FACTORS CONTRIBUTING TO LOW NATIONAL HEALTH INSURANCE COVERAGE IN TANZANIA
A CASE OF DODOMA CITY COUNCIL

By

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A Dissertation Submitted to Dar- es - Salaam Campus College in Partial Fulfillment of the Requirements for the Award of Master of Business Administration in Corporate Management (MBA-CM) Degree of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and here by recommend for acceptance by the Mzumbe University, a dissertation entitled: ***Factors Contributing To Low National Health Insurance Coverage In Tanzani : A Case Of Dodoma City Council*** in partial fulfillment of the requirements for the Award of Master of Business Administration in Corporate Management

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DEDICATION

This project is dedicated to my late father Beatus Gervas Chandika who passed away in 2011, you encouraged me to study hard, you spent your earning to ensure that I go to school and I become a successful man but you left me prematurely I still needed your guidance and advices. May your sole rest in eternal peace.

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LIST OF ABBREVIATIONS AND ACRONYMS

CBHI	Community Based Health Insurance
CHF	Community Health Fund
CHIP	Children’s health insurance program
GDP	Gross Domestic product
NHIF	National Health Insurance Fund
SPSS	Statistical Package for Social Science
USA	United States of America
WHO	World Health Organization

ABSTRACT

The study investigated factors associated with low NHIF coverage in Tanzania, a descriptive Cross-sectional survey design was used to study a total of 385 respondents residing in Dodoma city Council. The study focused on SME"s mainly Motor cyclist (Bodaboda), *Mama ntilie"s ,* Peasants as well as employees in private sector. Data was collected using pretested coded questionnaire and analyzed through the facilitation of SPSS. Data were presented using pie charts and frequency tables. The study revealed that increase of awareness through education and numerous channel of community sensitization plays a significant role in accelerating enrollment to NHIF (P = 0.005). That is to say the current low NHIF coverage is mainly attributed by low level of education and community sensitization for in-depth understanding of the NHIF concept as well as different packages it offers to the community to choose basing on their economic power. Other factors studied seemed not to be a reason for low enrollment to the NHIF, these included ability to pay membership fee (P= 0.657), Quality of medical services offered to NHIF beneficiaries (P = 0.770), NHIF being Voluntary rather than mandatory (P = 0.085) and lack of trust to NHIF managers (P = 0.600)

The study recommends that NHIF should develop a well-structured and numerous community awareness and sensitization programs ranging from National to local Government levels, this programs should be persistent to ensure that the community gains in-depth understanding of the NHIF concept and the different packages offered by NHIF .The study recommends further multicenter research to have a wide coverage of respondents for more understanding of the bottleneck toward rapid NHIF enrollment

TABLE OF CONTENTS

CERTIFICATION .... **i**
DECLARATION AND COPY RIGHT .... **ii**
ACKNOWLEGEMENT .... **iii**
DEDICATION .... **iv**
LIST OF ABBREVIATIONS AND ACRONYMS .... **v**
ABSTRACT .... **vi**
TABLE OF CONTENTS .... **vii**
LIST OF TABLES .... **xi**
LIST OF FIGURES .... **xii**

CHAPTER ONE **1**
GENERAL INTRODUCTION **1**
1.1. Back ground Information 1
1.2. Problem Statement 4
1.3 Research Objectives 5
1.3.1 General objective 5
1.3.2 Specific objectives 5
1.4 Research questions 5
1.5. Significance of the study 5
1.6 Structure of the Study 6

CHAPTER TWO **7**
LITERATURE REVIEW **7**
2.1 Introduction 7
2.2 Theoretical Literature Review 7
2.2.1 Definition of Key Terms 7
2.2.2 Health Insurance 7
2.3. Theoretical bases for Health Insurance 10

2.3.1 Expected Utility Theory....10
2.3.2 Neo- Classical welfare economic theory....11
2.3.3 Theory of Demand of Health Insurance....11
2.4. Factors affecting provision of Health Insurance....12
2.4.1 Moral Hazards....14
2.4.2 Health care financing....16
2.4.3 Social insurance contributions....16
2.4.4 Private insurance....16
2.4.5 Microfinance insurance scheme.....17
2.4.6 Direct out of pocket....17
2.4.7 Importance of health insurance....18
2.4.8 Challenges facing Health insurance sector....18
2.5. Empirical review....19
2.5.0. Factors affecting health insurance coverage....19
2.5.1. Inability to pay membership contribution....19
2.5.2. Awareness of the community on the benefits of Insurance....20
2.5.3. Mandatory versus Voluntary health insurance....21
2.5.4. Quality of services offered....23
2.5.6 Barriers posed by inaccurate and incomplete data....23
2.5.7 Barriers from under-investment....24
2.5.8 Lack of portability....24
2.5.9 Financial barriers....25
2.5.10 A typology of user fees....25
2.6. Research Gap....33
2.6. Conceptual Framework....34

CHAPTER THREE....35
RESEARCH METHODOLOGY....35
3.1. Research Design....35
3.2. Description of the study Area....35
3.3. Study population....35

3.4. Sample size and Sampling techniques ... 35
3.4.1. Sample size ... 35
3.4.2. Sampling procedure ... 36
3.5. Data Collection ... 36
3.5.1. Primary data ... 36
3.5.2 Secondary data ... 37
3.6. Data analysis ... 37

CHAPTER FOUR ... 38
RESULTS AND DISCUSSION ... 38
4.1 Introduction ... 38
4.2 Social-demographic characteristics of respondents ... 38
4.3 Awareness of the existence of NHIF and source of information ... 40
4.4 Enrolment of NHIF ... 41
4.4.1 Enrolment of NHIF scheme and social demographic characteristics ... 42
4.5 Awareness of the benefit of different NHIF packages ... 44
4.6 Multiple logistic regression analysis ... 44
4.7 Qualitative data analysis ... 47
4.7.1 Factor contributing to low National Health Insurances ... 47
4.7.2 Attraction of citizens to NHIF enrolment ... 47
4.8 Discussion of findings ... 48

CHAPTER FIVE ... 51
SUMMARY, CONCLUSION AND RECOMMENDATION ... 51
5.1 Introduction ... 51
5.2. Summary ... 51
5.3. Conclusion ... 52
5.4. Recommendation of the study ... 52
5.5. Limitation of the study ... 52
5.6. Suggestions for further study ... 53

CHAPTER SIX 54
DISCUSSION OF RESEARCH FINDINDS 54

REFERENCES 57

APPENDICES.. 61

LIST OF TABLES

Table 4.1: Social demographic characteristics 39

Table 4.2: Awareness of the existence of NHIF and source of information 40

Table 4.3: Enrolment of NHIF scheme and social demographic characteristics...43

Table 4.4: Awareness of the benefit of different NHIF packages 44

Table 4.5: Multiple logistic regression..46

LIST OF FIGURES

Figure 2.1: Conceptual Frame work 34
Figure 4.1: Enrolment of NHIF scheme 41

CHAPTER ONE
GENERAL INTRODUCTION

1.1 Back ground Information

World health organization advocates for universal health coverage for all the people regardless of their economic status, however in order to meet this requirement governments need to have sustainable health financing mechanism so that its citizens can access medical care any time they need without being denied of those services because of failure to meet cost of treatment. The WHO estimated in 2010 that 100 million people were pushed into poverty and 150 million suffered financial catastrophe because of out- of- pocket payment on health services every year (WHO, 2010:8)

Universal health coverage has been reported to lead to big improvement in economic conditions such as growth of GDP as well as improvement on health outcomes like increase in life expectance, reduction of mortality rates and reduction of infant mortality rates (Soonman Kwon, 2008, p65). Global development agenda considers universal health coverage as a priority as it is demonstrated by its inclusion in the sustainable development Goals, despite this global support for universal health coverage reaching this objective in developing countries remains highly debated (Kutzin, 2012, WHO, 2010)

Most countries who have been successful in insuring universal health coverage to its people have engaged in health system financing through insurance systems where by people are insured for their treatment through various mechanisms, in developed countries like the United states of America the health system is financed through various insurance schemes such as private health insurance coverage and public health plans which includes: Medicaid, Medicare, Children′s health insurance program (CHIP), military plans and states sponsored or other government sponsored health plans. Through this plans almost 90.9% of the USA population was covered leaving out only 9.1 %(28.6 Million) of population uninsured (Robin at el, 2015, p

10), South Korea spent only 12 years from introduction of social health insurance in 1977 to covering the entire population in 1989 (Soonman Kwon,2008) In Africa Rwanda demonstrates the highest health insurance coverage in Sub- Saharan Africa with a coverage of 87% of the entire population in 2015 , this achievement is through its community –based health insurance (81.6%) and other insurances (8.4%) (Rwanda security social board-RSSB)

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).

Tanzania National health insurance fund (NHIF) was established through the National health insurance Act No.8 of 1999 and started provision of health insurance services in 2001. The fund was established due to need of a well-organized institution that will provide health insurance to public servants and gradually extend the coverage to private institutions, organized groups and individuals to attain Universal health coverage. Inception of the fund was a result of socioeconomic reforms crisis in the 1980s and early 1990s as a result a Government embarked on cost sharing policies to complement its financial ability to render free medical services as it was since independency in1961. The Government intended to cover all citizens with social insurance but its implementation was planned to be done gradually starting with civil servants. (NHIF, 2010, NHIF, 2020)

Following full operationalization of the success of the scheme, several amendments followed, to the NHIF Act that enabled to enroll other groups of Tanzanians.in 2002 all public servants were made eligible to enroll; in 2009 retirees and councilors were made eligible to enroll; and in 2020 all formal employees in Private sector, NGOs, and faith based organizations could get enrolled. The fund took further initiatives of enrolling individuals from the informal sector by introducing a range of products which would suite each group such as Vifurushi, Ushirika Afya, Students premium and Toto Afya kadi. Vifurushi premium includes Najali Afya Premium, Wekeza Afya Premium and Timiza Afya premium, purpose of which is cover every individual citizen to attain Universal health coverage. Since inception of NHIF beneficiaries has increased from 691,773 in the year 2001/2002 to 4,403,581 in the year 2020 which is only 8 % of the entire Tanzanian population. (NHIF, 2020)

The government of Tanzania has been implementing different health insurance schemes which started with Community health Fund in 1996, private health insurance, health insurance through social security funds and National health insurance fund. Until December, 2019 only 33% of the entire population was covered by health insurance through this different schemes of which 8% was

coverage of NHIF, 1% was Private health insurance and the remaining 24% was coverage by CHF.(NHIF, 2020)

NHIF strategic plan 2015 to 2020 had an objective of achieving 50% coverage by December 2020 (this was for both NHIF and CHF), one of the strategy was to introduce various premiums like "vifurushi " premium to attract every citizen with different economic capabilities, but despite those effort the current coverage (2020) is only 34 % and 1% for private scheme insurance making a total of 35% overall coverage. This is a sluggish progress toward attainment of universal health coverage if compared to the duration taken by other countries who have attained universal health coverage, for example South Korea took 12 years from inception of Health insurance schemes to achieving universal health coverage. (NHIF, 2015, Soonman, 2009) Therefore this study has been formulated to look at factors contributing to low health insurance coverage in Tanzania

1.2. Problem Statement

Tanzania Health financing relies on the National health insurance, community health fund and private health insurance. However health insurance coverage by these schemes is still low. Until 2020 the entire population covered is only 35%, CHF contributing 26%, NHIF 8% and private insurance 1%. According to the NHIF strategic plan 2015 – 2020 the overall coverage was estimated to reach 50%, with the few months remaining it is unlikely that the objective will be met.

The national health insurance fund has progressively evolved various attractive packages with a purpose of encouraging more citizens to join the scheme voluntarily but it has recorded very minimal impact of the interventions for example, it introduced a new "'Vifurushi" packages in 2019 to attract more people but it only managed to raise the coverage by 1% from 7% 2019 to 8% 2020. (NHIF, 2020)

The packages launched by NHIF were designed to take on board every citizen in the country ranging from a peasant, small scale business people, large scale business and self-employed individuals with the aim of eventually attain universal health coverage.

Despite all these effort still the coverage is sluggishly increasing not meeting the expectation of the fund. NHIF has also noted an increasing tendency of people flooding their office to pay for insurance when they fall thick especially on the non-communicable diseases like kidney failure, cancers and heart diseases, the phenomenon which is not safe for the fund due to adverse selection.

1.3 Research Objectives

1.3.1 General objective

To determine factors associated with low National health insurance coverage in Tanzania

1.3.2 Specific objectives

The specific objective of the study will be:-

i) To assess the enrollment level (coverage) to the National Health Insurance Fund

ii) To establish factors contributing to low National Health Insurance Fund coverage

1.4 Research questions

i) What is the enrollment level to the NHIF?

ii) What are the factors contributing to low NHIF coverage?

1.5 Significance of the study

National Health insurance fund which was established in the year 2002, has only managed to enroll 8% of Tanzanians by 2020. According to the NHIF strategic plan 2015 – 2020, the overall coverage was estimated to reach 50% of the population.

Having spent almost 18 years to enroll 8% it is definitely unlikely that remaining few months to complete 2020 will enable the fund to attain the 50% coverage.

This study was formulated to find out the reasons for the low coverage encountered by NHIF which will help the fund to design strategies and tactics to address those reasons so that NHIF enrollment can be accelerated to attain the target set as well as finally lead a way towards universal health insurance coverage. Same findings can be used by the Community Health fund to accelerate enrollment to CHIF at the community level which in turns contribute toward Universal health insurance in the country. The findings from this study will also form a base for further studies in the area of health insurance.

1.6 Structure of the Study

Chapter one provides an introduction and background of the study, whereby the following aspects were discussed, background to the study, statement of the problem, objectives of the study, research questions, significance of the study and limitations of the study.

Chapter two provides literature review whereby following aspects are discussed, definition of key terms, theoretical framework, empirical literature review, conceptual framework and research gap.

Chapter three discusses the research methodology, whereby the following aspects are discussed: research design, study area, sampling procedures, data collection procedures, data analysis techniques, validity of the instruments, reliability of the instruments.

Chapter four presents findings both qualitatively and quantitatively with regard to the research tools used.

Chapter five covers the summary; conclusion and recommendations. In this chapter, the summary of the study is provided together with conclusion on the findings.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of different concepts and ideas that are related to the study objectives. The chapter presents general conceptual arguments from different authors so as give a clear understanding of the study. This has helped in determining the direction of the study.

2.2 Theoretical Literature Review

2.2.1 Definition of Key Terms

2.2.2 Health Insurance

This is a medical cover that provides for payments for medical care of an individual that results from sickness or injury as well as preventive care through wellness programs. It helps meet the cost for consultation by physician, hospital, nursing, investigations, medication and supplies (Green & Rowell, 2011). The beneficially may be reimbursed the actual expenses incurred (up to a certain limit), cash payments, or the direct provision of medical services.

Most common types of health insurance are managed care and fee for service plans, most people whether insured through their employer or self-insured are enrolled in some type of managed care plan. All managed care plans enters into contracts with Doctors, Hospitals, clinics as well as other health care providers. These groups of contracted providers becomes the health plan's network, a member may be required to receive all the health services from a network of providers while other managed care plan, a member may receive care from providers who are not part of the network but is required to pay larger amount of share of the cost to receive those services.

Fee for service plans involves insurances paying medical fee for each service offered to a beneficiary and this plan usually offers a wide choice of service providers. Fee for service plans are categorized into basic and major medical protection categories,

basic medical protection deals with short term services such as cost of hospitalization, investigation services, supplies, medication, surgeries and consultations whereas major medical protection deals with long term treatments such as cost of serious illnesses and injuries as well as rehabilitation period. These two plans can be combined to comprehensive health care plan (Vaughan & Vaughan, 2008). A general medical insurance plan/policy covers all medical related costs for a beneficiary that includes physician consultations, surgery fees, rehabilitation fees, investigations fees as well as an Ambulance services (Green & Rowell, 2011).

Health insurance is usually against of incurring medical expenses, it is important because of unpredictable nature of cost to be incurred on health care, though one may have an idea about their need for future medical services, the exact amount they spend on health care remains uncertain. In order to determine the amount / premium to be charged for health insurance cover, the provider usually estimates the overall risk of health care expenses among a targeted group and then develops a routine finance structure such as annual or monthly premium to ensure that money is available to pay for the health care benefits specified in the policy, this process is what is referred as medical underwriting (Vaughan and Vaughan, 2008).

Medical underwriting is normally done before someone is offered health insurance by gathering an individual's health information which guides in making decisions of whether to offer or deny coverage and what premium rate and conditions to set for the policy. Medical Underwriting helps to prevent adverse selection which is a tendency for individuals to go for health insurance coverage only when they are sick or need medical care, this means that if individuals are allowed to purchase health insurance without regard for pre-existing medical conditions which are considered during underwriting, one would wait to opt for health insurance until they get sick or are in need of medical care. This phenomenon creates a pool of insured with high utilization which in turn increases the premiums that providers must charge in order to pay for the claims incurred, the high premiums further discourages healthy people

from going for the coverage especially when they are aware that they will be able to obtain coverage when they need medical care.

Health insurance policy is a contract between an insurer and an individual or group of people, this contract can be renewable monthly or annually, the amount of health care costs that will be covered by the health insurance provider are stipulated in the policy documents (Vaughan & Vaughan,2008).

Most common types of managed care plans are Health Maintenance Organization (HMOs) where by beneficiaries receive most or all services from a network provider, beneficiaries who decide to get services outside the HMOs are supposed to pay all or most of the treatment cost. Preferred Provider Organizations PPOs) comprises of a list of medical care providers from which a beneficiary chooses the one they prefer (Green & Rowell, 2011).

Another Health insurance care plan is what is known as Self- funded care plan whereby an employer provides health care to employees using its own funds, this is a scheme where there is no cover purchased, but the employer sets aside funds for payment of medical expenses incurred by staff members and their dependents and also determines the benefits as well as limitations.

Generally a Standard Insurance Policy will cover the following benefits up to a stipulated limit per policy: Accidents, illness hospitalizations, all consultations, laboratory investigations, pathological investigations, radiological investigations, medications, physiotherapy, radiotherapy, chemotherapy, tests(like cardiological, neurological, ENT), ambulance charges, and rehabilitation services (Green & Rowell,2011)

A Normal Medical policy has exclusions and limitations as well, the cover usually has a limitation on age for new entrants who also require to wait for some time after paying the premium before they are covered, other limitations includes pre-existing

and chronic conditions, congenital defects, war and kindred risks, cosmetic surgery unless caused by an accident, treatment other than a registered medical doctor, intentional self-injury, or drunkenness.

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. 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)

2.3 Theoretical bases for Health Insurance

The theories that inform the demand for health insurance include expected utility theory and neo-classical welfare economic theory.

2.3.1 Expected Utility Theory

This theory is mostly used in utility values of economics to explain choices under uncertainty that is to say if the beneficiary knew with certainty that she /he would never need medical treatment , the she/he would mostly presumably not be willing to pay for medical insurance. It is the risk of becoming ill that drive a desire for access to health insurance that is to say one does not know the time he/she will fall sick, the severity of the illness as well as the duration.

The expected Utility Theory states that the consumer chooses between the risky or uncertain prospects by comparing their expected utility values, that is the weighted sums obtained by adding the outcomes multiplied by their respective probabilities (John, Hands, Maki &Elgar, 1997)

2.3.2 Neo- Classical welfare economic theory

This theory as presented by Kenneth Arrow assumes that people make choices based on cost-benefit calculations under varying conditions, that is individuals make choices to maximize their preferences over time and the society goals is to maximize social welfare. The Theory predicts that individuals will insure against catastrophic medical events and cover themselves the lower –cost services, meaning that individuals choose policies with low deductibles and co-payments (Arrow, 1963).

Individuals who are risk –averse are predicted to choose insurances against large risks leaving out smaller risks not covered, however in empirical studies, individuals find it difficult to come up with such choices simply because health insurance markets are also not entirely free. Insurance providers have information advantage to use to pick out kinds of beneficiaries they insure as well as kind of coverage they offer to them, this is for the purpose of maximizing profit and this results into most of comprehensive coverage be confined to wealthier individuals reducing the pooling of risks across the population as a result poorer people often fail to choose coverage that meets their health needs (Ruger, 2007).

2.3.3 Theory of Demand of Health Insurance

Conventional theory holds that moral hazard -- the additional health care purchased as a result of becoming insured -- is an opportunistic price response and is welfare-decreasing because the value of the additional health care purchased is less than its costs. The theory of the demand for health insurance presented here suggests that moral hazard is primarily an income transfer effect. In an estimation based on parameters from the literature, the value of moral hazard consumption is found to be

times greater than its costs, suggesting that income transfer effects dominate price effects and that moral hazard is welfare-increasing.

Conventional theory holds that people purchase insurance because they prefer the certainty of paying a small premium to the risk of getting sick and paying a large medical bill. Conventional theory also holds that any additional health care that consumers purchase because they have insurance is not worth the cost of producing it. Therefore, economists have promoted policies—copayments and managed care—to reduce consumption of this additional, seemingly low-value care.

Regarding risk, the new theory relies on empirical studies showing that consumers actually prefer the risk of a large loss to incurring a smaller loss with certainty. Therefore, if consumers purchase insurance, it is not because they desire to avoid risk. Instead, the new theory suggests consumers simply pay a premium when healthy in exchange for a claim on additional income (effected when insurance pays for the medical care) if they become ill.

Health insurance is substantially more valuable to the consumer under the new theory. The new theory moreover implies that copayments and managed care—central health policies of the last 30 years—were directed at solving problems that largely did not exist. Because these policies either reduced the amount of income transferred to ill persons or limited access to valuable health care, they may have done more harm than good. The new theory also provides a solid theoretical justification for insuring the uninsured and for implementing national health insurance.

2.4 Factors affecting provision of Health Insurance

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 citizen ns 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 20 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 soda] 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. Spreeuwers 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, Kouyaté, Becher, Gbangou, Pokhrel, Sanon, Sauerborn) have shown level of employment have significant impact on insurance coverage

2.4.1 Moral Hazards

Moral hazards occur when there is information asymmetry in the sense that one part in the transaction has more information than the other, the party with more

information tend to behave inappropriately from the perspective of the party with less information.

Moral hazards in Medical care policy holder does not consider the insurers costs, unregulated health care markets and private insurance encourages this behavior since the Insurance provider lowers or avoids the cost of treatment at the point of treatment also beneficiaries tend to demand more (consumer moral hazard) as well as health care providers render more or unnecessary care than might be medically appropriate (provider moral hazard) (Arrow, 1963 & Pauly, 1968).

To combat this problem, most insurance companies use mechanisms and conditionality's which at the end only create a burden on policyholders with the part of cost by adopting co- payment or co – insurance mechanisms , deductibles or a reduced bonus for the future (Sonderstrom, 1997)

Moral hazards practiced by health providers such as over prescription of medication or ordering unnecessary services knowing that the insurer and not the patient will be paying. This provider –induced demand decreases the affordability of coverage and dampens insurance demand (Sekhri & Savedoff, 2004)

Moral hazards drive the insurance companies to perceive as a low –profit business line because of the rising cost due to increased demand for medical care as well as unnecessary high claim rates (Mwaura, 2009)

Adverse selection is relevant in the health insurance market simply because an individual may choose a plan offered by insurance company basing on his /her expected probability of using health services , that is those who predict a medical problem in their near future for self or dependents tends to choose more generous plan than those who do not, this results in the situation that the health expenditure are greater or equal to the premium paid, then what ever the premium, the insurance company may end up with a loss on each customer (Cutler & Zeckhauser, 1997)

Adverse selection can lead to the following inefficiencies; participants price not reflecting marginal cost hence individual select the wrong health plans; desirable risk spreading is lost and the health plans manipulate their offerings to deter the sick and attract the healthy. Adverse selection can lead insurance provider to be unprofitable and fail as a result of the insurer having a pool of more risky cases. Insurers protect themselves from the risk of adverse selection by setting insurance premium higher and in voluntary markets this can result in healthier individuals not buying health coverage because their cost will be higher than the potential benefits. Sicker individuals will still choose to buy insurance resulting in a higher than expected level of risk in the insurance pool. At the extreme, adverse selection can lead to the collapse of the insurance market (Cutler & Reber, 1998)

2.4.2 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 and Liu, 2001). There are several mechanisms which can be employed in Heath 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 .

2.4.3 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.

2.4.4 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.

2.4.5 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.

2.4.6 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 13 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 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 bur- den of purchasing health care by pooling funds and sharing the risk of unexpected health events.

2.4.7 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 laisser-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.

2.4.8 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

2.5 Empirical review

2.5.0 Factors affecting health insurance coverage

Low- income and middle- income countries have difficulties in achieving universal health coverage. Lack of financial resources (inability to pay premium), poor quality of care offered, and lack of trust on the insurance providers has been found to major reasons for low health insurance coverage (Esther F.Adebayo, Olalekan A.Uthman, John E.Atuguba, 2015). On the other hand lack of basic information on the schemes design and operations, limited understanding on the principles underlying insurance schemes (Community awareness on the benefits of insurance), limited community involvement and lack of trust in the management of the schemes and people's ability to pay the insurance premiums were found to be the factors for low health insurance coverage (Robert Basaza, Bart Criel & Patric Van der stuyft, 2007)

2.5.1. Inability to pay membership contribution

Membership contribution has been reported to be one of the factors affecting enrolment to health insurance fund. A study done in Uganda reported that inability to

raise contribution for enrolment to the fund was one of the commonest reason for low community health insurance enrolment (8 out of direct respondents) (Basaza et al, 2007), a similar findings were reported by a study done in Tanzania which concluded that low Community health insurance fund enrolment was attributed to by inability of the citizen to pay membership fee (GC, KS, AK, 2002)

2.5.2. Awareness of the community on the benefits of Insurance

In developing countries low demand for health insurance commonly is due to limited understanding of its benefit, potential beneficiaries even educated individuals some time prefer to retain risk than trust a third party like an insurance company. Low income individuals' reason that they do not require insurance cover, this is probably due to lack of confidence in insurers and poor understanding of the risk- pooling concept. Many people do not comprehend the concept of insurance and how it works, in some cases poor people view insurance negatively, they perceive it as reserved for the rich only, but also they think that it is irrelevant, too expensive or even unfair (Cohen & Sebastad, 2005)

During inception of CBHI in Rwanda, 3 districts were piloted where sensitization campaigns began in February 1999 and only a year and a half 8% of the population in the pilot district has voluntarily enrolled, this increased health facility utilization and decreased out of pocket expenses. This results convinced Ministry of Health to roll out CBHI National wide (Schneider, Diop, & Bucyana, 2000, Schneider & Diop, 2001)

Involvement of local government officials to sensitize the community was a cornerstone for Rwanda to stimulate enrolment and therefore the local officials were made the mainstay for the expansion of the CBHI scheme. In 2003, MINALOC instructed province and district mayors to create Mutuelles as quickly as possible and stated that the creation of Mutuelles will be a criterion in their future evaluation (Musango, Doetinchem, & Carrin, 2009; 6)

In Uganda it was reported that many communities did not receive appropriate information of the CHI and in few occasions where relevant information was received the concept was not understood so the study concluded that lack of adequate information about the CHI was one of a major reason for people not joining Community health insurance (Basaza et al, 2007). In west Africa lack of adequate knowledge and understanding of health insurance scheme was among reasons low health insurance coverage (De Manuel Allegri, Sanon M, Sauerborn R, 2006), similarly in Tanzania poor education and limited mobilization of community members to join community health fund was also demonstrated as a reason for low coverage (GC, KS, AK, 2002).

2.5.3. Mandatory versus Voluntary health insurance

Mandatory enrollment of Health insurance has been reported to accelerate coverage in countries like Rwanda where community based health insurance became compulsory in 2006 and until 2015/2016 it has significantly paved way to universal health coverage by attaining 87% of the population when combined with other insurances (De Allegri, Sauerborn, Kouyaté, & Flessa, 2009; Soors, Devadasan, Durairaj, & Criel, 2010).

Mandatory enrollment of the population in health insurance was recognized as a cornerstone towards achieving universal health insurance coverage in Korea after revision of health insurance law in December 1976 which included mandatory enrollment. It began with employees in large corporations with more than 500 workers and gradually extended to reach small firms with just more than 16 employees in 1983. A medical aid program was started for the poor in 1977 and Government employees and teachers joined mandatory health insurance program in 1979 and finally it was extended to the self-employed. The Korean health insurance program achieved universal coverage of the population by including rural self-employed in January 1988 and urban self-employed in 1989 (Kwon 2005, 2008).

Community based health insurance (CBHI) in Rwanda before it become compulsory in 2006, it was already recognized as one of the rare successful health insurance in Sub Saharan Africa (De Allegri et al). Rwanda could have widely promoted CBHI as a tool to reduce the financial burden of accessing health care because since the 1990's CBHI was seen as a tool to improve access to health services in low and middle income countries where the size of the formal sector is small (Dror & Lacquier, 1999; Preker and Canin, 2004).

Mandatory enrolment is not the only mainstay of dramatic enrolment, for example health insurance is also mandatory in Ghana as in Rwanda but it is a mere declaration of intent (Jehu- Appiah et al, 2011: 158: Kusi, Enemark, Hansen, & Asante 2015). High enrolment rates in Rwanda has been facilitated by numerous sensitization channels at National and local government including official state speeches, community radios, churches, markets, cooperatives or women associations, tight networks of community health workers operating in each of the 14,744 villages (Mann, 1984), in other words dense, decentralized administrative structure, numerous channels of information and a tight network of community health workers was significant in ensuring high enrolment.

Rwandan local government strong pressure on the community for high enrolment comes from the imigo system or performance contracts signed annually since 2006 between district Mayors and the President , CBHI enrolment always features as an objective in those contracts (Chemouni; 2014). Officials were also backed by the 2007 and 2015 CBHI law which allowed fining of civilian who does not enroll between 5000 and 10000 RwF and 50,000 to 100,000 RwF for any person who incites others to refrain from enrolling into the CBHI, the Law also stated that an individual can benefit from health coverage only if all members of his/ her house hold are enrolled (CBHI Law articles 63 & 25 of 2007 & 2015)

One could relate the success of CBHI expansion in Rwanda with its small size and high population density, yet Burundi is a country with similar characteristics but has not reached the same level of enrolment into its health insurance scheme. Conversely Ethiopia is recording extremely fast enrolment yet is not densely populated (Lavers, 2016). The analysis still demonstrate that the necessary condition for the rapid scale-up of CBHI in Rwanda was the top-down pressure put on the local authorities underpinned by the nature of the political settlement.

2.5.4. Quality of services offered

A study done in Uganda reported that quality of health care provided to beneficiaries of the fund was never mentioned as a reason for either joining or not joining the health insurance scheme (Basaza et al, 2007), whereas study done in West Africa demonstrated that beside other reasons poor quality of health care services offered was a reason for low enrollment to the scheme. Similar findings were reported in Tanzania where poor quality of care was a reason for low community health fund enrolment (GC, KS, AK, 2002)

2.5.6 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 25 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.

2.5.7 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.

2.5.8 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 26 (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.

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. 19premiums, 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).

2.5.9 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, Janssenset 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.

2.5.10 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 analyze 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 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.

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.

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

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).

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 31 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).

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 32 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 core 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), Assed 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 33 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 34 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.

2.6. Research Gap

Most studies done in Tanzania to establish factors associated with low insurance coverage were done on Community health insurance fund. No studies has been done to establish reasons for low coverage of National health insurance fund. Therefore this study will add knowledge on the challenges facing coverage of National health insurance in Tanzania

2.6. Conceptual Framework

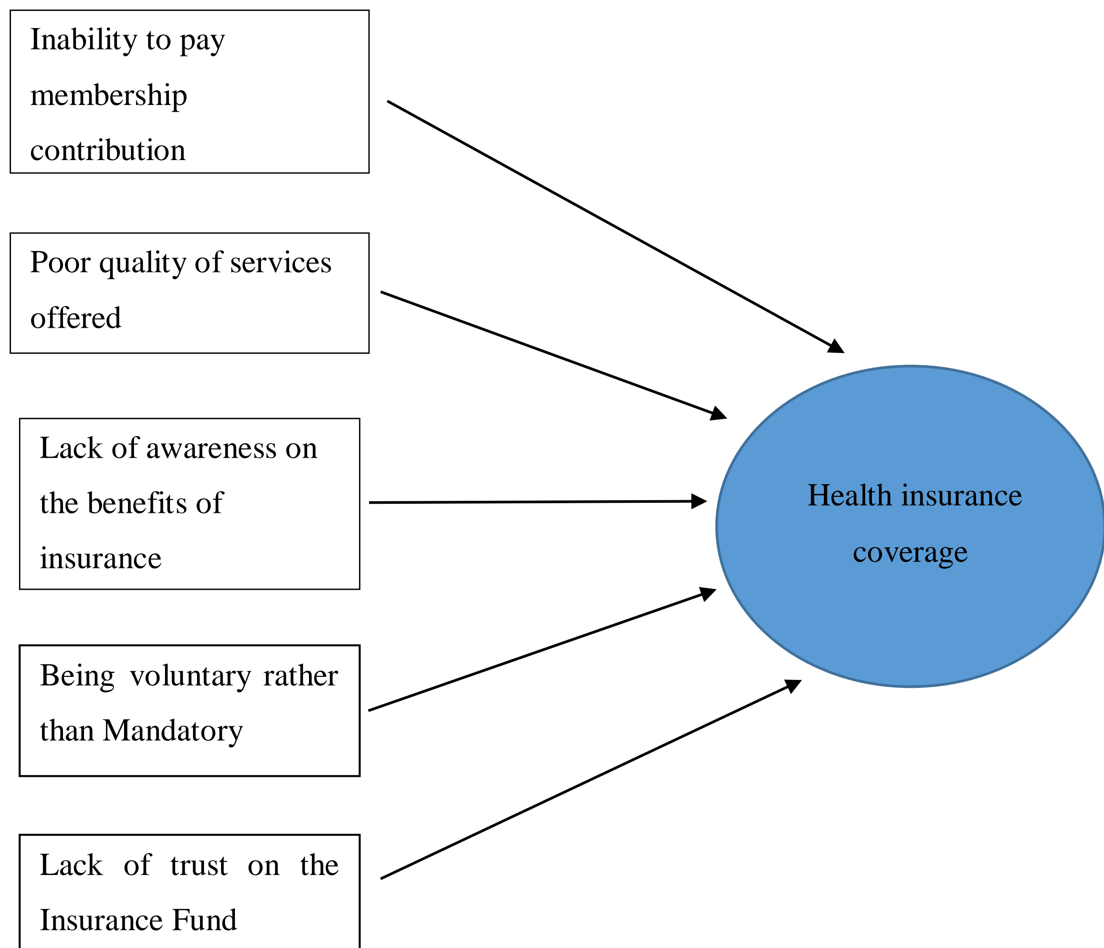

Figure 2.1: Conceptual Frame work

CHAPTER THREE
RESEARCH METHODOLOGY

3.1. Research Design

The research design used in this study was a descriptive cross- sectional survey design where variables were tested at once to get in-depth understanding of the factors associated with low health insurance coverage in Tanzania (Causal relationship)

3.2. Description of the study Area

This study was conducted in Dodoma city which has a population of about one million residents comprising of different social groups including all range of SME's, government employees, private sector employee and peasants . Dodoma city is among the area with low national health insurance coverage despite different strategies used by NHIF to attract people join the fund. For example for the recent launched NHIF packages a total of 1,664 citizens from Dodoma region visited NHIF office for getting information about different packages and of those only 468 took the forms for registration but only 95 people were registered by the fund. Therefore Dodoma city was considered to represent the entire target population of the country.

3.3. Study population

The population which will be studied in this study will be small to mediums scale entrepreneurs (boda boda, mama ntilie), business people, peasants and employees residing in Dodoma city council.

3.4. Sample size and Sampling techniques

3.4.1. Sample size

Sample Size Estimation

A minimum sample size of 385 participant was used which were obtained from Dodoma city population. The estimated sample size "**n**" was computed using the formula below

$$n = \frac{z^2pq}{\varepsilon^2}$$

Where;

n=Sample size

z= level of confidence (1.96 for 95% confidence level)

p = expected proportion (50%)

q = (1-P) = proportion

ε = Desired margin of error = 5%

3.4.2. Sampling procedure

Randomized Stratified sampling technique was used in this study to get the understanding of different groups about health insurance. The study population was stratified into different starter with similar characteristics from each starter simple random sampling was done to get the subjects to be enrolled into the study. The starter comprised of Boda boda Cyclists, Mama Ntilies, Peasants, business people with shops and employees in private sector. Each groups sampling frame was subjected to simple random sampling to get the study subjects

3.5. Data Collection

Data collection methods was primary and secondary data

3.5.1. Primary data

Primary data involved the following techniques, namely

- Questionnaire: A questionnaire is a list of question to be filled in by the respondent of the study. There are two types of questionnaire, open ended and closed ended. The respondent to be involved in this instrument included; management of NHIF and the other managers.

- Interview guide and schedule: An interview Guide involves guiding questions for the purpose of facilitating face to face interview between interviewee and the interviewer, for the purpose of this particular research, lower managers were

involved. Interview schedule involves the determination of the respondent to be involved in the interview process, additionally interview schedule serve as timetable to be followed during the process of interview.

3.5.2 Secondary data

The secondary data involved the review of different documents in a way this part governed the documentary review. Such documentary review involved performance of NHIF as well as enrollment of members to NHIF.

3.6. Data analysis

Both quantitative and qualitative were used in this study. Data obtained through questionnaire.

Quantitative data were analyzed in Statistical Package for social science (SPSS vision 20). Data were summarized in form of tables showing descriptive statistics for each variable. Chi-square test and multiple logistic regressions were used to assess for statistically significance. For Chi-square test was used to test the association between enrollments in the NHIF and explanatory variable. The Multiple logistic regressions were conducted to examine the determinants for participation in NHIF scheme. Qualitative analysis was done using content analysis techniques. Content of data, units for coding were identified and the coding categories were defined.

CHAPTER FOUR
RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the analysis and discussion of findings. The analysis and discussion in this chapter based on the responses of the 385 respondents who were interviewed.

4.2 Social-demographic characteristics of respondents

Majority of respondents were female who represented 51.2% of the sample while 48.8% were male. The mean age for all interviewer was 36 years which range between 20 and 72 years. The respondent were asked about their occupational, 78(20.3%) were business people, 77(20%) were motor cycle (Bodaboda), 68(17.7%) were peasant, 64(16.6%) were mamantilie's, 59(15.3%) were private employee and 39(10.1%) sold fruit and vegetable. Majority 209(54.3%) mentioned to have completed primary education, 92(23.9%) were achieved secondary education, 38(9.9%) had completed college, 28(7.3%) had acquired university level and 18(4.7%) were illiterate. Majority of the respondents were married represented by 199(51.7%), 104(27%) were single, 51(13.2%) were co habiting, 17(4.4%) were widow, 12(3.1%) were divorced and 2(0.5%) were widower.

Table 4.1: Social demographic characteristics

Social Demographic Variable	*Frequency*	*Percent*
Gender of respondent		
Male	188	48.8
Female	197	51.2
Total	385	100.0
Ages of respondent		
20-29	125	32.5
30-39	134	34.8
40-49	77	20.0
50-59	40	10.4
60+	9	2.3
Total	385	100.0
Occupation		
Bodaboda	77	20.0
Mamantilie	64	16.6
Fruit, vegetable	39	10.1
Peasant	68	17.7
Business	78	20.3
Private employee	59	15.3
Total	385	100.0
Highest education level		
Illiterate	18	4.7
Primary	209	54.3
Secondary	92	23.9
College	38	9.9
University	28	7.3
Total	385	100.0
Marital Status		
Single	104	27.0
Married	199	51.7
Divorced	12	3.1
Co-habiting	51	13.2
Widow	17	4.4
Widower	2	.5
Total	385	100.0

Source; Research findings 2020

4.3 Awareness of the existence of NHIF and source of information

The respondents were asked to assess the level of their awareness of the existence of NHIF, the results shows that 381 (99%) were aware of NHIF while 4 (1%) were not aware.

Table 4.2 provides a summary of different sources of NHIF information as 139 (36.1%) is from health facilities/Hospital, 83(21.6%) from Radio/TV, 43 (11.2%) from NHIF, 39(10.1%) from friends, 24 (6.2%) from market, 22(5.7%) from family, 20(5.2%) from neighbor, 5(1.3%) from their Customers, 4(1%) didn't know, 3(0.8%) from University while 3 (0.8%) mentioned other forms of advertisement.

Table 4.2: Awareness of the existence of NHIF and source of information

Variable	*Frequency*	*Percent*
Aware of existence of National Health insurance scheme		
Yes	381	99.0
No	4	1.0
Total	385	100.0
Heard about national insurance scheme		
NHIF	43	11.2
Radio/TV	83	21.6
Neighbor	20	5.2
Friend	39	10.1
From health facility /Hospital	139	36.1
Advertisements	3	.8
Market	24	6.2
Family	22	5.7
University	3	.8
From Customers	5	1.3
I don't know	4	1.0
Total	385	100.0

Source; Research findings 2020

4.4 Enrolment of NHIF

Majority of the respondents didn't enroll in NHIF Scheme by 94% of the population studied. Only 6% were enrolled as shown in Figure 4.1.

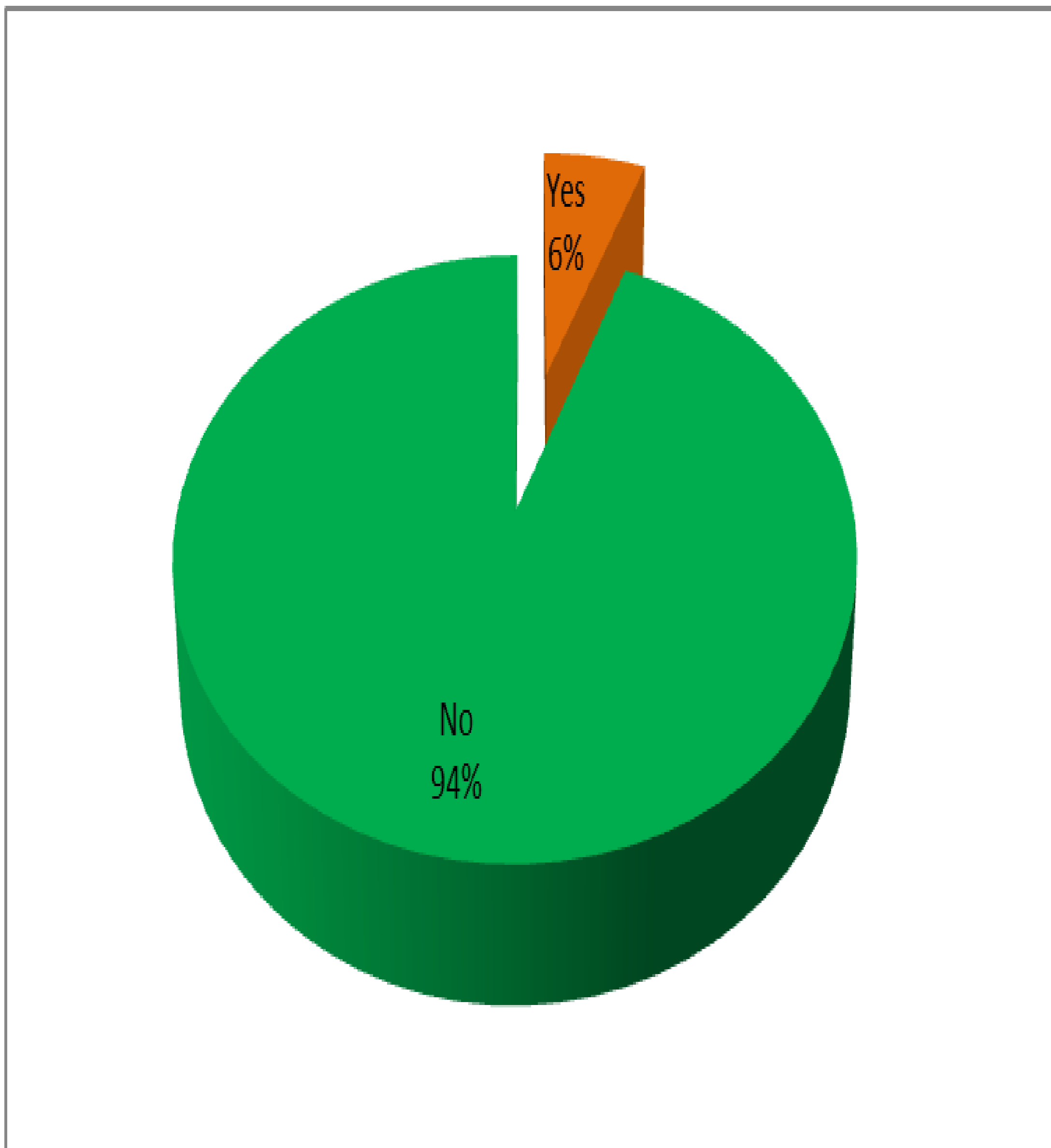

Figure 4.1: Enrolment of NHIF scheme

4.4.1 Enrolment of NHIF scheme and social demographic characteristics

The result in Table 4.3 shows that there is relationship between Age of respondent and enrolment of NHIF scheme (χ^2=39.701, P=0.000) and there is relationship between Marital status and enrolment of NHIF scheme (χ^2=18.904, P=0.002). This implies that Age and marital status of the respondent influenced the enrolment of NHIF. Meaning that people with higher age group has a tendency of enrolling to NHIF than those with low age group similarly married people has a high tendency of enrolling to NHIF than unmarried people. The result shows that there statistically Insignificance between the enrolment of NHIF scheme in gender (χ^2=0.010, P=0.921), Occupation (χ^2=8.881, P=0.114) and Level of education (χ^2=6.329, P=0.176).

Table 4.3: Enrolment of NHIF scheme and social demographic characteristics

		Member of NHIF		*Total*	*Pearson Chi Square*
		Yes	*No*		
Gender of respondent	Male	11	177	188	χ^2=0.010
	Female	12	185	197	(P=0.921)
Total		23	362	385	
Ages of respondent	20-29	1	124	125	
	30-39	6	128	134	
	40-49	5	72	77	χ^2=39.701
	50-59	7	33	40	(P=0.000)
	60+	4	5	9	
	Total	23	362	385	
Occupation	Bodaboda	1	76	77	
	Mamantilie	3	61	64	
	Fruit, vegetable and cereals	1	38	39	χ^2=8.881
	Peasant	7	61	68	(P=0.114)
	Business	8	70	78	
	Private employee	3	56	59	
	Total	23	362	385	
Highest education level	Illiterate	0	18	18	
	Primary	10	199	209	
	Secondary	5	87	92	χ^2=6.329
	College	5	33	38	(P=0.176)
	University	3	25	28	
	Total	23	362	385	
Marital Status	Single	2	102	104	
	Married	19	180	199	
	Divorced	1	11	12	χ^2=18.904
	Co-habiting	0	51	51	(P=0.002)
	Widow	0	17	17	
	Widower	1	1	2	
	Total	23	362	385	

Source; Research findings 2020

4.5 Awareness of the benefit of different NHIF packages

The respondent were asked if they were aware of the different NHIF packages. The result shows that majority 91.2% of the respondent were not aware of the different packages provided by NHIF and 8.8% were aware.

Table 4.4: Awareness of the benefit of different NHIF packages

Awareness	*Frequency*	*Percent*
Yes	34	8.8
No	351	91.2
Total	385	100.0

4.6 Multiple logistic regression analysis

Estimates from the multiple logistic regressions (Table 4.5) indicate that the awareness of the benefit of NHIF package showed statistically significant association with enrolment in the NHIF scheme, according to the Sig.value (P=0.005). The odds ratio for this variable however is 0.184 with (95% CI: 0.057 to 0.595).This indicates that the increase awareness of the NHIF packages (vifurushi) will be the factor for people to enroll in NHIF

The ability to pay membership contribution showed statistically insignificant association with enrolment in the NHIF scheme with Sig.value (P=0.657). The odds ratio for this variable however is 0.864 with (95% CI: 0.454 to 1.646). This indicates that the ability to pay membership contribution is not the factor people to enroll in NHIF.

The rationale for protecting against risks of illness also showed statistically insignificant association with enrolment in the NHIF scheme with Sig.value (P=0.334). The odds ratio for this variable however is 0.624 with (95% CI: 0.24 to 1.623). This indicates that the rationale for protecting against risks of illness is not the factor for enrolment in NHIF scheme

The quality of service offed by NHIF beneficiaries also showed statistically insignificant association with enrolment in the NHIF scheme with Sig.value (P=0.77). The odds ratio for this variable however is 0.947 with (95% CI: 0.659 to 1.361). This indicates that the quality of service offed is not influence people to enroll NHIF.

NHIF being voluntary rather than mandatory also showed positive statistically insignificant association with enrolment in the NHIF scheme with Sig.value (P=0.085). The odds ratio for this variable however is 1.283 with (95% CI: 0.966 to 1.704). This indicates that there is no association of being voluntary rather than mandatory and enrollment in NHIF scheme.

Lack of trust to NHIF manager also showed statistically insignificant association with enrolment in the NHIF scheme with Sig.value (P=0.6). The odds ratio for this variable however is 0.917 with (95% CI: 0.664 to 1.267). This indicates that lacks of trust to NHIF manager are not the factor for people to enroll NHIF scheme.

Table 4.5: Multiple logistic regression

							95% Confidence Interval	
	B	S.E	Wald	df	Sig.	Adjusted odds ratio	Lower Bound	Upper Bound
Intercept	0.394	1.057	0.139	1	0.709			
Awareness of the benefit of NHIF package	-1.69	0.598	7.994	1	0.005	0.184	0.057	0.595
Ability to pay membership contribution	-0.146	0.329	0.197	1	0.657	0.864	0.454	1.646
Rationale for protecting against risks of illness	-0.471	0.488	0.934	1	0.334	0.624	0.24	1.623
Quality of service offered	-0.054	0.185	0.086	1	0.77	0.947	0.659	1.361
Being voluntary rather than Mandatory	0.25	0.145	2.971	1	0.085	1.283	0.966	1.704
Lack of trust on insurance	-0.086	0.165	0.276	1	0.6	0.917	0.664	1.267

Source; Research findings 2020

4.7 Qualitative data analysis

4.7.1 Factor contributing to low National Health Insurances

Several reasons were mentioned which causing slow enrollment of citizens to NHIF from narrative during an interviews were lack of education, Low income (Financial problem), Inadequate community sensitization, Lack of time, wrong dissemination of information toward services offered to NHIF beneficiaries , negative attitude .Majority of the interviewer reported

> *"I can enroll myself to NHIF and stay for a year without being sick, my money will get lost for nothing. There are a lot of pharmacies in streets once I fall sick i go and meet the nurses/doctor and will advise the right medicine to buy, you use it and you recover at a low cost"(QN198)*

> *"Using a lot of efforts while people didn't have the education on NHIF insurance its nothing for example when we look at the period of Corona the government used the big effort to educate people and everyone understood the precaution even people living in the village. Why is this effort cannot be used by the government to educate people for them to understand?"(QN160)*

Other interviewer report that

> *"To tell you the truth we knew that, NHIF is for government employees and rich people and not for the people with low income" (QN303)*

> *"I am not aware of the changes made by the government that allow low income earners to enroll to NHIF scheme. The government should consider the income of small business people which is relatively low" (QN177)*

4.7.2 Attraction of citizens to NHIF enrolment

> *"I think Education should be provided to the community as whole and even reaching out to people on their working centers like Bodaboda center, Market area and use of local leaders, sensitization meeting, church & mosque leaders, community groups like VICOBA" (QN139)*

"For the insurance that ends every year, NHIF should allow people to contribute in installments for at least three months rather than paying a lump sum because the things that bring difficult to people especially the low income earners is to pay as lump sum " (QN49).

"Provision of education especially the Bodaboda driver who are likely to get into accidents at any time on the benefits of the National Health Insurance" (QN188).

4.8 Discussion of findings

This study found that the community is aware of existence of NHIF 99% of respondents, but most of them did not have in-depth understanding on how NHIF operates including the different packages it offers to the community to choice according to their disposable income 91.2% of respondents, lack of this in-depth understanding was supported by low level of enrollment among the respondents of just only 6%. That is to say many people do not understand the concept of insurance and how it operates. The study revealed that increase of community awareness of NHIF operations including different available NHIF packages (Vifurushi) is afactor for people to enroll to the fund (P= 0.005). This findings is in line with what was found by Cohen & Sebastad 2005 who found that low uptake of medical insurance was due to the fact that many people do not understand the concept of insurance and that the view of poor people about health insurance is negative they see it as a reserve for the rich. Mann, 1984 reported that Rwanda's high enrollment rate was facilitated by numerous sensitization channels at national and local government including official speeches, community radios, churches, markets, cooperatives or women association as well as tight networks of community health workers operating in each village country wise.

This study found that ability to membership contribution fee was not a factor for people not to enroll to NHIF (P = 0.657), qualitative data showed that inadequate community sensitization, wrong dissemination of information toward services offered to NHIF beneficiaries and negative altitude were the reasons for low

enrollment and not inability for pay contribution fee. A study in Rwanda where the economic status of citizen is similar to those of the study population revealed a rapid uptake of CBHI in three pilot districts just in a period of a year and a half 8% of the population had enrolled after intense sensitization campaigns (Schneider,Diop,& Bucyana,2000). However another study done in Tanzania revealed that inability to pay membership fee was a reason for low CHIF enrolment (GC, KS, AK, 2002), this was similar to what was reported by Basaza et al, 2007 in Uganda who found that inability to raise contribution was among the commonest reasons people not joining CHI. These differences could be explained by the fact that this study was done in a City where economic power is higher than in the rural setting where those other studies were conducted to study the community health scheme.

Quality of medical services offered to NHIF beneficially was not found to be a reason for people not to enroll to NHIF (P= 0.947) this was in line with what was found in Uganda by Robert Basaza et al, 2007 who reported that quality of health care provided through Community health insurance was not a reason for either joining or not joining the scheme. However a study done in west Africa reported that poor quality of health care provided was among other reasons for low enrolment (De Manuel et al, 2006), similar findings were demonstrated by a study in Tanzania which found that poor quality of health care was a reason for CHIF enrolment. This difference could be explained by the study setting and the difference in the Policy between NHIF and CHIF in that this study was based in City where there various medical services one can opt with his/her insurance cover unlike in rural setting where health care services are poor with limited resources. The National health Insurance scheme allows a wide choice of health care a mender can choose ranging from public health facilities to private health care facilities basing on the quality of health care one believes is the best for them where as in community health scheme in Tanzania a beneficiary is limited to a certain level o health facilities which in most cases the quality of services offered at that level are poor hence influencing negatively the enrolment to CHIF.

Lack of trust on the NHIF managers on fund utilization was found not to be a reason for low NHIF enrolment (p = 0.600) this was contrary to what was found by Robert Basaza et al, 2007 in Uganda who reported that lack of trust in the management of the schemes was among reasons for low community health insurance enrolment. This could be explained by the past experience of Uganda in the 90`s when there was a closure of various banks and building societies and some of the local non-Governmental organizations (NGO) took money from communities with the promise of subsequent assistance which failure materialize. This created a distrust of financial institutions, this situation has not been experienced in Tanzania hence there is no mistrust to the NHIF managers

This study found that NHIF enrollment being voluntary rather than mandatory was not a reason for low enrollment to the fund (P = 0.085), this was concomitant with what was found by Jehu- Appiah et al, 2011 who reported that mandatory enrolment is not the only mainstay of dramatic enrolment, for example health insurance in Ghana is also mandatory as in Rwanda but it is just a mere declaration of intent.

CHAPTER FIVE
SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction
This chapter presents a summary of the study, conclusion, recommendations as well as suggestions for further study.

5.2. Summary
The purpose of this study was to establish factors associated with low enrolment of Tanzanians to the National health insurance fund. Descriptive cross-sectional survey design was used to study SME's population residing in Dodoma city council, a sample of 385 respondents were interviewed using a pretested coded questionnaire and the data were analyzed using Multiple logistic regression to find out the association of the dependent variables with the independent variables. The parameters that were analyzed included Awareness of the benefit of the NHIF package, ability to pay membership contribution, rationale for protecting against risks of illness, quality of services offered, being voluntary rather than mandatory and lack of trust on the NHIF managers, these variable were analyzed to determine whether they had causal relationship with the low NHIF coverage.

The study revealed that increase of awareness of NHIF packages (Vifurushi) had a positive impact for people to enroll to NHIF (P= 0.005), this means that if people are made aware of NHIF concept as well as different packages it offers through community sensitization, then NHIF enrollment will significantly increase. The rest of the factors studied did not have impact on the NHIF enrollment such as ability to pay membership contribution fee (P = 0.657), Quality of service offered to NHIF beneficiary (P = 0.77), NHIF being voluntary rather than mandatory (P = 0.085), and lack of trust to NHIF managers (P = 0.66). Qualitative analysis revealed that majority of respondents reported that slow NHIF enrollment is mainly contributed to by lack of education on NHIF, low income, inadequate community sensitization, wrong

dissemination of information toward services offered to NHIF beneficiaries and negative altitude.

The findings of this study has demonstrated that awareness creation through education and community sensitization for in-depth understanding of the NHIF concept, operations as well as the available NHIF packages is the mainstay among other factors for accelerating enrollment to the fund.

5.3. Conclusion

The study concludes that low NHIF coverage is attributed to by lack of community awareness on the importance of insuring their medical treatment, though people are aware of existence of NHIF they do not understand how it operates including the different packages the fund has for the community to choose basing on their economic power. They generally lack the understanding of the concepts of health insurance as well as the benefits of being enrolled to the NHIF

5.4. Recommendation of the study

The research recommends that NHIF should develop a well-structured and numerous community awareness and sensitization programs ranging from national to local government levels using different approaches such as official state speeches, community radios, churches, markets, social gatherings, cooperatives and associations, use of community health workers operating in villages. The sensitization should be persistent to ensure that the community gains in-depth understanding of the NHIF concept and different packages it has to offer to the community. NHIF should persuade the Tanzania Government to include citizen enrollment to the fund as a performance measure of the local government leaders, the experience worked well in Rwanda.

5.5. Limitation of the study

i) The respondents were mainly SME"s which could have not reflected the sample of the entire population

ii) The study done in only one location that is Dodoma City Council, thus could not generalize to the entire country due to difference in culture and economic power among regions

5.6. Suggestions for further study

i) There is still a room to study other factors other than the one studied to establish reasons for low and sluggish NHIF enrollment
ii) Multicenter study is needed to have a wide coverage would be appropriate for getting in-depth understanding of the bottleneck toward rapid NHIF enrollment

CHAPTER SIX
DISCUSSION OF RESEARCH FINDINDS

This study found that the community is aware of existence of NHIF 99% of respondents, but most of them 91.2% did not have in-depth understanding on how NHIF operates including the different packages it offers to the community to choice according to their disposable income, lack of this in-depth understanding was supported by low level of enrollment among the respondents of just only 6%. That is to say many people do not understand the concept of insurance and how it operates. The study revealed that increase of community awareness of NHIF operations including different available NHIF packages (Vifurushi) is a factor for people to enroll to the fund (P= 0.005). This findings is in line with what was found by Cohen & Sebastad 2005 who found that low uptake of medical insurance was due to the fact that many people do not understand the concept of insurance and that the view of poor people about health insurance is negative they see it as a reserve for the rich. Mann, 1984 reported that Rwanda's high enrollment rate was facilitated by numerous sensitization channels at national and local government including official speeches, community radios, churches, markets, cooperatives or women association as well as tight networks of community health workers operating in each village country wise.

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was similar to what was reported by Basaza et al, 2007 in Uganda who found that inability to raise contribution was among the commonest reasons people not joining CHI. These differences could be explained by the fact that this study was done in a City where economic power is higher than in the rural setting where those other studies were conducted to study the community health scheme rural settings.

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Governmental organizations (NGO) took money from communities with the promise of subsequent assistance which failure materialize. This created a distrust of financial institutions, this situation has not been experienced in Tanzania hence there is no mistrust to the NHIF managers

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APPENDICES

QUESTINNARE FOR THE RESARCH TITLED:

FACTORS CONTRIBUTING TO LOW NATIONAL HEALTH INSURANCE COVERAGE IN TANZANIA, A CASE OF DODOMA CITY COUNCIL

PART I: SOCIAL DEMOGRAPHIC INFORMATION (*Write or Tick √ the correct answer*)

1. Sex: male [ ] female [ ]
2. Age ___________________
3. Residence ________________
4. Occupation ____________________________
5. Highest education level
   1. Illiterate ( )
   2. Primary ( )
   3. Secondary ( )
   4. University/college ( )
   5. No formal education ( )
   6. Other specify ____________

6. Marital status
   1. Single ( )
   2. Married ( )
   3. Divorced ( )
   4. Co-habiting ( )
   5. Other specify ______________

PART 2: FACTORS CONTRIBUTING TO LOW NATIONAL HEALTH INSUARANCE (Write or *Tick* √ the correct answer)

1. Are you aware of existence of National Health insurance scheme?
   YES [ ] NO [ ]
2. Where did you heard about national insurance scheme?
   1. Radio [ ]
   2. Neighbor [ ]
   3. Friends [ ]
   4. From health facility [ ]
   5. Other (mention)___________________________

3. Are you a member of NHIF?
   YES [ ]   NO [ ]

4. If you're a member which package
   a. ………………………………………………………………………
   b. ………………………………………………………………………

5. If No, why you're not a member?
   a. ………………………………………………………………………
   ………………………………………………………………………

6. Do you think there is any disadvantage of not being a member?

   YES [ ]   NO [ ]

7. If yes what are they?
   a. ………………………………………………………………………
   b. ………………………………………………………………………

8. Do you have any plans to become an NHIF member?
   YES [ ]   NO [ ]

9. If you told its benefits and important are you willing to provide your income to enroll to NHIF?
   YES [ ]   NO [ ]

10. If yes do you think it is important and beneficial to you to enroll to NHIF?
    1. Strongly agree [ ]
    2. Agree [ ]
    3. Disagree [ ]
    4. Strongly disagree [ ]

11. Are you aware of the different packages (vifurushi) offered by NHIF to beneficiaries?

    Yes [ ]   No [ ]

12. If yes please name them

   a. ……………………………………………………………………………
   b. ……………………………………………………………………………
   c. ……………………………………………………………………………
   d. ……………………………………………………………………………

13. Are the contribution fees charged by NHIF for the different packages providing a room for every Citizen to choose a package depending on his/her financial capability?

   1. Strongly agree [ ]
   2. Agree [ ]
   3. Disagree [ ]
   4. Strongly disagree [ ]

14. Do you think it is important for you to protect yourself against risks of illness by enrolling to NHIF to cover your treatment cost because you don't know your financial capability at the time you fall sick?

   1. Strongly agree [ ]
   2. Agree [ ]
   3. Disagree [ ]
   4. Strongly disagree [ ]

15. Do you believe that the quality of services offered to NHIF beneficiaries is better if compared to services offered when one pay out of pocket?

   1. Strongly agree [ ]
   2. Agree [ ]
   3. Disagree [ ]
   4. Strongly disagree [ ]

16. Do you think that NHIF enrollment being voluntary rather than mandatory is a reason for Citizens not joining NHIF?

   1. Strongly agree [ ]
   2. Agree [ ]
   3. Disagree [ ]
   4. Strongly disagree [ ]

17. Is lack of government intervention a factor for Citizen not enrolling to NHIF?

1. Strongly agree [ ]
2. Agree [ ]
3. Disagree [ ]
4. Strongly disagree [ ]

18. Do you think lack of trust on the NHIF Managers on the utilization of funds paid by beneficiaries a reason for people not enrolling to the fund?

1. Strongly agree [ ]
2. Agree [ ]
3. Disagree [ ]
4. Strongly disagree [ ]

17. What do you think NHIF should do to attract more citizens join the fund?

a. ……………………………………………………………………………………

b. ……………………………………………………………………………………

18. What do you think are the reasons causing slow enrollment of the citizens to NHIF?

a. ……………………………………………………………………………………

b. ……………………………………………………………………………………

19. Any comment?

a. …………………………………………………………………………………

b. …………………………………………………………………………………

QUESTINNARE FOR THE RESARCH TITLED:

FACTORS CONTRIBUTING TO LOW NATIONAL HEALTH INSURANCE COVERAGE IN TANZANIA, A CASE OF DODOMA CITY COUNCIL

PART I: SOCIAL DEMOGRAPHIC INFORMATION (*Write or Tick √ the correct answer*)

1. Jinsi: Me [ ] Ke [ ]
2. Umri ___________________
3. Makazi ________________
4. Hali ya kazi __________________________
5. kiwango cha juu cha elimu
   1. Sijasoma ( )
   2. Elimu ya msingi ( )
   3. Sekondari ( )
   4. Elimu ya chuo ( )
   5. Elimu ya chuo kikuu ( )
   6. Nyingine ,taja ____________
7. Hali ya ndoa
   6. Sijaoa/sijaolewa ( )
   7. Nimeoa/nimeolewa ( )
   8. Nimeachika ( )
   9. Co-habiting ( )
   10. Nyingine taja ______________

PART 2: FACTORS CONTRIBUTING TO LOW NATIONAL HEALTH INSUARANCE (Write or *Tick* √ the correct answer)

1. Je una uelewa wowote juu ya kuwepo kwa mfuko wa Bima ya Afya ya Taifa
   Ndio [ ] Hapana [ ]
2. Umesikia wapi kuhusu mfuko wa Bima ya Afya ya Taifa
   1. NHIF [ ]
   2. Radio [ ]
   3. Majirani [ ]
   4. Marafiki [ ]
   5. Kwenye vituo vya afya [ ]
   6. Zingine (zitaje)___________________________

3. Je wewe ni mwanachama wa mfuko wa bima ya afya ya taifa
   Ndio [ ] Hapana [ ]

4. Kama ni mwanachama umejiunga na kifurushii gani

   a. …………………………………………………………………………

   b. …………………………………………………………………………

5. Kama hapana kwa nini hujajiunga?

   a. ……………………………………………………………………………

   b. ……………………………………………………………………………

6. Unafikiri kuna hasara yoyote ya kutokuwa mwanachama wa mfuko wa bima ya afya ya taifa ?

   Ndio [ ]   Hapana [ ]

7. Kama ndiyo , ni zipi zitaje

   c. ……………………………………………………………………………

   d. ……………………………………………………………………………

8. Je una mpango wowote wa kujiunga na mfuko wa bima ya afya ya Taifa

   Ndio [ ]   Hapana [ ]

9. Kama hapana endapo utaambiwa faida zake utakuwa tayari kutoa kipato chako kujiunga na mfuko wa bima ya afya?
   Ndio [ ]   Hapana [ ]

10. Kama ndiyo una fikiri ni muhimu na ina faida kwako kujiunga na mfuko wa bima ya afya?
    1. Nakubaliana sana [ ]
    2. Nakubali kiasi [ ]
    3. Sijui [ ]
    3. Sikubaliani [ ]
    4. Sikubaliani kabisa [ ]

11. Je una uelewa wa vifurushi mbalimbali vya bima vinavyotolewa na mfuko wa mfuko wa bima ya afya kwa wanufaika wake?

    Ndio [ ]   Hapana [ ]

12. Kama ndiyo ,tafadhali vitaje

    a. ………………………………………………………………………

    b. ………………………………………………………………………

    c. ………………………………………………………………………

13. Kiwango cha fedha cha kuchangia kinachotozwa kwa vifurushi mbalimbali kinampa mwananchi nafasi ya kuchagua kifurushi kulingana na uwezo wake wa kifedha alionao?

    1. Nakubaliana sana [ ]
    2. Nakubali kiasi [ ]
    3. Sijui [ ]
    3. Sikubaliani [ ]
    4. Sikubaliani kabisa [ ]

14. Je ,unafikili ni muhimu kwako kujilinda dhidi ya hatari za magonjwa kwa kujiunga na mfuko wa bima ya afya ili kugharamia gharama za matibabu yako kwa sababu hujui hali yako ya kifedha itakuwaje pindi utakapougua?

    1. Nakubaliana sana [ ]
    2. Nakubali kiasi [ ]
    3. Sijui [ ]
    3. Sikubaliani [ ]
    4. Sikubaliani kabisa [ ]

15. Unaamini kwamba ubora wa huduma zinazotolewa kwa wanufaika wa bima ya afya ni nzuri ukilinganisha na zile zinazotolewa kwa kulipa fedha taslimu kutoka kwenye mfuko wako?

    1. Nakubaliana sana [ ]
    2. Nakubali kiasi [ ]
    3. Sijui [ ]
    3. Sikubaliani [ ]
    4. Sikubaliani kabisa [ ]

16. Je unafikili kwamba kujiunga na mfuko wa bima ya afya kwa hiari kuliko kwa lazima ndiyo sababu ya wananchi kutojiunga na mfukon wa bima ya afya ?

1. Nakubaliana sana [ ]
2. Nakubali kiasi [ ]
3. Sijui [ ]
3. Sikubaliani [ ]
4. Sikubaliani kabisa [ ]

17. Je unafikili kwamba wananchi kukosa Imani kwa viongozi na watumishi wa bima ya afya juu ya matumizi ya fedha zinazolipwa na wanufaika ni sababu ya watu kutojiunga na mfuko wa bima ya afya ?

1. Nakubaliana sana [ ]
2. Nakubali kiasi [ ]
3. Sijui [ ]
3. Sikubaliani [ ]
4. Sikubaliani kabisa [ ]

17. Unafikiri nini, Bima ya afya ifanye ili kuwavutia watu wengi kujiunga na mfuko?

c. ………………………………………………………………………………

d. ………………………………………………………………………………

18. Unafikili ni sababu zipi zinazofanya wananchi wajiunge na mfuko kwa kasi ndogo?

c. ………………………………………………………………………………

d. ………………………………………………………………………………

20. Je una mapendekezo yoyote?

………………………………………………………………………………