CUSTOMER SATISFACTION WITH NATIONAL HEALTH INSURANCE FUND SERVICES:

A CASE STUDY OF SELECTED PUBLIC AND PRIVATE HOSPITALS IN MOSHI MUNICIPALITY, TANZANIA

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By

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A Research Report Submitted to the School of Public Administration and Management in Partial Fulfillment of the Requirements of the Award of a Degree of Master of Science in Human Resource Management of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation entitled **Customer Satisfaction with National Health Insurance Fund Services: A Case Study of Selected Public and Private Hospitals in Moshi Municipality, Tanzania,** in fulfillment of the requirements for Award of Degree of Master of Science in Human Resource Management of Mzumbe University.

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Major Supervisor

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Internal Examiner

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External Examiner

Accepted for the Board of……

Signature

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DEAN-SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

DECLARATION

AND

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I, **Gilbert Owen Linje** declare that this dissertation is my own work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

Signature……

Date……

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DEDICATION

I dedicate this work to my lovely son, Clifford Gilbert and my beautiful wife, Elizabeth Anthony for their love and patience. My long absence from home has yielded this work, therefore your support and long loneliness have been well rewarded.

LIST OF ABBREVIATIONS

DBS	-	Dried Blood Spot
HMIS	-	Health Management Information System
ICT	-	Information Communication Technology
MMC	-	Moshi Municipal Council
MoHSW	-	Ministry of Health and Social Welfare
NBS	-	National Bureau of Standards
NEDLIT	-	National Essential Disease List
NEMLIT	-	National Essential Medical list
NHIF ID	-	National Health Insurance Fund Identification
NHIF	-	National Health Insurance Fund
SCHIP	-	State Children's Health Insurance Program
SP	-	Service Provider
SPSS	-	Statistical Package for Social Sciences
UHC	-	Universal Health Coverage
URT	-	United Republic of Tanzania

ABSTRACT

This study focused on the assessment of *customer's satisfaction with the National Health Insurance Fund (NHIF)*, a case study of selected public and private hospitals at Moshi municipality. These hospitals were Mawenzi, Kibosho and KCMC. The study developed two specific research objectives, namely: examining the availability of health care services under NHIF and the assessment of the quality of health care services provided by NHIF. These objectives were accompanied with two research questions: "How satisfied clients are with the availability of health care services under NHIF?" and ii: "Are the health care services under NHIF quality?"

The study population involved NHIF beneficiaries and service providers in the selected hospitals. Two sample categories were used: interview sample and questionnaire sample. The interview sample involved twelve respondents (health care providers) with four respondents selected from each hospital. The questionnaire sample involved ninety eight respondents (NHIF beneficiaries) randomly selected from sample hospitals' registers. Therefore the study employed the total number of one hundred and ten respondents. The study used multiple methods of data collection: questionnaire, interview and documentary review. Qualitative data derived from questionnaire responses and official statistics were analyzed by means of descriptive statistics whereby the SPSS version 16 was applied to summarize the data alongside the use of relevant frequency, tables leading to meaningful inferences. Analysis of qualitative data derived from interview, observations and documentations involved.

The research findings show that, the majority of the customers were not satisfied with the NHIF health care services provided to them. They claimed that the provision of health care services was so limited, including: poor supportive facilities, absence of specialized health care services, unsatisfactory number of service providers, poor laboratory services as well as the absence of some prescribed medicines/drugs from the hospital dispensary desk (Pharmacy). But the findings show that, the extent of these limitations varied from one hospital to another. From the study, Mawenzi hospital was

recorded to provide worst health care services compared to the others (Kibosho and KCMC).

The research concludes that, NHIF is considered by her members as nothing but chaos. The conclusion was made via the usage of respondents' views and opinions. The study involved documentation, themantic analysis and narrative presentation. The themes emerged from the interview and documentary transcripts were documented and their meanings assigned in relation to the research objective and questions. A number of direct quortes which show dissatisfactions have been presented in the analysis chapter. The findings indicate a number of limitations facing NHIF members during their treatment at the hospitals.

The study recommends: hospitals to incorporate government in hiring more staffs so as to solve the problem of shortage of service providers, working environment should be improved, government to ensure drugs and equipments to be available at all hospitals and communications systems should be improved, as it was noted that there is the gap of information between the patients with the agency (NHIF). The functionality of all this will lead towards the satisfactions among the clients.

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Definitions of the key terms

Insurance, according to Lambin (200) is the equitable transfer of the risk of a loss, from one unit to another in exchange for money. It is a form of risk management primarily used to hedge against the risk of a contingent, uncertain loss.

Health insurance is the insurance against the risk of incurring medical expenses by estimating the overall risk of health care services (Kettinger, 1997).

Health Insurance Fund is the not for profit agency which is there so as to supervise the health care services among her members (Muhondwa, 2008).

Members of the Health Insurance Fund, these are the people who are benefiting health care services under the specific health insurance agency (Makonomalonja, 2010).

CHAPTER ONE

INTRODUCTION AND PROBLEM SETTING

1.1 Overview of the chapter

This introductory chapter presents the background of the study, a statement of the problem, objectives of the study, research questions, significance, and limitations of the study. The chapter also presents the organization of this dissertation. Social economic profile of Moshi municipality is presented first.

1.2 Socio-economic profile of Moshi Municipal Council and characteristics

Moshi municipality is the Kilimanjaro region headquarters. It lies approximately 3°18' South of Equator and 37°20' east of the Greenwich (Moshi Municipal Council) [MMC] (2014). The municipality covers fifty nine (59) square kilometers and the majority (68%) of the residents is from Chagga and Pare ethnic groups. According to the 2012 National Population Census, the Moshi Municipal Council has a population of 184,292. The female population is 96,121 (50.8%) while male population is 88,171 (49.2%), and the annual population growth rate is 2.9% (National Bureau of Statistics) [NBS], 2014. The population growth in Moshi Municipal is attributed to a greater extent by the high rate of rural-urban migration (MMC, 2014).

The economy of Moshi municipality is based on productive sectors: small and medium scale agriculture, trading and manufacturing, industries and tourism activities. Agricultural activities are conducted nearby the slopes of Mount Kilimanjaro whereby coffee and bananas are grown (MMC,2012). Commercial activities are operated in the urban centre involving famous business centre known as "*Soko la Kati"* (central market) as well as the open-air market known as *"Kiborloni".* Also in the municipal there are a number of manufacturing industries such as Bonite Bottlers Limited and Tanzania Breweries Limited. Moshi municipality is also the home of the tourism sector. This is mainly associated with the presence of Mount Kilimanjaro that attracts many climbers from around the world (MMC, 2013). This sector employs local residents as

tour guides, porters and cooks. The municipality also is blessed with the presences of various health care sectors which involves a number of both private and public providers (MMC, 2014).

1.3 Background to the study

Health insurance is a global issue. Both developed and developing countries pay great attention toward health insurance. This is because human health is not only a basic human entitlement, but also a critical factor for community and national development. Thus state and at times the local governments around the world enact laws and regulations to promote heath insurance (Klugman, 2002). Health insurance is the type of insurance coverage that covers the cost of insured individuals in medical services. The insured can pay the cost out of-pocket that is then reimbursed (Marshal, 2000). Alternatively the insurer can make a payment directly to the provider. In health insurance, the "provider" is a clinic, hospital, doctor, laboratory or a pharmacy. The "insured" is the owner of health insurance policy, which is the person with health insurance coverage (Ribiere, 1999). The models of health insurance vary from country to country. This means each country has her own form of ensuring health care to her citizens (Bromley, 1990).

Historically, according to Ritzer (1992) the issues of health insurance started as early as 1870's in the USA. This was the age of the industrial revolution. At the time, health insurance was offered only to machine operators in the industries. This was typically due to the nature of their job that carried high health risk. Thereafter, in the nineteenth and twentieth century, health insurance agencies spread out to other European countries. This was the period of enlightement in European countries. In Germany, health insurance began in 1902, in Denmark it was in 1905 while in Sweden it began in 1910 (Ritzer, 1992). In African and Asian countries, health insurance was introduced in the twenty first century (Manongi, 2011). Today, health insurance helps many people across the world pay for their medical expenses, whether through privately purchased insurance, social insurance or a social welfare agency (Marsha, 2000).

According to Sikika (2011) health insurance in Tanzania is still a puzzle. Previously, before the establishment of health insurance, health services were available in accordance with one's income and accessibility. But to date health insurance is provided equally among her members (WHO, 2014). This is because the government introduced the Health Insurance in line with cost sharing policy and health policy of the year 1999 that aimed at involving community members (referred herein as civil servants). Civil servants together with the government have to share the medical cost through their monthly contributions deducted from their payrolls. This helps to simplify access to health care services as the services are pre paid by the agency, improve services delivery and equity in the provision of service to all social groups (Muhondwa & Leshabari, 2008).

In Tanzania National Health Insurance Fund (NHIF) is a government agency under the Ministry of Health and Social Welfare (MoHSW) which was established under the Act No 8 (1999) and commenced its operation officially on 1st of July 2001. The NHIF aims at providing insurance in health care services and social welfare to the citizen of United Republic of Tanzania via cost sharing policy. It aims at implementing health sector reforms started in 1993 when the cost sharing policy was introduced in government hospitals after three decades of free health services. Under this Act No 8 (1999), all civil servants are obliged to join the agency (Sikika & Muhondwa, 2010) to ensure their accessibility to health care services.

Clients in this agency are required to contribute 6% of their monthly income as the cost sharing with the government for medical services (where 3% of the medical cost is deducted from their payroll and the rest is contributed by the employer) at the end of every month (Makonomalonja, 2010). Clients get a wide range of health care services, including: basic diagnostic test, outpatient services involving medication as per the National Essential Medical List (NEMLIT), inpatient care as well as surgical services (Manongi, 2011).

According to Makonomalonja (2010) by 2001 the NHIF had 164,708 members. The membership increased from 295,205 in 2007 to 316,460 in 2008/2009, which was an increase of 7.2% that contributed to over 55.44 billion shillings. This occurred after reviewing the health policy in 2002 by extending membership coverage from involving only civil servants to the inclusion of all people in need. Up to 2008 the NHIF had a total number of 1,742,725 members. To date the NHIF has over two million members (Sikika, 2015).

1.4 Statement of the problem

Worldwidely health insurance is perceived as an important aspect of human wellbeing (Sikika, 2011). This is due to the fact that, the advancement of any national economy depends completely on the healthy man power (people) of that country. Accordingly, health insurance is introduced to solve the problem of ill health (Oliver, 1977). Nowadays, many countries introduce health insurances to her citizens so as to ensure the best health care services as well as reduction of medical cost to citizens (Muhondwa & Leshabari, 2008).

In the realization of the importance of health insurance, the United Republic of Tanzania introduced National Health Insurance Fund (NHIF) in 1999, which as stated earlier, began operation on the 1st day of July 2001. Thus, the government has spent a considerable amount of resources to ensure that NHIF operates efficiently in providing quality services to its members (mainly civil servants) (Sikika & Muhondwa, 2010).

Despite the fact that NHIF has been in its operation over 14 years since 2001, and that the government has been steadfast in ensuring easy access to health services (Manongi, 2011). Very little is known regarding the performance of the fund in extending health care services to its clients. There is continuing lack of information on whether the fund delivers on its promise of improved access to quality health care services to its members. This study, therefore intended to assess customer satisfactions with NHIF health care services in the selected public and private hospitals in the Moshi municipality in Tanzania.

1.5 Research gap

Worldwide the issues of health services have been widely researched on. The study carried out in Mwanza by Makonomalonja (2010), examined perceptions of patients on quality health care services. Another study conducted in South Africa by Smith (2008), assessed the determinants of quality health care services. A similar study conducted in the USA by Marshal (2000), examined the quality of health care. All of these studies dealt directly with the quality of health care services in general, with the exception of the study by Makonomalonja (2010) that dealt with only a single public hospital that examined the perceptions of patients on the quality health care services in government health care facilities. Very little attention has been paid by studies in assessing customers' satisfaction with the NHIF services. Therefore, this study is geared toward filling this research gap by exploring National Health Insurance Fund services in the selected public and private hospitals in the Moshi municipality in Tanzania.

1.6 General objective

The main objective of this study was to assess customer satisfaction with health care services under National Health Insurance.

1.6.1 Specific objectives

The specific objectives of the study were:

i. To examine the availability of health care services under NHIF.
ii. To assess the quality of health care services provided under NHIF.

1.7 Research questions

This study sought to answer the following questions:

i. How satisfied the clients are with the availability of health care services under the NHIF?
ii. Are the health care services under NHIF quality? To what extent?

1.8 Significance of the study

The study is significant in view of the following:

i. The study is the partial requirement for an award of Master of Science in Human Resource Management of Mzumbe University.
ii. The study explores the performance of the Fund. The findings are expected to shade some lights on whether this fund is performing as expected or not.
iii. Discovering the strength and limitations of the Fund and pinpoint areas requiring improvements.
iv. Stimulating discussion on the implementation of this important fund as a way of promoting awareness of the fund and prepare the discussion makers to act as necessary to make the fund work for its clients
v. To provide useful reading and reference material for researchers in health care services in Tanzania.

1.9 Limitations of the study

The study was limited by the following factors:

i. The schedule time exceeded the frame; this also affected the budget and plan of the whole report. The researcher was thought that data collection processes to be carried out in accordance with the time frame established. On the way forward in addressing that limitation, researcher focused only on the selected sample hospitals.

ii. Lack of cooperation from respondents, this was basically due to time constraints. The study respondents were participated while being provided or receiving health care services, due to this the cooperation between the researcher and the respondents was somehow limited The researcher addressed this limitation by promoting the cooperation from the respondents by employing minimum time in the interview as well as in the filling up of questionnaires.

1.10 Organization of the dissertation

This dissertation is organized into five chapters. The introductory chapter presents social economic characteristics of the study area, background to the study, a statement of the problem, objectives of the study, research question, and significance of the study and limitation of the study. The second chapter presents literature review: theoretical literature review, empirical literature review and final conceptual framework. The third chapter discusses the research methodology. The fourth chapter presents the data collected and discusses the findings. Chapter five presents the summary of the study, conclusion and the recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

The chapter reviewed the literature on customer's satisfaction in general as well as customer satisfactions with regard to health insurance services delivered by hospitals. It covered three main parts, namely: theoretical literature review, empirical literature review and final conceptual framework.

2.2 Theoretical literature review

This section reviewed the theoretical literature on customers' satisfaction with health care service delivery, focusing on National Health Insurance Fund services, the specific aspects reviewed include: the concept of customers' satisfaction, health care quality frameworks, health care strategies, health care reforms and the overview of NHIF.

2.2.1 The concept of customers' satisfaction

Customer satisfaction is an emotional post-consumption response that may occur among customers as a result of comparing expected service delivery and the actual performance. It is just client's perception on the provided services (Oliver, 1977). Customer satisfaction is influenced by customers' own evaluation of the quality and price of products or services (Derose, 2001). Satisfaction relies on product and service features: customer emotions, perception of equity or fairness and other customers/family or friends' influences on the provided services (Zeithaml, Bitner & Glemler, 2009). Based on this notion, satisfaction is perceived through comparison between expectation and experiences over many qualities or attributes of the particular service provided. However, what is considered satisfying services, today may be viewed differently tomorrow, this is because satisfaction is a dynamic aspect which tends to change time after time (Gronroos, 2000).

Bara (2002) adds that monitoring and evaluating customers' satisfaction with health care is a crucial input to improving the quality of health system and changes in the system as well as providing feedback for health care professionals and policy makers. Measures of consumer satisfaction with health care can provide important assessment of quality of health care not adequately captured by other health service statistics such as patient through put, waiting times, consultation times and proximity (Sitzia & Wood, 1997). In fact, it has been suggested that patient satisfaction is a major quality outcome in itself (Derose, 2001). The extent to which health care users are satisfied with their local providers may be a key factor underpinning their health behavior and health care utilization (Rakin, 2002). It is envisaged that timely, accessible, appropriate health interventions, continuous and effective health services are important components of health care quality as well as leading to customers' satisfaction. (Cambell, 2000).

2.3 Health care quality frameworks

Various frameworks have been introduced to assess quality of service delivered within the health care industry. These models play an important role towards ensuring the so called satisfaction among the customers in the health care industry. Some of these health care quality frameworks include: the Bonabedian Model, Bamako Initiative and WHO quality care framework.

(a) Bonabedian model

The Donabedian model is a conceptual model that provides a framework for examining health services and evaluating quality of care (McDonald, 2007). Donabedian developed the original model in 1966. According to the model, information about the quality of care can be drawn from three categories: "structure," "process," and "outcomes" (Donabedian, 1988). While there are other quality of care frameworks, including the World Health Organization (WHO)-Recommended quality of care framework and the Bamako initiative, the Donabedian model continues to be the prevailing paradigm for assessing the quality of health care (McDonald, 2007).

The model is most often represented by a chain of three boxes containing structure, process, and outcome connected by unidirectional arrows in that order. These boxes represent three types of information that may be collected in order to draw inferences about quality of health care in a given health facility.

(i) Structure

The structure includes all the factors that affect the context in which health care is delivered. It includes physical facilities, equipment, and human resources, as well as organizational characteristics such as staff training and payment methods. These factors control how providers and patients in a health care system act and are measures of the average quality of health care within the health facility. The structure is often easy to observe and measure and it may be the upstream cause of problems identified in the process (Donabedian, 2003).

(ii) Process

The process is the sum of all actions that make up health care (Donabedian, 1988). Process in health care commonly includes: diagnosis, treatment, preventive care, and patient education. Processes can be further classified as technical processes, how care is delivered, or interpersonal processes, which all encompass the manner in which care is delivered (Donabedian, 1980). According to Donabedian, the measurement process is nearly equivalent to the measurement of quality of care because process contains all acts of health care delivery (Donabedian, 2003). Information about process can be obtained from medical records, interviews with patients and practitioners, or direct observations from health facility visits.

(iii) Outcome

Outcome contains all the effects of health care on patients or populations. Outcome includes the occurred changes in health status, behavior or knowledge as well as patient satisfaction and other issues related to health.

Outcomes are sometimes seen as the most important indicators of quality because improving patient health status is the primary goal of health care. However, accurately measuring outcomes that can be attributed exclusively to healthcare is very difficult (Donabedian, 1988). Drawing connections between process and outcomes often requires large sample populations. Normally outcomes may take considerable time to become observable (Donabedian, 2003).

(b) Bamako Initiative

The Bamako Initiative model was developed by United Nations International Children's Emergency Fund (UNICEF) and WHO in 1987 in Bamako, Mali. The aim of the Bamako initiative is to protect the poorest and ensure that costs do not prevent access to essential primary health care services for poor and marginalized communities. The model evaluates health care quality through four quality care components which are effectiveness, efficiency, sustainability and equity.

According to WHO (2007b) *effectiveness* refers to services offered to overcome the most essential health problems through preventive and curative health care services. *Efficiency* addresses the rational use of health care resources. *Sustainability* reflects efforts taken to ensure participatory financing of health care services, in which the community or service consumers are fully involved in management and funding of health care services. *Equity* refers to service that are delivered to all who need without discrimination of geographical, economical or social background; it should allow exemption and cost subsidization.

(c) WHO quality care framework

This framework evaluates the quality of health care basing on three quality goals, namely: Optimum health for all, responsiveness and fairness in health care financing. According to this framework *optimum health for all* refers to health care services that lead to improved well being of the consumer, reducing the morbidity and mortality.

Responsiveness refers to health care services that do not result in poor and undesired health outcomes, it takes consideration of personal dignity, confidentiality and customer oriented services, it focuses further on increasing availability and utilization of health care services. The *fairness in financing* refers to security of service consumers in financing health care, it emphasizes on cost sharing that will not deprive customers.

2.4 Health care reform in the global context

National Health Sector Reforms have been defined as a sustained process of fundamental change in the national policy and institutional arrangements, which are evidence based, spearheaded by the Government, designed to improve the functioning and performance of the Health Sector and ultimately the health status of the population (WHO, 2000). The Government is at the forefront of the reforms to ensure that they acquire the needed credibility and sustainability. The ultimate purpose of health reforms is to have a functionally improved health sector leading to the achievement of a better health status of the population. Any reforms that will not lead to the achievement of this noble goal are not worth undertaking. There are considerable risks involved in any change process. Therefore, the decision to undertake reforms should not be for the sake of "fashion" (because everybody else is "reforming"). Rather, reforms should be undertaken after careful study, necessary preparations and out of the necessity to improve on the deficiencies identified (Pan American Health Organization, 1995).

The other important aspect to realize and take into account is that there is no "standard blueprint" for implementing health reforms. Every country has its own features, problems and peculiarities when it comes to the health sector. All these have to be taken into account when introducing reforms. The form and pace of the reforms in any country should be designed and implemented according to the needs and capabilities of the people. Advice on the ways and means to implement reforms from within and outside the country should be carefully analyzed for their relevance and feasibility (Zeithaml, Bitner & Glemler, 2009). Development partners from within and outside the country need to accept these realities, so as to foster real partnerships.

In reforms, these partnerships should be based on respect for each other, mutual trust and learning to responding to the needs and aspirations of the host country, rather than to the prescribed solutions which in the past have not worked.

2.4.1 Health care reform in Tanzania

In the Tanzania government reform policies, the health sector is one of the priority sectors. Among its main objectives, the government aims at achieving a high quality of livelihood for all Tanzanians, with a focus to those most at risk. Consequently, the overall objective of the National Health Policy is to improve the health and well-being of Tanzanians, with a focus on those most at risk, and to facilitate the provision of equitable, quality and affordable basic health care services which are gender sensitive. The services should be delivered within a dynamic health system that is responsive to changing environments and to the needs of the people who use the services (Quaye, 2004).

In the ongoing Health Sector Reforms (HSR), the district has been identified as the focal point for the operationalization of HSR in the context of the national health system. In the five-year Health Sector Strategic Plan of 2003 to 2008, the emphasis has been on the district health component, the level that is closest to the communities and where most of the essential health services are provided (Sikika, 2010).

(a) Areas of health care reform in Tanzania

The following areas of the Health Sector Reform influence district health systems. It is important for the Council Health Management Team (CHMT) members to understand them well, as they will invariably affect the way they will operate (Andaleeb, 1998).

(i) Decentralization: power of decision-making is given to the councils, and funds are allocated to, and managed by, the council.

(ii) Management and improvement of quality of care.

(iii) Efficient collaboration of public, private and faith-based providers: a health district can only succeed if everyone works together for the benefit of the people.

(iv) Strengthening the financial situation of the sector through the introduction of user fees and CHF as part of cost-sharing.

2.5 Overview of National Health Insurance Fund

The National Health Insurance Fund is a public institution established by the Act No.8 of 1999 (CAP 395 R.E 2002) with the main objective of ensuring health care services to; employees in the public and private sectors as well as their respective legal dependants (Sikika & Muhondwa, 2010). NHIF is the largest alternative health financing option (scheme) that commenced its operations in July 2001 as a driving force towards implementation of the Health Sector Reform Policy (1993/4).

The management of the fund is vested in the Board of Directors. However, day to day operations of the fund are executed by the Director General who is a secretary to the Board (Sikika & Muhondwa, 2010). NHIF is under the Ministry of Health and Social Welfare (MoHSW), a non-profit making entity which considers health as a societal affair rather than an individual need thus it operates under the principle of risk sharing and solidarity between members.

According to the NHIF Act, employers and employees in the public sector are obliged to register themselves and contribute to the Fund a total of six per centum of each employee's monthly basic salary which is equally shared between employer and employee (Manongi, 2011). The Fund has put in place a separate contribution arrangement for other special groups such as students, clergy, associations and private individuals registered by the Fund.

(i) Beneficiaries

Beneficiary to the scheme took into cognizance of the African pattern and social capital of taking care of the children and contributors (the parents). NHIF beneficiaries, thus include contributing member, spouse and up to four dependants who are legally identified. Under NHIF context, dependants include biological children or legally adopted children and parents. The size of NHIF beneficiaries is growing fast and as of 30th June, 2013 it stood at 2,502,794 beneficiaries, an exponential increase as compared to its size during the dawning days. The Fund is also managing Community Health Fund (CHF) with a total of 3,261,726 beneficiaries, thus bringing the total size of beneficiaries of NHIF and CHF to 6,225,022 by the end of June 2013, which is equivalent to 13.9% of the total population (NHIF, 2014).

(ii) Categories of NHIF members

The Fund has a wide category of members open to all so that no one is left out of scope of protection. Some of the categories are; Central Government Employees that include Ministries and Independent Departments, Regional administration and local government authority employees, public institutions, Students, retirees who were previously contributing members, private individuals (with no employers/self employed), Private Companies (Associations and NGOs) as well as spiritual leaders (Makonomalonja, 2010).

(iii) NHIF benefit packages

Throughout its operations, the Fund has been enhancing its benefit package with the aim of meeting its members' evolving needs (Manongi, 2011). The Fund is currently providing a wide range of attractive and cost effective benefits package which include: registration or consultative fee, outpatient and inpatient services, pharmaceutical services, diagnostics tests, surgical services, dental services, physiotherapy, optical

services, some of the orthopaedic appliances to retirees Health Insurance, an extension of service to members who retires from employment.

(iv) NHIF health facility network

NHIF beneficiary access health services through a wide network of accredited health facilities in Tanzania. The National Health Insurance Fund accredited health facilities include government and non government owned health facilities which are geographically scattered all over the United Republic of Tanzania (NHIF, 2014). The type and levels of accredited health care facilities under the Fund include: national referral and equivalent hospitals, zoning referral and equivalent hospitals, regional referral hospitals, district/Designated/Council designated hospitals, dispensaries, specialized clinics, diagnostics centers (Imaging and Laboratories), pharmacies and accredited Drugs Dispensing Outlets (ADDOs).

2.6 Empirical literature review

This section reviews some selected research works related to health insurance services. Empirical review is important as it provides information about what has been done by other researchers as well as the findings which have been obtained from their research. This review covers several studies: international, regional, and national.

(i) International study

A study conducted in the United States of America by Marshal (2000) on *assessing the perception of patients based on health care* using case study design revealed that 67% were moderately satisfied with quality of health insurance services and 29% were not satisfied with the services. However, the problem in America was unequal insurance service to racially and ethnically diverse groups where white people were highly privileged until the availability of Civil rights act of 1965 that brought some changes.

(ii) Regional studies

Smith (2008) conducted a study in South Africa to *Determinants of the quality health insurance employing* questionnaires and documentary review. The finding revealed that, despite a strong economic status of South Africa, the quality of health insurance scheme is still low compared with the schemes in other countries with similar economic status. The global experience of compulsory health insurance for lower socio-economic groups is drawn almost exclusively from the developing world.

Abel and Lawal (1994) carried a study in Ghana on *assessing the quality of health insurance:* using study design. The findings reveal that insurance members made greater use of more expensive hospital services; this is due to the poor services provided by the agency. Through these findings a compulsory insurance scheme has the potential to improve the quality of government health providers so as to maintain its members.

A study conducted by UNICEF (2012) in Asia and Africa on the *assessment of customer perceptions on health facilities, using* survey design reveals that contributions made by an employee are a burden to civil servants with low income as they do not get quality services as is the case with higher positioned personnel. The latter is capable of accessing such services at any hospital and at any time. However, the study reveals that many peripheral areas (district and semi-urban areas) lack medical experts and therefore insurance services are delivered in exactly the same way.

(iii) National study

Makonomalonja (2010) conducted a study in Mwanza on *Perception of patients on the quality of health care services in Government health care facilities:* a case study design. The findings show that, 55.7% of the respondents suggested that there are poor services in public hospitals, the major cause being unavailability of modern equipment, general conduct of health care providers, working hours, low number of qualified health workers and poor communication systems.

2.7 Conceptual framework

The conceptual framework is the theoretical structure of assumptions, principles and rules that hold together the ideas of the study (Kumar, 2002). The aim of this study was to assess customers' satisfaction with National Health Insurance Fund services, a case study of selected hospitals in Moshi municipal. This section presents a framework for assessment based on two independent variables: availability of health care services and quality health care services. These aspects alongside their associated indicators are clarified below. It should be noted that the selected conceptual framework is derived from literature reviewed.

a) Availability of health care services

This implies the presence of health care services which safeguard the health of the clients. Health care services are the medical services which are composed of the basic essential tools needed for smooth operation of any health care facility. Indicators used to examine the availability of health care services were:

i. Presence of laboratory services: laboratory is the special room in health care facilities where by diagnosing of client heath problems take place. This special room contains various equipment used in patients check up. In the laboratory there should be equipment such as: microscopes, ultrasound machines as well as the machine for checking the full blood picture.

ii. The presence of the medical dispensary desk (Pharmacy). This refers to the special room within the health facility which is responsible for providing the prescribed medicine. The best medical dispensary desk must contain all of the essential medicines required by the clients and administered by qualified staffs that are always available to serve.

b) Quality health care services

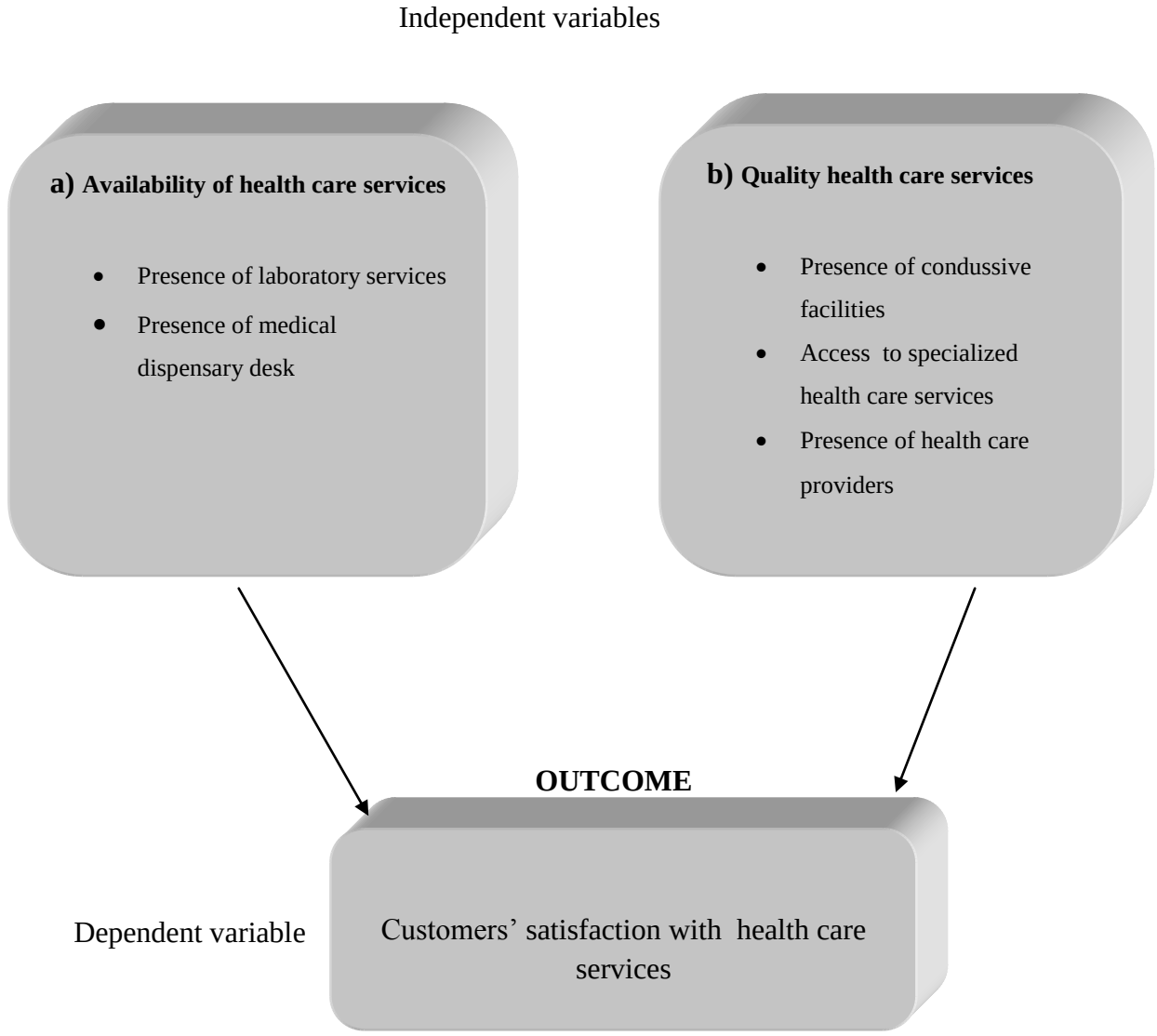
Quality health care services are services that meet the expectations of the users characterized by a number of indicators described below:

i. Presence of conducive facilities: consultation rooms, patient resting places, patient wards, laboratory rooms as well as theatre rooms.

ii. Access to specialized health services, this refers to special treatment offered to clients who need greater attention: diabetic clinic, voluntary counseling and testing (VCT) services, eye care clinic, and teeth care clinic, skin care clinic as well as Reproductive Child Health (RCH) clinic.

iii. The presence of health care providers: these include doctors and nurses. Health providers are the ones who provide health care services to the clients. They include: midwives, specialist doctors and general doctors. All of them are termed as health care providers.

Figure 2.1: Conceptual framework: Assessing customers' satisfaction with NHIF services



Source**:** Author (2015), based on the literature reviewed.

Figure 2.1 shows the relationship of factors used to assess customers' satisfaction with NHIF services in Moshi municipality. The two boxes on the top show two factors (Availability of health care services and Quality health care services) used to assess customers' satisfaction with NHIF health care services alongside their indicators in the bullets.

The bottom box shows the expected outcome of the two factors captured in the two boxes.

Table 2.1: Operationalization of the conceptual framework

Objective	**Variable**	**Indicators**	**Approach for analysis**
1.To examine the availability of health care services under NHIF	Availability of health care services	i. Presence of laboratory services. ii. Presence of medical the dispensary desk	i. Observation from the facility together with questionnaire provided to the clients. ii. Observation from the facility in collaboration with interview with health care providers.
2. To assess the quality of health care services provided by NHIF	Quality of health care services	i. Availability of supportive facilities. ii. Access to specialized health care services. iii. Presence of health care providers	i. Observation of physical presence together with interview with health care providers ii. Clients opinions on accessibility to specialized services iii. Interview with health care provider

Source: author (2015).

The table 2.1 presents the operationalization of the conceptual framework, indicating: objectives, variables, indicators and approaches for analysis to address the research objectives and questions.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter describes the methodology which was used in this study. The aspects covered include: research design, sampling procedures, data collection techniques, data analysis strategies and ethical considerations.

3.2 Research design

Research design refers to a plan, structure and strategy of investigation conceived so as to obtain answers to research questions (Kumar, 2002). Kothari (2004) defined research design as the arrangement of conditions for the collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure. Research design is important because it tells the investigator what to observe in the study, whom to observe, how to observe, why to observe, how to record observations, how to analyze the observation, and what reference can be drawn (Cauvery, 2010). There are four types of research design, namely: longitudinal design, survey design, case study design and the experimental design (Kothari, 2004). This study employed a case study design.

A case study is an empirical inquiry that investigates contemporary phenomena with its real life context, especially when the boundaries between the phenomenon and context cannot be drawn clearly or unambiguously (Yin, 2003). A case study design involves the intensive and in depth and detailed descriptions of an individual, group, institution or phenomenon within its real life context using multiple source of evidence (Bromley, 1990). Yin (2009) points out that a case study makes a possibility of capturing real life situations experienced by the respondents which can not be achieved by purely statistical survey. The selection of case study design was due to the following considerations: first, the design enabled investigation of NHIF to be made in its real operational context, involved three selected hospitals (Mawenzi, KCMC and Kibosho). It enabled original

data about the performance of NHIF to be captured and used to answer the research question (Yin, 1994). This was made possible by collecting views and experiences of members of NHIF at the sample hospitals.

Secondly, case study enabled the researcher to capture the NHIF operations in the very detailed as the researcher was able to fully use the potentiality of multiple methods of data collection (Flick, 2009). Thirdly, the use of multiple case study (private and public hospitals) approach enabled the investigator to collect stronger evidence on the performance of NHIF compared to the single case study approach. This is because, evidences from more case studies is more compelling (Bromley,1990).

3.3 Area of the study

This study was carried out in Moshi Municipal Council (MMC). The choice of Moshi was due to the following reasons: First the presence of the hospitals that provided the possibility for obtaining required data. Literature, Kumar (2002) recommends the researcher to avoid places that limits the possibility of accessing the required data. Second, some key people in the selected hospitals (Kilimanjaro Christian Medical Centre, Mawenzi hospital and Kibosho Hospital) were interested in the study, this further made the selected study area too good to turn down. Third, the selected hospitals provide similar health care services under the umbrella of NHIF. This facilitated the comparative analysis of results.

3.4 Study population

This study involved NHIF beneficiaries and service providers in the selected sample hospital at MMC. The criteria for the respondents' selection involved membership to NHIF (principal members, dependents, or retired members), above the age of eighteen years, mental fitness and legal competence, inpatient or outpatient clientele. Also, it involved using NHIF services at least three times and willingness to participate in the study. Service providers were included because they are the ones who offer the health care services to the clients and therefore they are better placed to assess both the

availability and quality of health care services. Service providers have information concerning the NHIF services. Hence, the inclusion of these two categories of respondents enabled the researcher to capture and document the reality of health care services under NHIF in the case study hospitals.

3.4.1 Study sample

A sample refers to items selected from the universe (population) selected for study (Kothari, 2004). Two types of study samples were used. First, was the interview sample; this included service providers whereby some health care providers were selected to form the interview sample. The sample size was twelve respondents that included four respondents from each of the three sample hospitals. The selection of the twelve respondents was consistent with qualitative research that tends to work with samples because the focus is to obtain in depth information on the study phenomena (Kothari, 2004). The selection of interview sample is clarified further in section 3.5.

The second type of study sample used was questionnaire sample. This sample included ninety eight people that were NHIF clients selected from the three hospitals. These hospitals were: KCMC hospital, Mawenzi hospital and Kibosho hospital. Mawenzi and KCMC hospitals provided thirty three respondents each while Kibosho hospital provided thirty two respondents. The selection of this sample was based on the logic of statistical sampling that requires the use of a large sample to enable statistical analyses to be carried out and also conclusions to be generalized to the entire population (Flick, 2009). According to Yin (1994), the sample of more than thirty elements is sufficient and can guarantee the application of statistical analyses. The selection of ninety eight respondents enabled the study to generalize the findings with regard to the user's satisfaction with NHIF services in Moshi.

3.5 Sampling techniques

This study employed two types of sampling techniques: probability and non probability sampling. These aspects are explained below:

3.5.1 Non probability sampling

Non probability sampling is a sampling technique where the samples are gathered in a process that does not give all the individuals in the population equal chances of being selected (Tayie, 2005). The study employed purposive sampling to select the interview sample that involved twelve medical service providers selected from the sample hospitals. Using purposive sapling the respondents were selected into sample based on their assumed ability to provide required information to address the research questions (Cauvery, 2010). Purposive sampling was also used to select three sample hospitals in that they administered NHIF services and had staff with experience on NHIF services.

3.5.2 Probability sampling

Probability sample was used to select the questionnaire sample involving ninety eight NHIF clients. According to Cauvery (2010), probability sampling is the method of obtaining sample which provides an equal opportunity to every unit in the population to be selected into the sample. Thus, probability sampling is assumed to be free from sampling bias which facilitates the validity of the study findings (Yin, 1994). Specifically, systematic sampling (without a random start) was used where every "3rd" NHIF visitor to the hospital was included in the sample. This process continued until thirty three respondents were selected from each sample hospital. This approach was realistic in the sense that it enabled the investigator to include into sample respondents who were physically available and willing to take part in the study.

3.6 Data collection methods

This research employed both primary and secondary data in gathering information for the study. These aspects are clarified below:

3.6.1 Primary data sources

Primary sources of data refer to the first hand data or evidence given out by participants or observers at the time of the event (Kelleher, 1999). Primary sources provide first hand

testimony or directly observed evidence concerning the topic under investigation. The sources of primary data in this study were questionnaire, interview and observation.

(i) Interview

Krishnaswami (2003) defines an interview as two way systematic conversations between an investigator and an informant, initiated by the investigator for the purpose of obtaining information which is relevant or specific to the study. As indicated above a sample of the twelve respondents was interviewed with a view to collect detailed information on users' experiences with availability of health care services and their own assessment of quality health care services. A specific interview guide attached as Appendix ii was used to guide the interviewing process.

(ii) Questionnaire

Questionnaire is a document containing questions pre-prepared and designed to solicit information appropriate from the large number of respondents (Babbie, 2004). According to Flick (2009), a questionnaire is the best method when the investigator wishes to gather evidence from a large number of respondents. The questionnaire (attached as Appendix i) was used in collecting data on satisfaction with NHIF health care services from ninety eight NHIF clients. The researcher distributed self-administered questionnaire to ninety eight respondents selected from three sample hospitals. The questionnaire was used because it enabled the investigator to reach and collect information on the perceptions on the quality of NHIF services from many respondents within a short period of time and using less resource (Silverman, 2005).

(iii) Observation

The observation method is the most commonly used method, especially in studies relating to behavioral sciences. In a way we all observe things around us, but this sort of observation is not a scientific observation (Tayie, 2005). Observation becomes a scientific tool and the method of data collection for the researcher, when it serves a formulated research purpose, is systematically planned and recorded and is subjected to

checks and controls on validity and reliability (Kothari, 2004). Under the observation method, the information is sought by way of investigator's own direct observation without asking from the respondent. The observation was used to assess the availability of NHIF health care services at case study hospitals. Aspect observed includes hospital opening time, availability of doctors and nurses, handling of patients by the health care providers, medical equipment and supply, availability of the resting rooms, sanitary situation, the mechanism used to solve clients' complaints as well as the presence of the inquiry desk and time the patients had to spend waiting to see a doctor and receive medical attention.

3.6.2 Secondary sources of data

Secondary data are the data that have been collected and recorded by other people (Oliver, 1977). Documentary review is a cheap source of data because the researcher uses the ready-made data (Kothari, 2004). The study reviewed various reports such as journals, leaflets and pamphlets regarding NHIF services as well as hospital reports on NHIF performance aiming at cross checking the effectiveness of NHIF services. Also other secondary sources of data were obtained from previous researches and newspapers on NHIF health care services. All these sources were used to provide relevant information on availability and quality of NHIF health care services at the case study hospitals.

Although secondary sources of data provide the already collected data. Flick (2009) advises researchers regarding the use of secondary sources of data as sometimes they might be inaccurate and misleading sources due to either being outdated data and or fabricated, they may not be easily available. Also, they may be expensive as they require a subscription. To avoid these weaknesses, documentary review was cautiously carried out counterchecked with other sources: questionnaire, interview and observation.

3.7 Data analysis

Data analysis is the process of evaluating data using analytical and logical reasoning to examine each component of the data collected (Oliver, 1977). This form of analysis is just one of the many steps that must be completed when conducting a research. Data from various sources are gathered, reviewed, and then analyzed to discern their meaning and draw conclusions (Yin, 2003). Questionnaire data were analyzed by using descriptive statistics, which where computer software called Statistical Package for Social Science (SPSS) version 16.0 was used to summarize and present data in relevant frequency and percentages tables that facilitated the assessment of customers' satisfaction with NHIF health care services.

The analysis of qualitative data involved the sorting, arranging and grouping qualitative data in terms of themes emerging from the transcripts of interview and interpretation of the emerging meanings in relation to the research objectives and questions (Kothari, 2004). The analysis of qualitative data also involved the use of direct quotes from the respondents to capture respondents' words or expressions, feelings and experiences with NHIF services, including their assessment of availability and quality of NHIF health care services. This approach helped to preserve the originality of data (Yin, 2003).

3.8 Validity of the study

Validity refers to whether the methods used in conducting research accurately measure what they intend to measure (Gronroos, 2000). Several approaches were used to ensure the validity of the study findings. First, triangulation approach was used to collect data on availability and quality of NHIF health care services. Interview, questionnaire and documentary review were used in such a way that data from one source were used to confirm on challenge data collected via other sources (Silverman, 2005).

Second, the principle of reflexibility was observed whereby the researcher ensured that the conclusions reached are based on the research data, unlike researcher's own bias (Yin, 1994). Third, a thorough review of the interview transcripts and observation notes

was made many times so as to accurately capture the meanings emerging from the transcripts. This enabled the researcher to make conclusions based on the high quality data collected from the field. Fourth, the interview guide used was very clear and straightforward so as to provide the best room for the interviewees to understand it well and provide responses that match the focus of the study (Tayie, 2005).

3.9 Reliability of the study

The term reliability of the study means how similar the result would be if another researcher conducted the same research in another place and time (Kothari, 2004). In an endeavor to satisfy the reliability standard several approaches were used.

First, an attempt was made to make the whole process of the research clear. It is the duty of the researcher to make in depth clarifications on how the research was conducted (Kelleher, 1999). This included clarification of methods of data analysis and interpretations, and also the criteria for selection of the study population, sample and data analysis procedures.

Second, an effort was made to ensure research problem, objectives and the research questions are clear. Research objectives and research questions are the cornerstone of the entire research (Kumar, 2002). That means un-clarity of these basic aspects of the research leads to confusion and unproductive research (Yin, 1994).

Third, all recommended approaches in the selection of the study samples, data collection methods and analysis were observed. Further, the conceptual framework guiding the study was carefully selected based on the research objectives and was actually used in the data analysis process (Kothari, 2004).

Fourth, the independent and dependent variables were relevant to the study and the indicators for the analysis of the study variables were clarified and consistently used to guide the analysis of availability and quality of health care services at the case study hospitals.

3.10 Ethical considerations

Research practice requires the investigator to exhibit sufficient understating and compassion to ethical convictions (Kelleher, 1999). This is because ethical considerations have great consequence to both the respondents as well as of the researcher. Explained below are some of the ethical considerations that were used during the study.

First, the permission to conduct the study at Moshi Municipal Council was sought. This entailed presenting application letters to the selected sample hospitals, asking the management to grant the researcher to carry out research in the respective hospitals. The letters explained the purpose of the research as well as identifying the people who would be interviewed. Seeking entry permission guaranteed the researcher with the chance of obtaining cooperation in the data collection process (Krishnaswai, 2003).

Second, the respondents' participation in the study was voluntary. The participants (the respondents) were made aware that they were free to participate or withdraw at any time during the interview process. Respondents have the right to understand the intention of the research as well as to know their entitlement on how the research findings will be used and what their participation will entail (Kumar, 2002).

Third, the findings from the study were shared with the case study hospitals. Literature suggests that research findings should be shared (Yin, 1994). Also the findings will also be submitted to Mzumbe University particularly at the School of Public Administration and Management (SOPAM) where the author is registered and expect to be granted an award of Master of Science in Human Resource Management.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents the data collected and discusses findings from the study in line with study objectives and questions. The chapter is divided into two parts: the first part describes the demographic characteristics of the respondents while the second part presents results of the study and discusses findings with respect to the research objectives and endeavors to answer the linked research questions.

4.2 Demographic characteristics of the respondents

The demographic characteristics of the respondents examined were sex, age, education level as well as NHIF membership type of the respondents. These characteristics are essential because they may suggest the nature of the respondents' responses or possible reasons for the responses provided by the respondents.

4.2.1 Distribution of respondents by sex

The rationale of obtaining data on the basis of sex was to determine whether there was NHIF membership difference between males and females. The findings (Table 4.1) show that fifty one respondent (51.7%) were males while forty seven (48.3%) were females. The findings suggest that the distribution of the respondents by sex was almost balanced with males exceeding by only 3.4%. This potentially suggests the findings of the study were derived from both male and female respondents.

Table 4.1: Distribution of the respondent by sex

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	51	52.0	52.0	52.0
	Female	47	48.0	48.0	100.0
	Total	**98**	**100.0**	**100.0**	

Source**:** Questionnaire data (2015).

The finding suggests that, the gathered data in this study roughly represents voice and experiences of both male and female members of NHIF.

4.2.2 Categories of respondents by age

The age distribution of respondents was grouped into five categories; 20-29, 30-39, 40-49, 50-59 and above 60. The findings show that the majority of the respondents (33.7%) were between the ages of twenty to twenty nine, followed by (23.5%) were aged sixty years and above. Other two age groups, those aged thirty to thirty nine and fifty to fifty nine were 16.3%. Ten respondents (10.2%) were between the ages of forty to forty nine.

Table 4.2: Age distribution of respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	20-29	33	33.7	33.7	33.7
	30-39	16	16.3	16.3	50.0
	40-49	10	10.2	10.2	60.2
	50-59	16	16.3	16.3	76.5
	60+	23	23.5	23.5	100.0
	Total	**98**	**100.0**	**100.0**	

Source: Questionnaire data (2015)

The findings show that most of the (49%) were middle aged, that is the youth and also members in the advanced age category. These findings suggest that the respondents were adults likely to take health care issues seriously and also in a position to make informed and independent assessment of the quality of health care services under the NHIF.

4.2.3 Education level of the study participants

The education level of the respondents was categories into four groups. It involved those who had reached post secondary education, secondary, primary and those who had never been to school. The findings (Table 4.3) show that fifty four (45%) had attained secondary education, thirty two (33%) respondents had reached post secondary education. Twenty respondents (20%) had primary education while two respondents (2%) had never been to school.

Table 4.3: Education levels of the respondents

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never been to school	2	1.7	1.7	1.7
	Primary education	20	20.0	20.0	21.7
	Secondary education	44	45.0	45.0	66.7
	Post secondary	32	33.3	33.3	100.0
	Total	**98**	**100.0**	**100.0**	

Source: Questionnaire data (2015).

The findings suggest that the majority (78%) of the respondents were sufficiently educated and therefore, capable of expressing their experiences and even make an analysis on the performance of NHIF compared to its stated objectives.

4.2.4 NHIF Membership

In this study, NHIF membership was categorized into three major groups: the principal members (public civil-servants), dependants of the principals and the retired (ex-principals). The findings show that the majority of the respondents (50%) were the principal members, followed by (38.3%) who were the dependants of the principals while (11.7%) were the retired member. Since the principal members were the majority, they were likely to take interest in the study, considering their contributions to the fund compared to the find they received.

Table 4.4: Respondents' membership categories.

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Principal	49	50.0	50.0	50.0
	Dependant	38	38.8	38.8	88.8
	Retired	11	11.2	11.2	100.0
	Total	**98**	**100.0**	**100.0**	

Source: Questionnaire data (2015)

The findings suggest that the majority (50%) of the respondents was the principal members. Therefore, they were capable of assessing the performance of NHIF regarding the fact that they are the one whom their salary is deducted monthly. Apart from that, they are more experienced in NHIF services

4.3 Result and discussion of the findings

This section presents the data collected and discusses the findings obtained from the case study hospitals in an endeavor to address the two research objectives presented in the introductory chapter. This analysis begins with the first research objective and proceeds to the second objective.

4.3.1 Availability of health care services under NHIF

The first objective of the study was to *examine the availability of health care services under NHIF*. With respect to this research objective, the associated research question was, *How satisfied are the clients are with the availability of health care services under the NHIF?* The examination was done based on the conceptual framework in collaboration with the established indicators in the second chapter (See Figure 2.1).

(i) Presence of laboratory services

As stated in the conceptual framework, the laboratory is the special room in the health care facilities where by diagnosis of clients health problems take place. The room contains various tools which are used in various patients check ups. The presence of laboratory services indicates the availability of health care services (Donabedian, 1980).

Interview with the doctor in-charge at Kibosho hospital claimed that their laboratory services was not good enough compared to KCMC. There was frequent clients transfer from her hospital to KCMC for further laboratory diagnostic. There are some of the laboratory diagnosis which her hospital was not eligible to conduct, this was because of lack of capacity. She cemented her arguments by saying:

> *……Indeed, we have some challenges here (Kbosho). There are a lot of client transfers from here to KCMC due to inadequacy of some laboratory services. There are some diagnosises whereby our hospital is not eligible to carry on. This is due to the levels ranked by WHO (2000) in service delivery depending on the level of the hospital. We are not allowed to conduct Dried Blood Sport testing (DBS). Therefore, when we come up with testing like this, we simply transfer the particular client to KCMC.*

Observation from the field showed that from the three selected hospitals, only KCMC Referral hospital had majority of modern operating equipment in her laboratory, but the rest (Kibosho and Mawenzi) had poor laboratory services. Mawenzi regional hospital and Kibosho were seen to possess poor tools in their laboratory, that's why Mawenzi and Kibosho have been referring more patients to KCMC for further medical investigation. Both Mawenzi and Kibosho hospitals have inadequate medical equipments like radiological (CT-scan, MRI, Ultrasound, ECG) in her laboratory.

Questionnare data (See Table 4.5) noted that laboratory services in all selected hospitals not satisfactory.

Table 4.5: Clients' satisfactions' on laboratory services

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Very satisfied	9	9.2	9.2	9.2
	Satisfied	17	17.3	17.3	26.5
	Less satisfied	10	10.2	10.2	36.7
	Not satisfied	62	63.3	63.3	100.0
	Total	**98**	**100.0**	**100.0**	

Source: Questionnaire data (2015)

The majority of the respondents (63%) claimed that, the laboratory services in all selected hospitals were unsatisfactory. The majority of the patients who claimed on this

were the patients from Mawenzi hospital. Despite of it being the regional hospital, but still the hospital normally lacks various re-agents needed by the attended patients. Mawenzi hospital also used to transfer many patients to KCMC hospital for further investigations. One of the clients at Mawenzi claimed:

> *.....for realy this is embrassing, the big hospital ours (Regional hospital) lack some of the re-agents needed in testing. We have been waiting for that re-agent for more than four days. We have transferred many clients to Kibosho and KCMC. We had already ordered it from MSD but till now they have not provided us. It is really terrible (23/4/2015).*

The findings from all sample hospitals showed that NHIF clients together with the services providers were no satisfied with the availability of health care services. Literature from Bonabedian (1988) instead that customers satisfaction basing on the availability of accessible health care services. Therefore indeep the respondents from the field claimed that, they were not happy with the availability of health care services under the umbrella of NHIF.

(ii) Presence of medical dispensary desk

As stated in the conceptual framework, medical dispensary desk refers to the special room within a health facility which is responsible for providing the prescribed medicines. The best medical dispensary desk must contain all essential medicines required by the clients (WHO, 2013).

The study noted that, the major problem in all hospitals was the issue of drugs. Respondents were asked if they accessed all drugs as prescribed by physicians. The response was, 87.7% of the study populations had an experience of collecting drugs from outside the hospital pharmacies using forms filled at the hospital pharmacies and sometimes buying drugs outside the hospital pharmacy.

Table 4.6: Patients' decision to buy drugs outside the hospital pharmacy

	Response	Frequency	Percent
Valid	Yes	86	87.8
	No	12	12.2
	Total	**98**	**100.0**

Source: Questionnaire data (2015)

The findings revealed that, the availability majority of the NHIF members tend to buy drugs outside the hospital. This implies that, NHIF is not stable enough in guaranteeing the availability of drugs in the hospitals.

In this study, 12.2% of the study population received their drugs as per Physicians directives within the hospital environment while 87.8% of the population had not, and have an experience of collecting or buy drugs outside the hospitals. This proves that, unavailability of drugs was the major problem that hospitals confront. Other reasons include unavailability of prescribed drugs in the NEDLIT, ineligibility of the hospital to offer drugs (there were some drugs that must only be prescribed by doctors at the referral level), long procedures to get drugs and treatment. Table 4.7 summarizes the findings.

Table 4.7: Reasons for patients to buy drugs outside the hospital pharmacies

		Frequency	Percent
Valid	Drugs were not available in the hospital	55	56.7
	Drugs were not listed in the NEDLIT	22	21.7
	The hospital was not eligible to dispense the drugs	9	9.2
	Long procedure to get drugs	12	12.4
	Total	**98**	**100.0**

Source: Questionnaire data (2015)

The findings above show that, patients had to walk outside the hospital to collect drugs or to get the NHIF consent form before they are given prescribed drugs. Despite NHIF ability to cover the costs incurred by every patient, still hospitals run out drug stock by either late ordering, or receive late their order from Medical Store Department (MSD).

Moreover, it was noted that, late payments of debts by NHIF especially in private hospitals cause up the unavailability of drugs. On the other hand, patients were not supplied with drugs because they were not listed in the NEDLIT. It was further observed that, rigidity or lack of understanding of few pharmacists affects patient's treatment. It was noted that, there were prescribed drugs in the pharmacy that had different names, but having similar functions and not enlisted and were not given out by the pharmacist. However, 12.5% of respondents decided to buy drugs due to the long procedures available in hospitals either when drugs are available or they are out of stock. To get drugs to other recognized pharmacies outside the hospital, there was a form to be filled by the pharmacist, treating doctor and NHIF officials. This has made the said percentage number of patients to leave hospitals after being diagnosed.

Interview with the doctor in-charge at Kibosho concerning the issue of drugs. He said that, there was poor coordination between the hospitals and the Medical Store Department (MSD). When the medicines are about to stock out in his hospital, the data clerk immediately presses the request order of the respective medicines to MSD. MSD delay in providing out the requested medicines on time, due to this majority of their clients suffer completely. The doctor imphasised by saying:

> *.....The MSD department is completely worthless. They normally delay in providing out the ordered medicines to our hospital. Sometimes they delay even more than two weeks in providing the demanded medicines. We normal face the problem of stock out due to their poor performance. Our clients suffer completely due to this. MSD management must do something to solve this.*

Generally, the findings from the field showed that medical dispensary desks from all hospitals do not meet the expectations of her clients. This was evidenced by a lot of complaints from the clients of all hospitals. All patients were not satisfied, some of the prescribed drugs by the physicians were not available in those health care facilities. Literature by Muhondwa (2008) stated that, the best hospital pharmacy should possess all essential medicines demanded by their clients in the day to day hospital operation.

Hence medical dispensary desks in all hospitals were not stable enough in possessing essential drugs.

4.3.2 Quality of health care services provided by NHIF

Assessing the quality of health care services provided by NHIF was the second research objective. The accompanied research question was, *are the health care services under NHIF quality? To what extent?* As established in the conceptual framework of the study three variables and associated indicators were used to address this objective.

(i) Presence of supportive facilities.

As stated in the conceptual framework of the study, supportive facilities involve all amenities used in the provision of health care services. These include: consultation rooms, patients waiting places, patients' wards as well as laboratory rooms. The availability of these facilities leads toward the provision of quality health care services (Donabedian, 1980).

Interview with health care service providers from the selected case hospitals showed that, of the three hospitals, only KCMC referral hospital had the majority of supportive facilities compared to Mawenzi regional hospital and Kibosho. This was according to the doctor in-charge at Mawenzi hospital. He claimed that Mawenzi and Kibosho hospitals have been referring more patients to KCMC for further investigation due to inadequate of these supportive medical equipments like radiological (CT-scan, MRI, Ultrasound), modern laboratory, lack of modern equipments at physiotherapy and occupational therapy.

During the interview doctor in-charge of Mawenzi hospital, claimed that the issue of inadequate facilities was one of the major challenges limiting the provision of health care services to the NHIF members. The doctor emphasized by saying:

> *... In fact, the issue of supportive medical facilities in our hospital is very challenging. In short, we lack major medical facilities which are very essential in the proper functioning of hospital services. You can't imagine the regional hospital does not possess radiological machine for investigations, the laboratory lack modern tools. Therefore, we tend to transfer the majority of patients to KCMC hospital (Interview23/4/2015).*

Indeed, questionnaire data confirmed that, NHIF patients faced the problem of lack of sufficient beds when they were admitted. One the respondent said:

> *"Even in the NHIF arrangement where we contribute a lot of money monthly. You have to share a bed with the stranger in a hospital expected to deliver quality services. This is highly frustrating.*

The bedding capacity of the selected hospitals was very low compared to the number of patients admitted. 45% of the respondents were totally unsatisfied with the services due to unavailability of supportive facilities in all hospitals. The majority of patients from KCMC and Mawenzi hospitals unlike Kibosho hospital claimed to sleep on the floor due to overcrowding of patients, particularly in the surgical, obstetrics and gynecology wards. Such congestion could not be supported by fewer physical facilities (in terms of building/few wards, beds and toilets). This finding suggests that all case study hospitals had not adequately invested in the creation of infrastructures capable of meeting the even increasing demand for health care services. Literature for instance Donabedian (1980) emphasizes the presence of adequate facilities in order to realize quality health care.

Moreover, observation revealed that, Mawenzi and KCMC had specific waiting areas for their NHIF outpatients though they were not capable of accommodating the number of patients attending per day, unlike Kibosho hospital which was not having the specific waiting area for the NHIF outpatient. Records at the case study hospitals indicated that Mawenzi received an average number of 120 NHIF patients per day, KCMC receives 160 patients, including in and out patients and Kibosho received less than fifty patients per day respectively. Doctor in charge at KCMC said that:

> *"…We really fail, our patients deserve better care than currently provided. You can not have patients sleeping on the floor in a modern hospital like oures. We really have to do something to improve the situation (Interview23/4/2015).*

Furthermore, observation revealed that all hospitals had fewer numbers of consultation rooms. Despite possessing its own NHIF premises, Mawenzi hospital had only three consultation rooms. In KCMC and Kibosho, all patients (NHIF members and non members) shared the consultation rooms as the result, patients waited for so long to see the doctors. Other areas like laboratory and radiology were overwhelmed by the number of patients per day, therefore patients had to wait for two or three days for investigation results. The doctor in-charge at Kibosho hospital cemented the issue of radiology by saying.

> *…Radiology service is still a difficult puzzle here at our hospital. Radiology service is provided once per week (Wednesday), this is due to the fact that the technician who conduct radiology invetgestion works as a part time worker in our hospital. Apart from this, our hospital is depended with other surrounding health care facilities for this service (radiology). Therefore delay in the investigation results occurs. Normally investigation results take two to three days (Interview29/4/2015).*

Table 4.8: Presence of supportive facilities

Hospital	Facilities	Availability	Quality
1. Mawenzi	Consultation room Patient waiting places Patients wards Laboratory services	Available Available Available Available	Not satisfactory Satisfactory Not satisfactory Not satisfactory
2. KCMC	Consultation room Patient waiting places Patients wards Laboratory services	Available Available Available Available	Not satisfactory Satisfactory Not satisfactory Satisfactory
3. Kibosho	Consultation room Patient waiting places Patients wards Laboratory services	Available Available Available Available	Not satisfactory Satisfactory Not satisfactory Not satisfactory

Source: Interview and observation data (2015)

The table 4.8 above presents the availability of supportive facilities in all three hospitals. The table shows that majority of supportive facilities are available in all sample hospitals, but the limitation is, majority of them are not satisfactory. This reflected that NHIF health care facilities are operating while possessing poor supportive facilities.

(ii) Access to specialized health care services

As stated in the conceptual framework, specialized health care services include: diabetic clinic, skin care clinic, voluntary counseling and testing (VCT) services, eye care and teeth care clinic as well Reproductive Child Health (RCH). The accessibility of these services leads toward the provision of quality health care services (Donabedian, 1980).

Interview with health care service providers of the sample hospitals showed that, all three hospitals provide the specialized health care services to her clients. That was heavily evidenced by the doctor-incharges of all hospitals. The majority of them said that the accessibility to specialized health care services to the NHIF clients was somehow satisfactory. Interview with doctor in-charge at KCMC hospital had the following to say:

> *…We offer different clinical services to the NHIF beneficiaries at the competitive level but still we don't reach the expectations of the clients. We try our level best to ensure satisfaction to our patients by eliminating frequent complaints from our patients in the clinical services. We not have enough number of qualified health care providers in our clinics.Thats why our clients are complaining. But we have many clinics at our hospital such as: skin care clinic, teeth care clinic, eye care clinic, diabetic clinic, post and pre natal care clinic last but not least we also provide Voluntary Counseling and Testing (VCT) services. We use the proper scheduled time table for each clinic, but more importantly VCT and RCH services are conducted daily (Interview29/4/2015).*

Moreover the accessibility of specialized health care services to all is the corner-stone of health care services worldwide (WHO, 2012). Every health care facility is responsible for providing health care services as stated in the global heath care strategy (WHO, 2014). The sample hospitals tried their level best at providing the demanded specialized services in the well arranged time table. Those time tables were pinned to the hospital

notice boards to allow all patients to have a look at the specific time as well as the day in which the particular service is provided in the respective hospital. Interview with the doctor in charge at Mawenzi explained:

> *…….Provision of the clinical services at our hospital is well scheduled. Each clinical service has its own specific day and time, except Reproductive Child Health (RCH) clinic. RCH clinic is provided daily. Clinical service starts from 8:00 AM to 3:00 PM. The eye clinic is provided on Monday, diabetic clinic is on Wednesday, skin and teeth care clinic is on Friday while diabetic and VCT services are provided daily. The scheduled time table for other clinical services is pinned on the hospital public notice board. Every client is responsible to counter check on the notice board so as to know when is the specific clinic day. But still we fail in meeting the standard of the services. Majority of our service providers have not attended the specific training of those specialized care. In my hospital only one nurse has attended the training on RCH. For really this is the major challenge facing specialized health care services (Interview23/4/2015).*

Indeed questionnaire data supported the above findings whereby 78% of the respondents from all selected hospitals were no satisfied with the accessibility of the specialized health care services (diabetic clinic, skin care clinic, VCT services, eye care, teeth care clinic as well as pre-natal and post natal care) offered by the sample hospitals. The majority of respondents agreed that the provision of specialized health care services was poorly provided in all hospitals. This finding is against the consistent of WHO (2012) observations that, unless countries may have many health care facilities, the issues specialized health care services, the quest for quality health care will remain exclusive. One of the respondent said that:

> *…..Am very disappointed simply because there are some of the drugs I have missed. I am living with HIV/AIDs for more than seven years now. But normally I failed get CTX drugs which are so useful in boosting up my CD4s'. Most of the time when I came here these drugs are out of stock, am very embossed with this.*

Observation data also revieled that, all of the three hospitals their patients were not real accessible with the specialized clinical health care services. The observation showed that these services were not provided equally to all the patients who went there for the

specific clinic. Bamako Initiative (1987) insisted in protecting the poor people in the treatment and ensure that the medical cost do not prevent poor people from the accesssesibity to specialized health care services. Inspite the fact that all hospitals (Mawenzi, KCMC and Kibosho) have specific days in the provision of the specific health care services. The public notice board of all sample hospitals were having the scheduled time table indicating the days in which clinical services are offered, but still the services were poorly provided. One of the respond who was over looking at the hospital public notice board said:

> *.....This time table is so useful to us. It reduces the inconviniences of coming in the day in which the particular services is not provided. Previously this time table was not here, I remember on August 20014, I came for the teeth care clinic in the day in which the particular service was not provided. But if this time table was there hopefull I wont came at that day. But the management together with NHIF should improve the services because we are not really satisfied with the provision of these specialized.*

Table 4.9: Patients access to specialized health care services

Hospital	Specialized services	Availability	Quality
1. Mawenzi	Diabetic clinic	Available	Not satisfactory
	Skin care clinic	Available	Not satisfactory
	VCT services	Available	Not satisfactory
	Eye care	Available	Not satisfactory
	Reproductive Child Health	Available	Not satisfactory
2. KCMC	Diabetic clinic	Available	Not satisfactory
	Skin care clinic	Available	Not satisfactory
	VCT services	Available	Not satisfactory
	Eye care	Available	Not satisfactory
	Reproductive Child Health	Available	Not satisfactory
3. Kibosho	Diabetic clinic	Available	Not satisfactory
	Skin care clinic	Available	Not satisfactory
	VCT services	Available	Not satisfactory
	Eye care	Available	Not satisfactory
	Reproductive Child Health	Available	Not satisfactory

Source: Interview and observation data (2015)

Table 4.9 above show the accessibility of specialized health care services to the NHIF clients. The table insist that though the services are available, but they are not satisfactory. This implied that customers were not satisfied with the accessibility of specialized health care services under the umbrella of NHIF.

(iii) Presence of health care providers

As narrated in the conceptual framework, health care providers include doctors and nurses who provide out health care services to the clients. The presence of providers at any services indicates that the service is being provided (Andaleeb, 1998).

Interview with service providers indicated that, KCMC and Mawenzi hospitals had fewer service providers serving NHIF patients compared to an average number of patients attending clinics per day. KCMC referral hospital had nine employees who serve an average of one hundred and sixty patients per day; Mawenzi had eleven personnel while Kibosho hospital had three personnel dealing with NHIF clients. KCMC which is consultative hospital had fewer service providers than Mawenzi hospital. Doctor in-charge at KCMC said that:

> *…….Our hospital is having an inadequate number of service providers dealing with NHIF. This is a serious challenge in our hospital. We are having only 9 service providers in NHIF department, this number is too low compared to the number of clients attending the clinic per day. We reported this challenge to the DMO but till now the Ministry of Health and Social Welfare did nothing to rescue the challenges. The medical doctor on average is supposed to deal with not more than ten patients per day, but in our hospital this is not applicable.*

Table 4.10: Number of service provider against number of patients attending per day

Name of hospital	Number of service of services providers	Average number of patients per day	Needed service providers
KCMC hospital	09	160	16
Mawenzi hospital	11	120	12
Kibosho Hospital	03	40	05

Source**:** Interview data (2015).

The table above show that, each hospital had the shortage number of health care providers, as an average according to the doctor in-charge at KCMC the medical doctor is supposed to treat not more than ten patients per day. Doctors of all three hospitals treat more than the required number of patients per day. This result to poor provision of health care services.

Observation from the field showed that, patients had to spend an average of two hours to be served only at the registration counter. This was due to the fact that, the number of patients was big enough compared to the service providers. Patients spent the whole day in the hospitals for treatments. The observations from the field prove each hospital encountered the problem of inadequate of the human capital problem and especially when you compare it with the number of patients attending clinics or admitted per day. All three hospitals confront the shortage of both medical and non medical staff something that affect patient treatment in terms of quality and time.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summarized what have been discussed regarding the study. The chapter concludes and recommends to respective institutions on what should be done to sustain or improve health care services so as to guarantee customers satisfaction in health care services. The summary of the study is presented first.

5.2 Summary of the study

This study intended to assess customer's satisfaction with NHIF services in Moshi municipal. The motive of the study was to appraise if there is satisfaction with NHIF health care services. To make the assessment possible, two research questions were used to accomplish the target of the study. Those research questions were (i) How satisfied the clients are with the availability of health care services under NHIF? And the second research question was (ii) Are the health care services under NHIF quality? To what extent? The multiple case study research design was applied.

To gather accurate information, researchers' employed various methodologies in this study. These methodologies include interviews, questionnaire, observations and go through secondary data by reading various related journals, leaflets and reports as well. Also collected data were analyzed by using statistical techniques and presented in the tables: percentages and frequency distributions.

With respect to the first research question, the study finds out that the majority of patients were not satisfied with the availability of health care services under NHIF. Participants were not satisfied with the whole treatment procedures (starting from registration, consultations and admission) in all sample hospitals. All hospitals were providing poor laboratory services, except KCMC which possessed modern diagnosis machines in her laboratory. Drugs availability was also seen as the great challenge

facing all hospitals (Mawenzi, Kibosho and KCMC). Majority of the clients from all hospitals were complaining on this. Some of the prescribed drugs by the particular hospital physicians were not available in the hospital medical dispensary desk. The government and hospital managements should ensure availability of necessary equipments and improves alternatives in case of lack of equipments or drugs. To assess the performance of their employee, the agency should think of 360 degree performance appraisal, a system that also involves service beneficiaries. This system will reduce complaints as well in turn improve the service provision quality as people get satisfied when they receive comprehensive services with full care.

The study findings regarding the second research questions revealed that there low quality of health care services provided by NHIF. Majority of the clients claimed that health care services provided were poorly in quality. This was evidenced by the poor presence of supportive facilities, unsatisfatory access to specialized health care services to some hospitals as well as the shortage of health care service providers. Both patients and service providers confront several challenges in regard to the mentioned above.

5.3 Conclusion

Based on the data presented and analysis made, this study concludes that:

Generally, the health care services under NHIF did not meet the expectations of the clients (NHIF members). The majority of the clients claimed that, health care services offered to them were unsatisfying. This includes services from when the patient comes at the OPD's reception desk, admission processes until his/her discharged.

Moreover, they claimed that their 3% contributed through the deduction from their salary is large. The government contributes much, but NHIF members don't get all services despite being indicated by NHIF. Thereafter, the government together with NHIF must work smart enough in order to guarantee the so called satisfactions among its beneficiaries so as to resolve the ongoing complaints.

5.4 Recommendations

Relied on the study findings and the conclusion drawn above, the study recommends the following:

(i) Health care service providers

The average number of service providers versus patients attending NHIF health care services was incomparable. Average number of patients that were served by NHIF teams in all hospital was in a ratio of 1/15 (this was only at the NHIF reception point) that was why it took so long time to offer services to the patient, therefore hospitals has to incorporate government in hiring new staffs and where possible to use its own funds for new vacancies so as to increase efficiency and care of patients.

Moreover, it was identified that all hospitals had no personnel with insurance background. In other countries like Kenya and South Africa, employment for medical insurance specialists is highly considered due to the availability of many insurers and companies, likewise in Tanzania where there are over ten insurance companies. The specialists will be helpful in managing day to day insurance activities within the hospital.

It has been noted that many hospitals had no personnel that will ensure desired operating standards are well observed. Researcher suggests all hospitals to hire quality assurance officers who will ensure and evaluate the daily performance of each hospital department and comment to the management for further action.

(ii) Working environment

Hospitals should consider the working environment of their staff as well as patients waiting areas. Unlike KCMC and Mawenzi hospitals, Kibosho have to introduce specific waiting area for NHIF patients that will also include offices for her staff. KCMC and Kibosho hospitals have to find ways to serve NHIF patients specifically as how it is

done at Mawenzi where they get comprehensive treatment with the exclusion of laboratory and radiological.

(iii) Drugs and equipment availability

Government should ensure drugs are always available in the hospitals at all the time. Also, system in procurement of drugs and equipments must be reviewed and changed. Currently, hospitals have to press an order through DMO while all payments are directly done by the government to MSD. If hospitals operated autonomously and receive subsidies only from the government, it will be easy for them to make an order to MSD or buy from other medical distributors directly, but they should abide by the procurement act. The Government must also ensure there is competitive price between MSD and other private distributors who are currently not distributing drugs in public hospitals because not all drugs are available in the MSD. Furthermore, the Government must ensure that her hospitals specifically Mawenzi possess equipments that will not only favor NHIF patient but also the public patient at large. This will reduce referrals to KCMC or to other private hospitals.

(iv) Government: Insurance and law

Under Parliamentary Act No.8 of 1999, each public servant must involuntarily join the scheme despite the availability of other private insurance companies that operate their activities under the Insurance Act No. 18 of 1996. The government should allow competition between these health insurance companies and let employees choose for the service they wants. This will reform the health sector and finally improve service delivery to patients.

(v) Communication system

The research findings revealed that, the majority of the patients' has never been involved in any activity related to NHIF by either service provider or NHIF herself. This study identified that there were a gap between NHIF and beneficiaries.

Communication between NHIF and beneficiaries occurred incidentally when the patient had an issue to confirm with NHIF. The organization should change on the way in which it should be communicating with its beneficiaries.

It is recommended that, NHIF in collaboration with hospitals should develop a system that links information of served patients in all NHIF operating hospitals directly to NHIF database. However, it is noted that NHIF has local ID cards that are not durable and older ones. They are supposed to introduce electronic/smart cards that will simplify and reduce unnecessary inconvenience to patients. The smart card can be helpful in getting all information (bio data) of patients, allow a service provider easily access contribution information of patients, check the eligibility of members as well he can verify the member.

5.5 Area for further research

i. The research recommends that future researchers may concentrate on private health insurance or compare all insurance schemes by looking at the benefits, relationship with the hospital and quality of their services.

ii. They may go further and investigate how NHIF operate in rural areas or in districts where most of civil servants, lives by looking at the opportunity to grow and challenges. Moreover, they may base on a large sample size as the statistical significances of data could also be revealed.

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WORK PLAN AND PROPOSED BUDGET

Table I. Time line (work plan)

Item/ Activity	Time allocated
Writing, completion and submission of research proposal	April to August 2014
Consultation and data collection	September to November
Data analysis, interpretation and writing first draft result	December 2014 to January 2015
Finalizing report writing, final overall draft and submission of theses to the department	February 2015
Internal and external marking and these defence	March 2015
Grades compilation	April 2015

Table ii, Proposed Budget

Item	Cost in Tshs.
Stationeries, inc and cartridges	300,000/=
Printing, Photocopy and binding	500,000/=
Consumable materials	200,000/=
Transport cost	500,000/=
TOTAL COST	**1,500,000/=**

APPENDICES

QUESTIONNAIRE FOR NATIONAL HEALTH INSURANCE FUND BENEFICIARIES

Dear Respondent:

My name is Gilbert Owen Linje, a Master of Science student at the Mzumbe University of Tanzania (Main Campus), and pursuing a Master of Science in Human Resource Management course (MscHRM). I am conducting a study on assessment of customer satisfaction with National Health Insurance Fund Services, a case study of selected hospitals in Moshi municipality, Tanzania. This is the compulsory part of my program; I kindly request your assist in filling in this questionnaire with accuracy so as to enable me to reach at the reliability, validity and scientific conclusion. I would be very grateful if you would spare some few minutes in filling up of this questionnaire. The information which you will give will be treated confidential and your identity will not be exposed.

Instructions:

- Please put √ where appropriate

A: Demographic characteristics of respondent

1. Gender

1.Male	2. Female

2. Age (In Years)

1. 20-29	2. 30-39	3. 40-49	4. 50-59	5. 60 +

3. Education Level

1. Never been to school	
2. Primary level	
3. Secondary level	
4. Post secondary	

4. What is your membership type?

1. Principal	
2. Dependant	
3.Retired	

B: Assessment of customer satisfactions with NHIF services

1. When did you start using health insurance?

1. six month to 2 years	
2. 3 years to 5 years	
3. 6 years to 10 years	

2. On average, how long do you have to wait to consult the Medical Doctor?

1. Less than an hour	
2. One to two hours	
3. More than two hours	

3. Are you satisfied with the laboratory services?

1. Very much satisfied	
2. Satisfied	
3. Little satisfied	
4. Not satisfied at all	

4. Do you receive your drugs from this hospital as per physician directives by using insurance scheme?

1. Yes	
2. No	

If your answer is "No" in Q. 8, then answer Q. 9

5. Do you buy those missed drugs from other pharmacy by using your pocket money?

1. Yes	
2. No	

If your answer is "Yes" in Q.5, then answer Q. 6

6. Among the following, what was the reason for you to buy those missed drugs?

1. Drugs are not available in the hospital	
2. Drugs are not listed in the National Essential Disease List (NEDLIT)	
3. The hospital isn't eligible to dispense these drugs	
4. Long procedure to get the drugs	

7. Are the health providers available at the health facility?

1. Adequately available	
2. Inadequately available	
3. Not available	

8. Are you satisfied with the health care service delivery at the ward?

1. Very much satisfied	
2. Satisfied	
3. Little satisfied	
4. Not satisfied	

9. Are you satisfied with NHIF services?

1. Very much satisfied	
2. Satisfied	
3. Little satisfied	
4. Not satisfied	

C: Limitations and recommendation

1. What limitations you encountered during treatment?

……
……
……
……

2. What is your recommendation on the improvement of NHIF services?

……
……
……

Thank you for your cooperation.

INTERVIEW GUIDE FOR SERVICE PROVIDERS

1. Availability of health care services

i. Presence of laboratory services

Does the laboratory room contain essential equipments for diagnosis?

ii. Presence of pharmacy

Does the pharmacy posses essential medicines?

2. Quality health care

i. Availability of supportive physical facilities.

Are the supportive facilities (consultation rooms, patient resting places, patient wards, dressing rooms, laboratory room and theatre room) satisfactory?

ii. Access to specialized health services.

Does the hospital (under NHIF) provide the following specialized health care services?

i. Diabetic clinic
ii. Voluntary counseling and testing (VCT) services
iii. Eye care clinic
iv. Teeth care clinic
v. Skin care clinic
vi. Reproductive Child Health (RCH) clinic

iii. Presence of health care providers

- ✓ Does the hospital have enough health care providers under NHIF?