skilled labor force. Secondary and tertiary education should ideally respond to such training needs. Related markets, such as in financial services, other insurance businesses and even well-established community health insurance schemes, can also provide appropriately trained personnel. Their staff can also be called upon to be involved in the training and general capacity building of schemes staff. An insurance scheme's administration is also reinforced when a social security system is in place, thanks to the availability of personnel skilled in functions common to all branches of social security. The fifth factor is the level of solidarity within a society. A society with a higher level of solidarity is interpreted here as being one where individuals are more willing to support other individuals. A system of full financial protection requires a significant amount of cross-subsidization, both from

rich to poor and from low risks to high risks. Each country needs to define what an appropriate level of solidarity to enable such cross-subsidization is. Policymakers can, at times, impose solidarity, but a sufficient degree of innate solidarity in society is needed in order to implement and sustain the cross-subsidization inherent within insurance schemes.

Finally, the five facilitating factors discussed above may be present to a lesser or larger degree, but it will still take government's stewardship to launch and guide a process that leads to compulsory health insurance for all. Stewardship can be best understood as a function of a government that is responsible for the welfare of the population and concerned about the trust and legitimacy with which its activities are viewed by the citizenry. One important element of governmental stewardship is therefore to allow the various stakeholders and the population at large to have a voice in social policymaking. Open political debate and availability of financial information help the population to gain trust in government and other agencies involved in SHI implementation. It is therefore warranted that the contributors to SHI, the providers and the population ( A.M. Spreeuwiers and Geert-Jan Dinant)

Apart from economic point of view, there are other social demographic factors that have been describe to affect insurance coverage in many studies factors that may affect increased awareness to newer health financing methods. Researches done in Kenya Uganda, Burkina Faso, Malaysia and Ghana(Stephen Mulupi, Doris Kirigia and Jane Chuma) (Robert Basaza, Bart Criel and Patrick Van der Stuyft ) (De Allegri M, Kouyaté B, Becher H, Gbangou A, Pokhrel S, Sanon M, Sauerborn R)have shown level of employment have significant impact on insurance coverage

### **2.3.9Barriers of insurance coverage**

As discussed briefly in the empirical literature review there are several factors that may be hinder coverage of National and private insurance scheme coverage

#### **1) Barriers of enrolment**

Restrictions to enrolment stem from numerous sources, including inconsistent or incomplete policies regarding eligibility, inadequate information management systems to ensure access, and enrolment costs.

### **Lack of citizenship**

Non-recognition as a citizen, i.e., having 'stateless' status, bars illegal immigrants, refugees, and others lacking formal proof of citizenship from accessing any social protection scheme, including health insurance. Such disenfranchised individuals and families can only access health care services for which they can pay out of pocket. A report by the United Nations High Commissioner for Refugees notes that only 46 per cent of newborns in 103 refugee camps were issued birth certificates" (UNHCR 2010). Another source notes that Vietnamese women married to foreign husbands who renounce their citizenship when moving abroad, become stateless once they return to Vietnam following a failed marriage. These women lose access to Vietnamese social protection as well as the legal right to work, even if their foreign husband abandons them (McKinsey 2007). A similar issue influences pastoralist or nomadic populations who routinely cross national borders. Kenyan Somalis are one example, as they routinely face refusal in attempts to obtain citizenship papers. Lacking these proofs of citizenship, they are excluded from health insurance and other social safety nets, denied preventative and promotive health care, and face significantly greater risk of illness, death and health-related impoverishment (Carrin 2007; Kenya National Commission on Human Rights 2007).

### **Weak birth registration systems**

A fundamental challenge is the effectiveness of birth registration systems to enroll poor and vulnerable groups. Obstacles include high fees, inadequacy of administrative infrastructure, overly complicated registration processes, and gender-based discrimination. There is also a pervasive problem of insufficient awareness of the requirements and benefits of registration among the poor, the functionally illiterate, and other at-risk groups. At the same time, weak information systems and poor quality data limit the potential of administrators to measure the extent of under-registration. Complicating matters further is the fact that birth registration also requires coordination across multiple line ministries and programmes, so systemic improvements are difficult to design and implement (UNICEF 2010).

In China, incomplete birth registration, common in rural and poorer areas, limits the ability of authorities to quantify or identify the target population. China's complex

system involves multiple administrative steps that prevent many parents from registering their children. This makes it impossible for them to enroll in a social protection scheme, including health insurance. China is not alone in facing the challenges of sub-par birth registration rates, as the literature indicates unrecognized citizenship is a barrier to UHC in many countries in Africa and Asia (The World Bank 2010; UNESCAP 2010).

### **Preferential enrolment of formal and civil sector workers**

The typical sequence in countries implementing health insurance is to first cover the formal sector before extending coverage to the informal sector, the poor, and the unemployed, even if actual rollout plans call for enrolling the entire population. Evidence suggests that coverage gaps are due in large part to the limited public resources budgeted towards implementation. Complicating factors include incomplete and inaccurate demographic data to ascertain actual coverage levels for various groups, and insufficient coordination of different health insurance elements to cover specific vulnerable groups, such as street children (Vietnam), migrant workers (China), and rural populations (Pakistan). Specific health insurance benefits intended to cover the particular needs of migrants, the indigent, pregnant women, mothers, and children are often lacking.

Several countries have sought to build political will for expanded coverage by establishing a timeline for the provision of full coverage to initially excluded groups. Strong political support is required in such cases to ensure adherence to the timeline and that planned coverage of vulnerable groups is not perpetually deferred. China provides a good example of such strong political will; the latest data from the Chinese government report in March 2010 indicates that its three national insurance plans cover 0.93 billion people, amounting to over 90 per cent of the total population (Barber and Yao 2010). Other countries, such as Rwanda and Vietnam, have built upon strong community-based insurance schemes to increase rapidly the breadth of coverage. Among the countries with some form of the health insurance majority reported that civil servants and the formal sector were mandatorily covered, despite traditionally being the least vulnerable segments of the population. For more vulnerable groups studied, such as women, children, and the indigent, the information

collected through the phase 1 questionnaire indicated that less than half the countries have managed to extend to them any mandatory coverage, either through health insurance.

Motivation for countries having succeeded in expanding coverage beyond the formal sector and civil servants appears to be an equity agenda, driven by national commitments to achieving UHC.

### **Inability to identify and enroll vulnerable groups**

The most common pattern for expanding the breadth of SHP plans is to commence with enrolment of the formal and civil sector workers. This presents a challenge to effective enrolment of at-risk groups. One contributory factor is a lack of clear data and reliable measures for identifying vulnerable persons and sub-populations (Morestin, Grant et al. 2009). In India, the survey found the BPL (Below-Poverty-Line) lists, which record who is eligible for various social health protection plans, are often outdated. There, as elsewhere, lack of information to accurately describe and quantify the eligible BPL population means that it is difficult to assess regional variations in insurance coverage rates, utilization, and the impact of enrolment strategies for BPL at the household level. As a result, it can be dauntingly hard to detect areas where targeted enrolment drives could be beneficial, and close to impossible to gauge the level of actual protection insurance could offer to the BPL population (Jain, O'Connell et al. 2011).

Especially common in the countries surveyed are large informal sectors, with a significant percentage living off subsistence farming or fishing. In such cases, the inability to identify or apply reliable and accurate inclusion and exclusion criteria seems to lead to under-enrolment in plans. Countries such as Burkina Faso, India and Vietnam report that it is difficult to define enforceable guidelines on who is entitled to join various insurances.

Further, given the multi-component nature of health insurance at the implementation level there often are differing and inconsistently applied eligibility criteria for the constituent plans. In China, each region can set its own eligibility benchmarks for the poor, with correspondingly inconsistent subsidies for poor families' insurance premiums. The Chinese government has increasingly supported research on barriers to

health insurance, with the result that it has identified coverage for migrant workers, along with inadequate birth registration, as a central issue to resolve health insurance is to be achieved.

Issues can also arise when a country elects to expand the breadth of coverage rapidly, while being unable to predict the feasibility of enrolment goals or what constitutes a sustainable enrolment strategy. Mass enrolment days, i.e. inviting universal enrolment on a specific date, may not be practical in poorer countries given the technical, financial and human resources required. However, some countries have used targeted enrolment windows with some success, including India, which instituted a four-month annual enrolment period in each area, and Ghana, which hosts periodic enrolment camps. One exciting development is the growing use of ‘smart’ (microchip embedded) national identity cards, as in India and China, to establish eligibility and facilitate universal enrolment into insurance and other social service plans. Uganda has a plan to eventually encode the unique patient ID number provided at the time of birth into a smart card, to ensure access to all entitled social services for various at-risk groups throughout the lifecycle.

## **2) Barriers to accessing benefits once enrolled**

In many countries, a discrepancy exists between nominal, or recorded, and real, or effective, enrolment in insurance plans. Nominal enrolment reflects the number of persons administratively registered in a given scheme, while effective enrolment signifies the portion of all enrolled persons that truly are able to access all of benefits when needed. Although surveyed countries employ a range of policies to increase enrolment of vulnerable populations, they usually rest upon the flawed assumption that enrolment equates with access.

### **Barriers posed by inaccurate and incomplete data**

The survey found pervasive data and information deficits in most countries, greatly hindering determination of the extent to which vulnerable populations can actually use the benefits for which they are nominally eligible.

The experience in India illustrates the problems with assuming that enrolment automatically translates into the ability to take advantage of benefits. Indian insurance

companies receive compensation based on how many families they enroll during the four-month annual enrolment period, which incentivizes the enrolment of as many people as possible, regardless of whether or not enrollees live close to a plan-eligible service provider. As a result, due to distance and costs, many enrollees cannot reasonably access authorized health providers. All countries examined describe a similar lack of accurate data on vulnerable populations. Interviews with health administrators in countries as dissimilar as Bangladesh, India, Kenya, Mali, Nigeria, Uganda and Zimbabwe indicated a common concern that many remote and rural populations are unable to use benefits to which they are entitled.

### **Barriers from under-investment**

In addition to addressing issues related to geographic access, ensuring sufficient investment in supplies, staff and equipment for facilities is essential. Inadequate investments in supplying public health facilities with sufficient commodities, equipment and staff are common throughout Africa and Asia. If a health system is unable to provide consistently the fully-defined benefit package to the entire population, introducing or expanding health insurance will not be effective. Recognizing this fact, many countries have undertaken initiatives to increase health system capacity to deliver defined service packages. For example, in Ghana, the Community-based Health Planning and Services program has worked to expand clinics across the country, leading more people to be closer to a point of service, and more likely to see a professional when needed.

### **Lack of portability**

Another barrier relates to the ‘portability’ of benefits; that is, the right to access benefits while away from a person’s home. In both China and Vietnam, household registration systems effectively tie people to their place of residence. In both countries, migrant workers who enroll into the rural component of the national insurance schemes are not entitled to protection under urban insurance plans when working in metropolitan centers. Although migrant workers enrolled in their home districts can maintain coverage for their families, individual workers effectively have no protection at their distant place of employment. Their only option is to pay out-of-pocket

(OOP) for needed healthcare, as returning home for healthcare is likely too costly and time consuming, and may endanger their employment. The problem is significant; in China alone there are over 100 million migrant workers, with the majority lacking insurance coverage. Recent changes have loosened some restrictions to permit migrant workers to enroll outside

Of their home district, though this typically requires paying for dual coverage.<sup>vi</sup> However, Chinese migrants, like those in many other countries, are often ‘undeclared’ workers. It is common practice for employers not to register them as formal employees in order to avoid having to contribute the employer portion of insurance. The migrant worker could take an individual policy for coverage at the place of employment, while the family is covered under another plan purchased in the community where worker resides. However, a review of literature for the LA suggests that few migrants are willing or able to pay for dual coverage. <sup>19</sup>premiums, thereby leaving workers unprotected. China, as with several countries, have or are beginning to enact policies to increase portability by waiving regional limitations on accessing insurance benefits. Unfortunately, little data yet exists to assess the impact these revisions have had (Estacio, Charlet et al. 2012).

### **Financial barriers**

Evidence collected during this LA suggests that a persistent barrier to is an health insurance over-reliance on private financing of health interventions, primarily through OOP payments for services. OOP payments can impoverish reduce the amount of services they can receive, or even lead them to avoid seeking needed care altogether (Kruk, Goldmann et al. 2009; Gustafsson-Wright, Janssens et al. 2011; Minh and Ngyen 2011) The removal of financial and other barriers to access is requisite to achieving Universal Health insurance Coverage, the health-related MDGs and other pro-poor social outcomes. Fortunately, most governments are responding to this challenge with a range of solutions, from health insurance to other approaches, all in an effort to remove financial barriers to health insurance.

### **A typology of user fees**

User fees are a form of health system financing; they are charges levied for healthcare at the point of use that shift some of the costs of services to those receiving care.

Proponents of user fees had hoped for improved quality and better service provision, though opponents cite mounting evidence of increased exclusion of the most vulnerable and most at-risk population groups in virtually every country instituting user fees. However, user fee abolition must be part of a coherent approach that replaces revenues lost by providers with tax-based financing,

to ensure all appropriate services are delivered (Ridde 2011). It is therefore important to analyse types of user fees, as the choice of strategies to reduce financial barriers will depend on the kinds of fee faced by each vulnerable group. It is useful to think of three broad categories of user fees:

**Formal fees:** Official tariffs set by the government for specific services rendered, such as fees for caesarean sections and other in-patient services; fees for treatments, consultations and medicines provided in out-patient services; and fees for services rendered in communities, such as spraying the walls of family dwellings with insecticide to exterminate mosquitos that transmit malaria. Social protection mechanisms such as insurance, cash transfers, or fee waivers can address barriers to access imposed by formal fees. Additionally, there are ranges of fees that vary from unofficial, but legal, fees, to ‘informal’ and largely unsanctioned fees. While the two types often co-exist, they have different underlying causes; therefore, the removal of bottlenecks caused by their presence typically requires quite different strategies.

**Unofficial fees:** Fees users pay for supplies and commodities that are out of stock at the public health facility from which they seek care. For instance, in remote, rural areas in Burkina Faso, Uganda and Nepal, patients must purchase gloves, bandages and medicines from private sector providers in order to obtain treatment at ‘free’ public facilities. These end-user expenses fill the gap caused by insufficient government spending for supplies and equipment for public services. In theory, full funding of all needed supplies and commodities would end such out-of-pocket expenses by health service clients.

**Informal fees:** Additional fees charged at the point of service provision by health staff with the primary aim of supplementing their income. These fees are more difficult to manage, as they require a combination of improved governance (enforcement of user fee waivers, pro-poor subsidies and social protection schemes), plus improved

motivation and incentives for public health care providers (e.g., higher wages, other non-wage incentives or some mix). Community-based oversight, for example clients using SMS texting to report instances where they are charged informal or unofficial fees, is another potential strategy that could help to reduce these fees.

However, financial barriers from a multitude of causes continue to curtail access to healthcare even in countries with health insurance schemes. Although insurance premiums are commonly indexed to income, these fees still pose a significant barrier to poorer households in several countries. A related concern is the various forms of user fees (see box above) not covered by health insurance or. Co-payments at the time of service are common among schemes; in Rwanda, such payments were found to pose a significant barrier to service access (Dhillon, Bonds et al. 2011). Another factor is the height of coverage, typically much less than 100 per cent, indicating that significant barriers in the forms of additional necessary OOP spending, may persist even where health insurance have been implemented (Jain, O'Connell et al. 2011).

A third issue is reimbursement schemes, which require upfront payment of healthcare costs with repayment occurring later, and often with a significant delay. In the instance of insurance coverage for rural residents in China, final OOP payments, after all reimbursements, were equal to over half of annual per capita income for 2009.

The Chinese government has highlighted this as an area for action and has recently enacted reforms to eliminate most OOP spending by shifting reimbursement for costs of services from patients to service providers, limiting OOP spending to a small co-payment and expanding low-income waivers of co-payments to the near poor. Important to the success of this initiative will be the degree to which medical officers in Chinese health facilities enforce the new regulations on payments. Although data is not yet available to quantify the impact of the reduced OOP fees, interviews conducted during the development of this project's case study on China indicates access for the poor is increasing (Meng 2011). Fourth, temporary or permanent loss of income due to illness can be catastrophic and push families deep into poverty, in particular seasonal workers, small-plot farmers, and informal workers. Health insurance generally focus only on financial protection from the direct costs of illness. Although rife with difficulty, it is essential to explore coverage of lost wages as part of a comprehensive social protection approach to removing financial barriers to health insurance. Survey

evidence appears to indicate that no offers health insurance protection against lost income due to illness, either as a benefit or via a link to an anti-poverty cash transfer scheme. Several countries have social security plans, though these are uniformly limited to subsets of civil sector and formal sector workers. One example is Myanmar's social security scheme, which provides covered workers with cash benefits for employment injury, temporary and permanent disability, maternity leave, and for loss of income due to other reasons. No country reported a scheme for reimbursing lost wages from death or disability to informal workers or subsistence farmers themselves, or their families.

### **3) Barriers to appropriate and quality Universal Health Coverage**

#### **Lack of adequate data and analysis on patterns of inequities**

A critical barrier in designing evidence-based benefit packages is the absence of data on the causes underlying why certain groups suffer disproportionately higher rates of illness and preventable illness. The need clearly exists for coverage of sufficient depth to prevent and eliminate dissimilar causes of illness and burden of death profiles between differing vulnerable groups. Countries with rarely health insurance define their benefit packages on explicit equity criteria, or on an analysis of differences in vulnerabilities across various at-risk groups. Defining an ideal package of covered interventions for each endangered group remains challenging due to the limited nature of research on health outcomes related to the breadth and depth of insurance. Outside of China, Ghana and Rwanda, the survey identified few countries that had used local research to define benefit package .UNICEF promotes enhanced monitoring of barriers to equity at the country level, and supports efforts to assess systematically specific vulnerabilities of various at-risk groups. The organization has a long-term commitment to work with governments to put into place information and management systems that expose patterns of inequity and their causes, and which will inform national plans to reach health insurance.

#### **Lack of incentives for preventative and primary care**

A number of existing benefit packages, such as those in Rwanda and Ghana, are extremely comprehensive and include emphasis on preventative care. However, many other countries limit insurance coverage to certain types of services or care. In India,

for example, only inpatient care is covered under RSBY, although health authorities are exploring possibly increasing the depth of coverage to include outpatient services.

### **Weak national and sub-national governance**

Health insurance plans frequently lack adequate supervision and oversight of their implementation, particularly in regards to addressing barriers. An example is the absence in many countries of a Quality Assurance mechanism to investigate if appropriate care actually reaches the population. Few countries participating in the survey have functional regulatory bodies, or strong oversight mechanisms able to ensure attention to treatment guidelines and standards. Rwanda is one of few countries to have set up a “Health Insurance Council” to assure that the national health insurance plan achieves Health insurance of adequate quality to increase the level and equity of health outcomes for the entire population (Republic of Rwanda 2010).

Vietnam provides another example of a high-level political commitment to improving the inclusiveness of social health protection plans. Figure 2 below presents the successive policies having influenced enrolment in health insurance since 1992. Strong governmental support allowed the passing of the Vietnam Law on Health Insurance in 2009, under which all children under six years old and all near-poor people were compulsorily covered by health insurance. The law also provided for the enrolment of students and pupils from January 1, 2010; farmers and workers in the agriculture, forestry, fishery and salt production sectors as of January 1, 2012; and all remaining population groups as of January 1, 2014.

### **Barriers to receiving care of sufficient quality**

Ensuring universal access to appropriate health care is critical for reaching the goal of equitable health outcomes. While indispensable, access is not sufficient. Numerous researchers and public health experts over the years have noted that coverage of interventions has to be of sufficient quality to be effective, that is, to reduce substantively the rates of preventable illness and death. The “effective coverage” of an intervention is the specific type and quality of coverage associated with a measurable reduction of illness or death, validated by peer-reviewed research. The package of insurance benefits needs to have suitable breadth, depth and height to achieve quality coverage. Only this can lead to real improvements in equity as well as overall health

outcomes (Pariyo 2008). In effect, the ability of the health systems to deliver quality coverage measures progress in health system performance at local, district and national levels to achieve. Health insurance (.Ha 2011)

### **2.3.8 Different review from difference authors**

According to URT (2008) explain that Quality in health services means working according to specific standards, which aim at improving the health status of individual and communities reducing suffering due to diseases and illnesses and increasing client's satisfaction. At the same time effectiveness and efficiency is increased. In all activities in the health sector the focus on quality will be enhanced and centered on evidence based medicine and public health and rational decision making.

Mutalemwa and Shillingi (2012) argued that on health services decides by the Bukoba Municipal council, using the sample of 100 patients and 40 health staff, clinical officer, laboratory technician, medical desisting). The convenience sampling method was used for administration of the questionnaire. The finding of the study found out that 63% expressed dissatisfaction with health care services, 26% were satisfied and in 10% of interviewed respondents the delivery of BRK health service were average. The study concluded that the delivery of quality health services was hampered by obstacles related to technical competence, access to services, affordability, interpersonal, relations between clients and health staff, reliability of services and amenities. This situation was not likely to support delivery of quality health service that leads to enhanced work productivity, education performance, life expectancy, and savings and invest and reduced expenditures on health care. The study recommended that partnership between and among different levels of government and with the private sector and civil society organizations is necessary to increase accessibility and quality of health services. This requires clear delineation of complementary roles and responsibilities.

According to URT (2007) examined that the overall objectives of the health policy in Tanzania is to improve the health and well-being of all Tanzania, with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. This policy objective is translated into local government authority's level in order to further extend and strengthen accessibility, provision and utilization of

quality of health services in Tanzania, despite remarkable improvement over the years since the advent of health sector reforms in the early 1990s is still unsatisfactory. For long time the performance of the health sector has been negatively affected by limited resources which have led to an unsatisfactory quality of health care provision at all levels.

Muhondwa et al (2008), Examined the extent to which patients at the Muhimbili National Hospital were satisfied with the service and care they received at Muhimbili National Hospital. The sample size was 2,741. The study found that most patients were satisfied with the service and care they received. Some patients expressed dissatisfaction with specific aspects of the service that they received. They were particularly dissatisfied with long waiting time before receiving services, the high costs of treatment and investigation charged at the hospital, poor levels of hygiene in the wards and negative attitude of staff towards patients. The overall recommendation was that Muhimbili National Hospital should maintain the high standard it has in order to keep patients satisfied with the service they receive. AlAdham (2004), Assesed on perceived health care service quality at Palestinian Hospitals. Using sample of 500 draw from all working hospitals in the city of Nablus (two public, two private for profit and two charitable) the patients questionnaires conducted by face to face interviews. Duodu and Amonkwah, (2011) Assessed and Analyzed on the determination and effects of customer satisfaction on behavioral intentions of consumers in Ghana's insurance industry, it was a cross sectional survey that used self-administered structured questionnaire to the target population of customers of insurance companies in Ghana the sample size was 1100 the finding was the impact of customer satisfaction in behavior intention as found in this study does not depend on the demographic characteristics of the respondents such as their gender, age, income and education the recommended that insurance service provides should Endeavour to satisfy and delight their customers as means of influencing behavior intention.

Leelartapin et al (2012), Assessed on patients expectation and satisfaction pertaining to hospital service quality data collected from 450 patients the study was conducted at one hospital located in western part of Thailand. Findings shows that the service quality level of this hospital with lean management concept is moderate also indicated that the reliability and tangibility are two most important dimensions of hospital

service quality perceived by patients. The study concluded that provide managerial implication in continuously improving the service quality thereby enhancing customer satisfaction.

Ayodo et al (2012) explored the factors affecting provision of service quality in the public health sector in Kenya, as total of 103 respondents were draw. Data was collected using closed and open ended questionnaires the finding of the study found that low employee capacity, low technology adoption, ineffective communication channels and insufficient food delivery of service quality to patients in public health sector affecting health service quality perception patient satisfaction and loyalty. The study concluded that organization must enhance employee's capacity in order to improve provision of service quality. Adequate number of high skilled and experience employees must be employed continuously, discourage ineffective recruitment, encourage monitoring of doctors and staff, and ensure that performance and practice standards are met to enhance service quality provision.

Mohmoud and Al-khalil(2012), assessed on the patients perception towards the quality of health care services provided by the public hospitals affiliated to the Syrian Ministry of health and social welfare in Damascus. The sample size was 677; the study found that female lower educated patients would hold less positive perceived quality for the health care services than other categories of patients do. The cross section survey was conducted using the tool of questionnaires. Gender and education were found to predict the perception quality of health care service. So it advised for public hospitals to pay more attention to this category of patients. This could be done through some practices like offering well specialized medical staff and a stay in separated rooms from other categories of patients as well as using simpler language and tools in explaining the conditions especially to those with lower education .It is recommended to enhance the quality of health service at these hospitals, so they can compete with other private hospitals. Having patients surveyed periodically regard their satisfaction could be effective in enhancing the quality of the health care service at this stage.

Alrubaiee and Alkaa'ida (2011), investigated on the relationship between patient perception of health care quality, patient satisfaction, and patient trust and the mediating effect of patient satisfaction. The study was descriptive quantitative in nature aiming to develop a better understanding of the patients perception of health

care quality and its relation to patient satisfaction and patient trust the sample size was 330, The finding was that public hospitals are performing poorly quality health care service. Patients were found to be generally dissatisfied with the service quality. This may probably reflect the low investments in public hospitals. The study also showed that, socio-demographic characteristics are significance in determining health care quality thus recommended public hospitals need to carefully design patients oriented strategies focusing on reliability, empathy and responsiveness improvement in order to compete effectively with private hospitals that enjoy great investments.

#### **2.4 Conceptual Framework of factors influencing enrollment, non-enrollment and drop Out from health insurance schemes.**

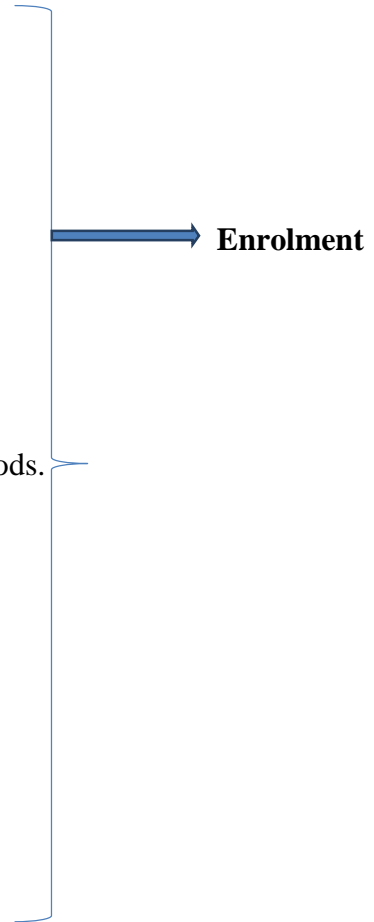
At consultant hospital level both the health care providers and beneficiaries are important factors in the enrollment to of health insurance schemes. Invariably affects the decision making of head of household in the enrolling in health insurance schemes. Education level, health status, Occupation, Economic status, quality of care provided at health facilities greatly affects the decision of the household to join the Health insurance schemes. Awareness is another determinant for enrolling or not enrolling into scheme. Household heads may opt for user fees knowing that they may pay the health insurance schemes. premiums and not use it as they may not get sick or that paying for the user fees may be cheaper than paying the health insurance schemes. Premium. Another important factor to the enrolling or not enrolling into the CHF is the perceived quality of care received bearing in mind one paying for user fees or enrolled in CHF may have a choice of health providers. Demographic factors like Age, Sex, Marital status, Education level have an impact to joining the schemes.

**Beneficiary characteristics**

Age, Sex, Marital status, Education level, health Status, Occupation, Economic status

**Factors influencing the decision to join Scheme**

- i. Perceived quality of care provided at health
- ii. Awareness.
- iii. Health financing method.
- iv. Perceived usefulness of choice in any of the methods.
- v. Political will
- vi. Financial barriers.
- vii. Portability.



## **CHAPTER TWO**

### **RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter presents a systematic analysis of the research strategies, techniques, survey population that adopted during collection and analysis in order to achieve the specific objective of the study, The methodology include the choice of the research area, sampling design and procedure, sampling Techniques, variables, measurement procedure, data collection techniques, data analysis, research activities of schedule, work plan, estimate research budget, expected time of commencing the study and the expected time of completing the study.

#### **3.2 Area of study**

This study was conducted in Mwanza region with population of 2,772,509 at Bugando medical center. Bugando Medical Center is among of four Tanzanian consultant hospitals in the country situated in Mwanza Tanzania serving more than 20 million citizens of lake zone,western and central Tanzania(Shinyanga, Mwanza, Tabora ,Sigida, Dodoma, Kigoma, Mara, Kagera,Rukwa and Dodoma regions) including the neighboring countries like Congo, Burundi, Rwanda and Uganda. It's currently owned by Tanzania Episcopal Conference since 1985 from Tanzania government.

#### **3.3 Research Design**

The researcher used case study design due to the fact that studies are greatly comprehensive and reliable because of their ability to explore in detail and enables the researcher to get more information. The researcher used study a cross-sectional exploratory case study carried out in April and May 2012 in BMC in Mwanza. The researcher used cross-sectional exploratory because he has no enough resources to enable him to make wider study

### **3.4 Sampling procedure and Sample size**

#### **3.4.1 Sample size**

According to Kothari (2004) Sample size refers to the number of items to be selected from the universe to constitute a sample. The researcher used representative sample from each targeted population. Also the sample size of targeted population depends on the size or largeness of the population. The sample size of the population was 100 that researcher decided to work with. This will included 50 respondents who used Health insurance or other non out pocket method as the source of funding in treatment and other 50 respondents who did not employ the method.

#### **3.4.2 Sampling Techniques**

The researcher applies both randomly sampling and cluster sampling. The importance of simple random sampling gives each individual an equal chance of being selected from the population. Cluster sampling is a sampling technique used when natural groupings are evident in a statistical population. The selection of two categories of respondents was done by the researcher purposely with the expectation of getting data which helpful in accomplishing the research.

### **3.5 Data collection Methods**

Depending on the nature of data, questionnaire and interview was useful in the study. All questions are structured or closed items which require respondents to write responses they want and left them behind, Each question has relate to the research problem or research objectives.

#### **3.5.1 Interview**

Interview method involves presentation of face to face and replies in terms of face to face. The study was conducted purposely to ensure every respondent are participating and necessary information is included. It was conducted to get in-depth view on the subjects of the study regarding the objectives. The interviewer with Swahili version questionnaires asked questions and recorded and then transferred to excel computer programs.

### **3.5.2 Questionnaire**

The use of the questionnaire method is intending for the collection of primary data. The questionnaire instrument is physically administered to the intending respondents. The questionnaire method is administer to employees other than managers, series of questions in logical order are distributed to selected respondents, Through the method the researcher is able to get information from many people without necessarily meeting them. The questionnaire method prefers as it enable the respondents to get enough time to think and to respond accurately to the question without interference by the researcher and it is relatively inexpensive to administer as it do not require much time to administer

### **3.5.3 Documentary review**

This method involves relying on information that already exists such as newspapers, brochures, journals, personnel manuals, annual report, and official information. Secondary data was collected from BMC medical records and Accounts department.

### **3.6 Data Analysis**

This study guided, enlighten and show the plan on how the information or data to be collected analyzed to give meaning. The data was coded and entered by the researcher. The researcher analyst breaks data into constituent parts in order to obtain answers to research questions and to test research hypothesis. The descriptive data was statistically analyzed by using SPSS and provide the analysis in ratio and percentages. Data interpretation was done by using tallying, table, graphs and where necessary in chart.

#### **3.6.1 Qualitative Approach**

The study employs participatory approach via qualitative design. Structured (standardized) and unstructured interviews with key informants and observation method was maintained to allow new insights.

#### **3.6.2 Quantitative Approach**

The study employed survey technique for quantitative approach, because it is simply expressed as gathering information about a large number of people by collecting

information from few of them. For this purpose questionnaire was supplied. The design could save cost in terms of money and time.

### **3.7 Ethical considerations**

Ethical issues addressed by the researcher consider respondents by seeking consent from the respondents, checking the cultural aspects of the people, confidentiality of the information obtained from the respondents providing correct data without manipulation.

## CHAPTER FOUR

### DATA PRESENTATION AND ANALYSIS OF FINDINGS

#### 4.1 Introduction

This chapter deals with the research findings, data analysis and interpretation of data.

**Instruments of Data Collection:** Both Primary and Secondary Sources of data collection were used to collect the information. These involved series of consultation of related dossiers and records with other source. Questionnaire used in this study was a close and open ended questionnaire purposely designed by researcher.

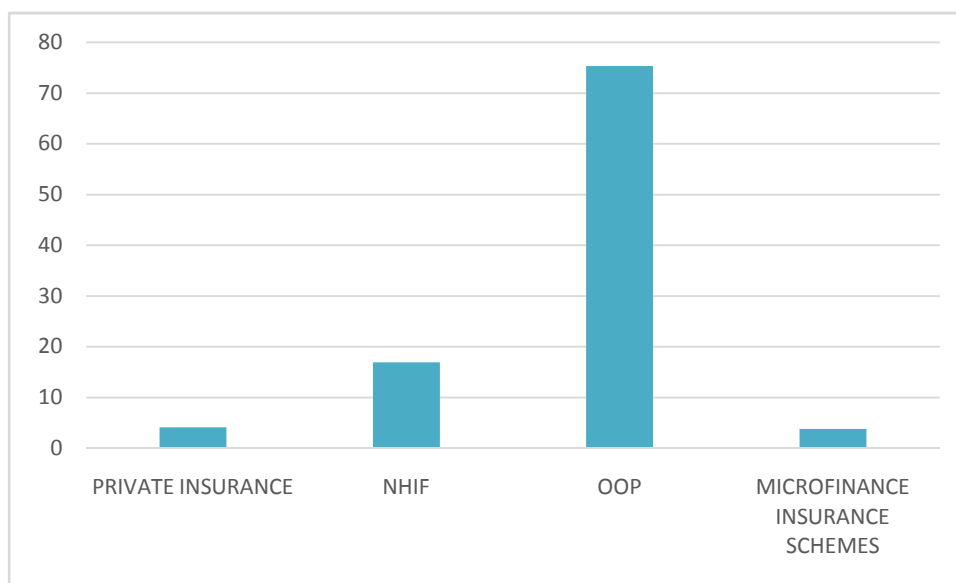
**Procedure of Data Collection:** The respondents were given the questionnaire in their place. Instruction on how to fill the questionnaire was given. Confidential treatment of information was assured. Two types of questionnaires were employed, the first type were used for 50 respondents who used Health insurance or other non out pocket method as the source of funding in treatment at the time of interview and the other 50 who did not employ the method.

#### **Health care financing at BMC in year 2012/13**

Secondary data from BMC medical records department and account department showed that among 247,970 services which were provided to the patients attending at BMC from July 2012 to June 2013, 39134(24.70%) of health care financing were through non- direct out pocket means of payment of which (16.9%) belonged to NHIF scheme (see fig 1), Microfinance insurance schemes contributed only by (3.80%). Majority (75.3%) received their services through OOP method.

To mention, the microfinance insurance schemes were SAUT, TANESCO, Singita Reserve, GGM, Catholic Diocese, Butimba Prisons, Military Hospital, BMC-VYUO, IRC-Kigoma, AUSDRILL(T)LTD, TRA; UCCRSO-MWANZA, Religious Institutions, and ELCT Bugando. To note no patient was recorded to use CHF as the source of funding.

**Fig 1 Histogram showing coverage of different health financing methods among BMC Patients in year 2012/13**



**Source; Research findings 2014**

## **4.2 DATA ANALYSIS OF RESPONDENTS WHO ARE USING HEALTH INSURANCE MODE OF HEALTH FINANCING SYSTEM.**

### **4.2.1 Gender of respondents**

Gender in the study it reflect that in the health insurance beneficiary male are more than female in terms of number, therefore the researcher look gender as important matter so as to look the ratio of the female and males so as to balance the responds both from male and female

**Table 1; Gender of respondents**

Gender	Frequency	Percent
Male	31	62.0
Female	19	38.0
Total	50	100.0

**Source; Research findings 2014**

Table 1 above show the response on the gender of the respondent that contribute on their view which state that 62% of the respondents were male while 38% of the respondents were female. Result show that health insurance beneficiary worked in the study male are more than female so it means that male are more educated in the health insurance than female.

#### 4.2.2 Age of the respondents

Age of the respondents worked in the study reveal that are young people which prove that is the active group which contribute to the national development. So there is need for this group to have health insurance so as to protect them with diseases so to contribute to develop their nation.

**Table 2; Age of the respondents**

Age	Frequency	Percent
15-30	14	28.0
31-45	24	48.0
46-60	8	16.0
61-75	4	8.0
Total	50	100.0

**Source; Research findings 2014**

The table 2 above show that 48% of the respondents their age rank between 31-45, other 28% of the respondents their age rank 15-30%, also 16% of the respondents their age rank between 46-60 and their remain 8% of the respondents their age rank between 61-75.

#### 4.2.3 Marital status of the respondents

Most of the respondents participated in the study were married so it prove that married people are aware on the health insurance compare to the other group of the marital status.

**Table 3: Marital status of the respondents**

Marital status	Frequency	Percent
Single	19	38.0
Married	31	62.0
Total	50	100.0

**Source; Research findings 2014**

Table 3, above show the response on the marital status of the respondents worked in the study in which 62% of the total respondents were married and remain 38% respondents were single. So the result proves that married people are in large in number among the health insurance beneficiary.

**4.2.4 Educations of the respondents**

Educations are more important to the health insurance beneficiary because it help them to understand the benefit of the health insurance. Clear the study prove that the large number of health insurance beneficiary are educated and most of them their education start from secondary to college.

**Table 4: Educations of the respondents**

Education	Frequency	Percent
No formal education	3	6.0
Primary education	7	14.0
Secondary education	14	28.0
Collage education	20	40.0
University graduate	6	12.0
Total	50	100.0

**Source; Research findings 2014**

Most of the respondents participated in the study with 40% have college education, 28% of the respondents have secondary education, 14% of the respondents have primary education, 12% of the respondents have university graduate and remain respondents. The result prove that health insurance beneficiary who had collage education are large in number so means that large number of the health insurance beneficiary are more educated.

#### **4.2.5 Occupation of respondents**

Most of the respondents tends to join the health insurance scheme because of the regulations set by the authority that every employees must have the health insurance in which result prove that majority of the respondents were employed.

**Table 5: Occupation of respondents**

Occupation	Frequency	Percent
Employed	28	56.0
Unemployed	7	14.0
Peasant	6	12.0
Business	3	6.0
Student	6	12.0
Total	50	100.0

**Source; Research findings 2014**

Table 5 above prove that the large number of the respondents with 56% of the respondents were employed, 14% of the respondents were not employed, 12% of the respondents were peasant, other 12% of the respondents were student and remaining 6% of the respondents were dealing with business. So the findings prove that majority of the respondents participated on the study were employed.

#### 4.2.6 Response on insurance/community financing health funding scheme do you belong

**Table 6: Financial health funding scheme do you belong**

Scheme	Frequency	Percent
NHIF	20	40.0
STRATEGIES	5	10.0
AAR	7	14.0
NSSF	15	30.0
RESOLUTION	3	6.0
Total	50	100.0

**Source; Research findings 2014**

Majority of the respondents with 40% of the respondents said they belong on NHIF, 30% of the respondents said they belong to NSSF, 14% of the respondents said they belong to AAR, 10% of the respondents has said they belong to STRATEGIES, and 6% of the respondents remain said they belong to RESOLUTION. Result proves that NHIF have more members compared to other health funding scheme.

#### 4.2.7 Response on the source of funding for your insurance

**Table 7: Source of funding for your insurance**

Source of funding	Frequency	Percent
My pocket	7	14.0
My/principle member's Salary	43	86.0
Total	50	100.0

**Source; Research findings 2014**

Majority of the respondents with 86% of the said the source of the funding's for their insurance is principle member's salary from their employer and remain 14% of the

respondents said that source of the financial funding they get from their own pocket. So the result proves that majority depend on the principle member salary as the source of their fund to the health insurance.

#### 4.2.8 Response on reasons to join the scheme

**Table 8: Reasons to join the scheme**

Reasons to join the scheme	Frequency	Percent
Its policy of the employer	15	30.0
For taking care my Health when sick	15	30.0
Influence of my principle member	15	30.0
Because I have chronic illness/patient	5	10.0
Total	50	100.0

**Source: Research findings 2014**

Majority of the respondents with 30% of the respondents have said that policy of the employer made them to join the scheme, other 30% of the respondents also said that they have joined the scheme to take care of their health when they sick, also another 30% of the respondents said they have joined the scheme because of the influence of principle member and remain 10% of the respondents have said that they have joined because of they have chronic illness/patient.

#### 4.2.9 Response on the satisfaction by the services of health current insurance scheme

**Table 9: Satisfaction by the services of health current insurance scheme**

	Frequency	Percent
Satisfied	35	70.0
Dissatisfied	15	30.0
Total	50	100.0

**Source: Research findings 2014**

Majority of the respondents with 70% have been satisfied with services of the health current insurance while 30% of the respondents did not satisfied with the current scheme. So it proves that the current health insurance scheme is supported by large number of the members.

#### 4.2.10 Response on the dissatisfaction on the scheme

**Table 10: Reasons on why they were dissatisfied on the scheme**

Reason of dissatisfaction	Frequency	Percent
Lack of access to other services	3	20.0
No drugs	6	40.0
Low quality of services	6	40.0
Total	15	100.0

**Source; Research findings 2014**

The 6 (40% ) respondents responded low quality of the service is the big reasons on why they dissatisfied in the scheme, and also 40% of the respondents have said no drugs also the reasons too and remain 20% of the respondents said lack of access to other services. So study proves those are the challenges to members that led to dissatisfied among them.

### 4.3 DATA ANALYSIS OF RESPONDENTS WHO USE OUT OF POCKET MODE OF HEALTH FINANCING SYSTEM

#### 4.3.1 Age of the respondents

Age of the respondents worked in the study reveal that the ratio between young people and elder people which prove that did not join the health insurance is the active. So there is need for this group to have health insurance so as to protect them with diseases so to contribute to develop their nation.

**Table 12; Age of the respondents**

Age	Frequency	Percent
15-30	17	34.0
31-45	11	22.0
46-60	17	34.0
61-75	5	10.0
Total	50	100.0

**Source; Research findings 2014**

The table 12 above shows that 22% of the respondents their age rank between 31-45, other 34% of the respondents their age rank 15-30%, also 34% of the respondents their age rank between 46-60 and their remain 10% of the respondents their age rank between 61-75. The result prove that large number of respondents does not have health insurance their ratio is between young people and elder in which young people compare to other group of age and this is the active group that can help the nation development so there is a need to protect them by introduce the good health insurance policy for youth people. Also the elder people are the group need high health insurance coverage.

#### 4.3.2 Gender of respondents

Gender in the study it reflect that in the health insurance non beneficiary male are more than female in terms of number, therefore the researcher look gender as

important matter so as to look the ratio of the female and males so as to balance the responds both from male and female

**Table 13; Gender of respondents**

Gender	Frequency	Percent
Male	29	58.0
Female	21	42.0
Total	50	100.0

**Source; Research findings 2014**

Table 13 above show the response on the gender of the respondent that contribute on their view which state that 58% of the respondents were male while 42% of the respondents were female. Result show that health insurance non beneficiary worked in the study male are more than female.

The figure 13, below describe the gender of respondents in the percentage in which 58% of the respondents were male and 42% were female.

#### **4.3.3 Marital status of the respondents**

Most of the respondents participated in the study were married so it prove that married people are not aware on the health insurance compare to the other group of the marital status.

**Table 14: Marital status of the respondents**

Marital status	Frequency	Percent
Single	16	32.0
Married	34	68.0
Total	50	100.0

**Source; Research findings 2014**

Table 14, above show the response on the marital status of the respondents worked in the study in which 68% of the total respondents were married and remain 32%

respondents were single. So the result proves that married people are in large in number among the health insurance non beneficiary.

#### 4.3.4 Educations of the respondents

**Table 15: Educations of the respondents**

Education	Frequency	Percent
No formal education	3	6.0
Primary education	11	22.0
Secondary education	20	40.0
College	10	20.0
Graduate	6	12.0
Total	50	100.0

**Source; Research findings 2014**

Majority of the respondents participated in the study with 40% have secondary education, 20% of the respondents have college education, 22% of the respondents have primary education, 12% of the respondents have university graduate and remain respondents with 6% had no formal education.

#### 4.3.5 Occupation of respondents

Majority of the respondents tends to join the health insurance scheme because of the regulations set by the authority that every employees must have the health insurance in which result prove that majority of the respondents who are not member of the health insurance were not employed.

**Table 16: Occupation of respondents**

Occupation	Frequency	Percent
Employed	4	8.0
Unemployed	26	52.0
Peasant	8	16.0
Businessman/women	4	8.0
Students	8	16.0
Total	50	100.0

**Source; Research findings 2014**

Table 16 above prove that the large number of the respondents with 52% of the respondents were not employed, 8% of the respondents were employed, 16% of the respondents were peasant, other 16% of the respondents were student and remaining 8% of the respondents were dealing with business.

#### 4.3.6 Knowledge of other health financing mechanisms apart from direct out-pocket payment

**Table 17: Knowing other health financing mechanisms apart from direct out-pocket payment**

Knowledge	Frequency	Percent
Yes	44	88.0
No	6	12.0
Total	50	100.0

**Source; Research findings 2014**

Majority of the respondents with 12% of the said they didn't know other health financing mechanisms apart from direct out-pocket payment and remain 88% of the respondents said they did know health financing mechanisms apart from direct out-pocket payment.

### 4.3.7 Response on reasons not to join the scheme

**Table 18: Reasons not to join the scheme**

Reasons	Frequency	Percent
I don't know the procedure to join	2	33.3
They are useless	1	16.6
I am not employed	1	16.6
I often fall sick	1	16.0
I don't like queue	1	16.0
Total	6	100.0

**Source; Research findings 2014**

Majority of the respondents with 33.3% of the respondents have said that they don't know the procedures to join, other 16.6% of the respondents also said that they are not employed, also another 16.6% of the respondents said they have not joined the scheme because they are useless, other 16.6% of the respondents have said they didn't fall sick and remain 16.6% of the respondents have said that they have not joined because of they don't like queue.

#### 4.3.8 Response on if they would like to join insurance/community financing health funding scheme later

**Table 19: Would like to join insurance/community financing health funding scheme later**

Would like	Frequency	Percent
Yes	46	92.0
No	4	8.0
Total	50	100.0

**Source; Research findings 2014**

Majority of the respondents with 92% of the said they would like to join insurance/community financing health funding scheme later and remain 18% of the respondents said they didn't like to join insurance/community financing health funding scheme later.

**Table 20: Reasons on why they would like to join the scheme later**

Reason	Frequency	Percent
I have no regular income for treatment	30	60.0
For taking care my Health when am sick	15	30.0
I have chronic illness	5	10.0
Total	50	100.0

**Source; Research findings 2014**

The majority of the respondents with 60% have argue that they would like to join the scheme later because they don't have regular income for treatment, followed by 30% of the respondents have said they would like to join the scheme later for taking care of their health when they sick and remain 10% of the respondents said they would like to join the scheme later because they have chronic illness.

**Table 21: Insurance/community financing health funding scheme would you like to join**

Scheme	Frequency	Percent
NHIF	15	30.0
NSSF	19	38.0
STRATEGIES	5	10.0
JUBILEE	5	10.0
AAR	6	12.0
Total	50	100.0

**Source; Research finding 2014**

Majority of the respondents 38% of the respondents have said they would prefer NSSF, 30% of the respondent said they prefer to join NHIF, 12% of the respondents have said that they would prefer to join AAR, 10% of the respondents said they would prefer JUBILEE and remain respondents with 10% would prefer to join STRATEGIES.

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATION

#### 5.1 Summary

Health insurance helps individuals receive timely access to medical care and protects them against the risk of expensive and unanticipated medical events. In addition to the socioeconomic profiles that distinguish individuals with coverage from those who are uninsured, attitudes regarding the need for and value of health insurance coverage may also affect coverage decisions. Given the potential for individuals' health care preferences to influence health behaviors, it is important to measure the population's attitudes towards health insurance coverage and to examine the persistence of these attitudes over time

The out-of-pocket means of health financing included majority of people receiving services at BMC contributing by 75.3%. Insurance coverage to people attending BMC is very low contributing by 24.70% of health care financing largely contributed NHIF by 16.9%, followed by private insurance 4.1% and microfinance insurance (3.80%), The insurance coverage is even less popular in Nairobi community in Kenya where in 2012, Only 10% were participating in the NHIF program, while 0.8% private insurance coverage; CBHIs, approximately 1.2% of the Kenyan population. In nearest sub-Saharan African country, Rwanda National community based insurance scheme covers 90% of the population in the same year 2012 Most through CHF (Mulupi, Kirigia and Chuma 2013).

In this study among all the patients none was recorded to know or to use CHF as insurer, the reason behind is that at the moment in Tanzania CHF is restricted only in some district Hospital and not to referral centers like BMC but generally CHF coverage in Tanzania as in many sub-Saharan Africa is very low only with exception to some countries like Rwanda where insurance coverage is more than 90%. (Andrew Makaka, Sarah Breen, Agnes Binagwaho)

In this study 56% patients who were already enrolled to schemes responded to have joined schemes because they were employed and it was employer's policy made them to join schemes. 82% of insured patients had formal employment (compared 6% in

noninsured group) this study has similar findings as that of Kenya where people who have employment formal were more likely to join health insurance schemes compared to the rest of the population, Similar reason were stated in Uganda, Burkina Faso, Malaysia and Ghana(Mulupi, KirigiaandChuma2013).The Obvious reason here is that,the most of the schemes tend to enroll people with formal employment because most of them have regular and secured source of funds for Insurance fees with added advantage of employer's policy to contribute for health insurance of their employees. General (knowledge of these people is also likely to contribute to their enrollment.

The study shows 30%of insured patients reported to not to be satisfied by the service provided by their insurers as well as health care providers, the main reason of non-satisfaction were Low quality of services under insurance were 50%, 30% responded that there are no drugs while 20% said they had limited access to other services. In Ghana Reasons cited for non-renewal of insurance included poor service quality (58%), lack of money (49%) and taste of other sources of care (23%). (Boateng and Awunyor-Vitor, 2013)where in USA almost a third (31%) report being dissatisfied with costs, 12 percent are dissatisfied with their ability to get the latest treatments, and six percent are dissatisfied with the quality of care they receive. Not surprisingly, 70% of those rating their health coverage as "poor" express dissatisfaction with costs, 41% report dissatisfaction with their quality of care, and 39% say they are dissatisfied with their access to new treatments. Results from a qualitative, in-depth interview study of 60 African Americans who had one or more chronic illnesses found that low-income respondents expressed much greater dissatisfaction with health care than did middle-income respondents(Becker and Newsom, 2003).Similar reasons were observed in Kenyan study where Perceived poor quality of services at accredited facilities, inadequate benefit packages and high co-payments also hindered people from joining health insurance schemes and/or contributed to drop out rates. Poor service provision was exemplified by lack of laboratory equipment and x-ray machines, long waiting times, corruption (and conflict of interest), and discrimination of patients according to scheme membership or perceived socioeconomic status. Other complaints included poor hospitality, including rude hospital staff and inadequate ward facilities (overcrowded wards, inadequate bedding, worn-out patient uniforms) and poor diet (Mulupi, KirigiaandChuma 2013).

Education towards health insurance is another factor which influence membership enrollment. In this study results shows 88% of patients who were not enrolled in any health insurance were aware of existence of these service. Respondents who knew the existence of the health insurance but not enrolled responds for the question why don't you want to join schemes were; I don't know the procedure to join (33.3), I am not employed (16.7%) I often fall sick (16.7 %) I don't like queue (16.7 %) They are useless (16.7%).The results are different from a study done in Nairobi community in Kenya 2012 where 55.7% were aware of existence of insurance and even lower than the city of Mangalore in Karnataka state (India). The awareness of health insurance was found to be 64.0%, among noninsured individuals, lack of awareness of health insurance could be caused by limited efforts to by the Government to promote Insurance, being a rural setting, people hardly travelled to urban areas, where such information are readily available, the reason could be due to increased awareness to newer health financing methods through national campaigns through media and other methods. In Nigeria study media like TV and billboard are the major sources of awareness of health insurance (Boateng and Awunyor-Vitor, 2013)

In Kenya factors that made it easy for people to belong to health insurance schemes were. However, joining the scheme depended on an individual's willingness, preferences and ability to pay. formal employment were more likely to join health insurance schemes compared to the rest of the population, while others did not see the reason of making contributions towards health insurance when they were in good health. ((Mulupi, Kirigia and Chuma)

## **5.2 Conclusion**

Insurance coverage to people attending BMC is very low contributing by 24.70% of health financing methods. Based to our results and supported by different literatures in both developing and developed countries the major factors for non-enrollment are financial status and poor general knowledge towards insurance on how it operates. Awareness of existence of these newer health financing method is another reason for non-enrollment Perceived poor quality of services at accredited facilities, inadequate benefit packages are other factors for non-enrollment to the schemes. All these reasons could be as a result of the level of income, the structure of the economy, the distribution of the population, the country's ability to administer, and the level of solidarity within a society. It is essential that policymakers take these factors into account and try to use them as policy levers. Improving administrative capacity and fostering a sufficient level of solidarity are among those factors that can be impacted upon more directly via government stewardship. Thus, while experience demonstrates that development in a particular country to a large extent depends on that country's own specific socioeconomic and political context, experience also shows how the transition to universal coverage is dependent on the government's stewardship of the health system.

Greater awareness on the benefits of the scheme especially among the largely informal sector and purposeful targeting of the core poor will help improve on the coverage and membership of the scheme. More client-oriented community education on the benefits of the scheme and membership registration at community durbars, major market days should be undertaken to improve access and coverage.

## **5.4 Recommendation**

- The study recommends registering the informal sector through existing groups and associations in which premium could be paid on installment basis through them.
- There is the need to take a critical look at expanding geographical access to quality healthcare, especially primary health care in order to achieve universal coverage.

- There is also the need to establish permanent and functional structures of insurance to constantly engage the scheme management, healthcare providers and subscribers in order to minimize the mistrust and improve uptake and service delivery.
- Government and stakeholders should set strategies to make there is enough education about health insurance to its citizens.
- Researcher recommends that there is a need for the Ministry of health and social welfare in Tanzania and the government to provide enough budgets in health sector so as to citizen to be satisfied with the health services.

#### **5.5. Areas for further Research.**

There have been few researches regarding factors affecting health insurance in Tanzania. This study was hospital based and not to the community at large there is need to asses these factors at the community level.

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**APPENDIX 1; ENGLISH VERSION QUESTIONNAIRE 1**

**QUESTIONNAIRE TO ASSESS THE ATTITUDE OF PEOPLE TOWARDS  
DIFFERENT METHODS OF HEALTH CARE FINANCING (FOR OUT  
POCKET PATIENTS**

1. ID No.....

A. Age.....

B. Gender.....

C. Marital status.....

2. Education.

A. No Formal education.

B. Primary education.

C. Secondary Education.

D. College/higher education.

E. University graduate.

**3. Occupation.**

A. Employed.

B. Unemployed.

C. Peasant.

D. Business man/Woman.

E. Fisherman.

F. Others.....

**4. Do you know anything about health financing mechanisms apart from direct  
out-pocket payment?**

A. Yes.

B. No (if no interview ends here.....)

**5. What is the reason(s) that made you not joined the scheme?**

- A. I can't afford.
- B. They are useless.
- C. I am not employed.
- D. I often fall sick.
- E. I don't like queue.
- F. Poor services.
- G. Other specify.....

**6. Would you like to join insurance/ Community financing health funding scheme later?**

- A. Yes.
- B. No.

**7. Why would you like to join the scheme later?**

- A. I have no regular income for treatment.
- B. For taking care my Health when sick.
- C. I have employment.
- D. I have chronic illness.
- E. Its policy of my employer.
- F. Others (specify.....)

**8. Which insurance/ Community financing health funding scheme would you like to join?**

- A. NHIF.
- B. CHF.
- C. Strategies.
- D. AAR.
- E. Company's Community financing health funding scheme (specify company.....)
- F. NSSF.
- G. No scheme.
- H. No idea.
- I. Others specify .....

## **APPENDIX 2 ENGLISH VERSION QUESTIONNAIRE**

### **QUESTIONNAIRE TO ASSESS THE ATTITUDE OF PEOPLE TOWARDS HEALTH CARE FINANCING (NON OUT POCKET PATIENTS)**

#### **1. ID No.....**

- A. Age.....
- B. Gender.....
- C. Marital status.....

#### **2. Education.**

- A. No Formal education.
- B. Primary education.
- C. Secondary Education.
- D. College/higher education.
- E. University graduate.

#### **3. Occupation.**

- A. Employed.
- B. Unemployed.
- C. Peasant.
- D. Business man/Woman.
- E. Fisherman.
- F. Others.....

#### **4. Are you the principle member?**

- A. Yes.
- B. No.

#### **5. Which insurance /Community financing health funding scheme do you belong?**

- A. NHIF.
- B. CHF.

- C. Strategies.
- D. AAR.
- E. Company's Community financing health funding scheme (specify company.....)
- F. NSSF.
- G. Others.....

**6. What is the source of funding for your insurance?**

- A. My pocket.
- B. My/principle member's Salary
- C. Other specify.....

**7. What is the reason for you to join the scheme?**

- A. Its policy of the employer.
- B. For taking care my Health when sick.
- C. Influence of my principle member.
- D. Because I have chronic illness/patient.
- E. Others.....

**8. Are you satisfied by the services of your health current insurance scheme?**

- A. Yes (if yes interview ends here.)
- B. No.

**9. What dissatisfy you in the scheme?**

- A. Long queue.
- B. Lack of access to other services.
- C. No drugs.
- D. Low quality of services
- E. No challenges at all
- F. Others specify.....

**14. If you are not satisfied by your current scheme which ,scheme would you like to join?**

- A. NHIF.
- B. CHF.
- C. Strategies.
- D. AAR.
- E. Company's insurance scheme (specify company.....)
- F. NSSF.
- G. No scheme.
- H. Others.....

## SWAHILI VERSION QUESTIONNAIRE 1

### DODOSO LA UCHUNGUZI KUHUSU MTAZAMO WA WATU KUHUSIANA NA ULIPAJI WA HUDUMA ZA AFYABUGANDO(KWA WAGONJWA WALIPAO FEDHA TASLIMU TU)

#### 1. NAMBARI YA KUMBUKUMBU .....

- A. Umri.....
- B. Jinsia.....
- C. Ndoa.....

#### 2. Elimu.

- A. Sijasomakabisa.
- B. Elimuyamsingi.
- C. ElimuyaSekondari.
- D. Chuo.
- E. Chuo kikuu.

#### 3. Kazi.

- A. Sinaajira.
- B. Nimeajiriwa.
- C. Mkulima.
- D. Mfanyabiashara.
- E. Mvuvi.
- F. Mengineyo.....

#### 4. Je unajuanjanyingineyakulipiahudumazaafya Zaidi yakulipiamojakwamojafedhatastimu?

- C. Ndiyo.
- D. Hapana(usailiunaishiahapa.....)

#### 5. Ni sababuganihujaungananjazinginezakulipiahudumazaafya?

- A. Siwezimudugharama.
- B. Haizinamsaadawowotekwangu.
- C. Sinaajirarasmi

- D. Siugui Mara nyingi/sinamgonjwamwenyeugonjwasugu.
- E. Folenikubwa.
- F. Hainahudumanzuri.
- G. Mengineyo.....

**6. Je,**

**ungependakujiungananjiazinginezakulipiahudumayaafyakablahapobaadaye?**

- A. Ndiyo
- B. Hapana.

**7. Je,**

**kwaniniungependakujiungananjiazinginezakulipiahidumayaafyakablahapobaadaye?**

- A. Sinakipato cha kinachoridhishakwamatibabu.
- B. Inisaidieninapopamatatizokiafya.
- C. Sinaajira
- D. Nina ugonjwa/mgonjwaSugu.
- E. Ni sera yamwajiriwangu
- F. Mengineyo.....

**8. Je ungependakujiunganahudumaganikatiyahizi?**

- A. NHIF.
- B. CHF.
- C. Strategies.
- D. AAR.
- E. KulipakupitiaMwajiriwangu (specify company.....)
- F. NSSF.
- G. Sijui.
- H. Mengineyo.....

**9. Jeninimatatizoyakutumianjiahiiyaulipajimojakwamojapindiu japohosipitali.**

## SWAHILI VERSION QUESTIONNAIRE 2

### DODOSO LA UCHUNGUZI KUHUSU MTAZAMO WA WATU KUHUSIANA NA ULIPAJI WA HUDUMA ZA AFYA(KWA WAGONJWA WASIOLIPA MOJAKWA MOJA FEDHA TASLIMU TU)

#### 1. NAMBARI YA KUMBUKUMBU .....

- A. Umri.....
- B. Jinsia.....
- C. Ndoa.....

#### 2. Elimu.

- A. Sijasomakabisa.
- B. Elimuyamsingi.
- C. ElimuyaSekondari.
- D. Chuo.
- E. Chuo kikuu.

#### 3. Kazi.

- A. Sinaajira.
- B. Nimeajiriwa.
- C. Mkulima.
- D. Mfanyabiashara.
- E. Mvuvi.
- F. Mengineyo

#### 4. Je, wewenimwanachamawamsingiwahudumahii?

- A. Ndiyo.
- B. Hapana.

#### 5. Je unatumiahudumaganikatiyahizi?

- A. NHIF.
- B. CHF.
- C. Strategies.
- D. AAR.
- E. Hudumayakampuniyangu (.....)
- F. NSSF.

G. Mengineyo.....

**6. Je, ninichanzochako cha mapatokatikakulipiahudumahii?**

- A. Nalipamwenyewekutokamfukonimwangu.
- B. Mshahara.
- C. Mengineyo .....

**7. Je nisababuganiumejiunganahudumahii?**

- A. Sinakipato cha uhakikakinachoridhishakwamatibabu.
- B. Inisaidieninapopatamatatizokiafya.
- C. Sinaajira
- D. Nina ugonjwa/mgonjwaSugu.
- E. Ni sera yamwajiriwangu
- F. Mengineyo.....

**1. Jeunaridhikanahudumahii?**

- A. Ndiyo (maswaliyaishiehapa)
- B. Hapana

**9. Je? Ni sababuganihuridhikinahudumahii?**

- A. Siwezikumudugharama.
- B. Haizinamsaadawowotekwangu.
- C. Sinaajirarasmi
- D. Hakunamadawa
- E. Siuguimarakwamara.
- F. Folenindefu.
- G. Hainakiwangokizuri cha huduma.
- H. Mengineyo.....

**10. Kamahujaridhikanahudumahii, Je ungependakujiunganahudumaganikatiyahizi?**

- A. NHIF.
- B. CHF.
- C. Strategies.

- D. AAR.
- E. KulipakupitiaMwajiriwangu (.....)
- F. NSSF.
- G. Sijui.
- H. Mengineyo.....