CLIENTS' SATISFACTION ON SERVICES OFFERED BY ACCREDITED HEALTH FACILITIES: A CASE OF NATIONAL HEALTH INSURANCE FUND (NHIF)

By

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A Dissertation Submitted in Partial Fulfillment of the Requirements for Award of the Degree of Master of Business Administration (MBA) of Mzumbe University

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CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for the acceptance by the Mzumbe University, a dissertation entitled **Clients ' Satisfaction on Services Offered by Accredited Health Facilities: A Case of National Health Insurance Fund (NHIF)**,in partial fulfillment of the requirements for award of the degree of Master of Business Administration of Mzumbe University.

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DEDICATION

I, dedicate this work to my parents in a way that cannot be forgotten due to their vital responsibility of forming, directing and influencing me in all circumstances to get my education.

ABBREVIATIONS AND ACRONYMS

AHF	-	Accredited Health Facilities
CHIS	-	Compulsory Health Insurance Schemes
CHF	-	Community Health Fund
HI	-	Health Insurance
HIS	-	Health Insurance Schemes
MDGs	-	Millennium Goals Development
MOH	-	Ministry of Health
NHIF	-	National Health Insurance Fund
SHI	-	Social Health Insurance
WHO	-	World Health Organization

ABSTRACT

The study on clients' satisfaction on services offered by accredited health facilities was conducted at National Health Insurance Fund (NHIF). The objectives of the study were; to determine NHIF clients' perception on NHIF services; to analyze problems faced by NHIF when providing services to customers; to analyze problem faced by clients when seeking services provided by NHIF and to assess the extent the problems have been faced by NHIF and clients.

A case study design was used whereas a sample of 120 was involved. In collecting primary data the study used questionnaire and in-depth interview. Secondary data were collected through documentary analysis. Data were analyses by using Microsoft Excel, tables and figures were used to present data.

It was revealed from the study that, NHIF clients' were satisfied by services provided by the fund. The study found majority of the respondents (95.8%) are aware of the existence of problems facing NHIF. Also, the study found there are different problems facing NHIF clients. It's observed that out of 120 respondents, 49 (40.8%) identified shortage of medicine is a major problem facing NHIF clients. The study found majority of the respondents (64%) identified the problem face clients and NHIF for large extent

The study concluded that NHIF members are satisfied with the services offered by the scheme. Moreover, the study concluded that, NHIF faced different problems; these include low awareness, forgery/fraud and low compliance. Finally, the study concluded that, for high extent the problems are facing NHIF and clients. The study recommended that all stake holders should facilitate the involvement of clients in decision making so that they can contribute to matters they are concerned, this will help to maintain the provision of quality health services.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Problem

Many developing countries are currently considering the possibility of introducing Compulsory Health Insurance Schemes (CHIS) (Humba, 2012; Carrin, 2003). Health insurance schemes are increasingly recognized as a tool to finance health care provision in developing countries and have the potential to increase utilization and better protect people against (catastrophic) health expenses and address issues of equity (Kontarygyris, 2010). This attracts more resources to the heath sector, if employees and employers can pay for health services and are made to do so by insurance. Also is dissatisfaction with the existing services in which staff motivation is poor, resources are not used in the best advantage and patients are not treated with sufficient courtesy and respect (Agyepong and Agyei, 2008).

Patients perceptions about health services seem to have been largely ignored by health care providers in most developing countries (Oliver and Mossialos, 2004).Those perceptions especially about services quality might shape confidence and subsequent behavior with regards to choice and usage of the availability health care facilities. Social Heath Insurance Schemes play significant role in enhancing health of the member. The major challenges to social health insurance in developing countries are satisfaction of clients on services offered through accreditation (Sukumar, 2007).Social health insurance pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the other, and is generally organized by national governments (Carrin, 2003, WHO 2010). Most social health insurance schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay forthemselves (Stephen *et al.,* 2011).

Clients' perception on quality health care services is very important to disregard. Clients' satisfaction with overall services can have tremendous impact on the future

health of the communities, For this reasons it is recommended that the quality of care strategy incorporate a section geared directly to clients satisfaction (Karinga,2010). This segment should address the following concerns to the best of its ability in provider training, provider competence, interpersonal relations, availability of providers, short waiting time, improve infrastructures, presence of equipments and suppliers (Bennett *et al.*, 2008).

Tanzania like other African countries, most of the clients who get services in different NHIF accredited health facilities are not satisfied with the quality of health services provided to them (USAID, 2009; MOHSW, 2009).

1.2 Statement of the Problem

National Health insurance Fund was established by the Act No.8 of 1999 (CAP 395 R.E 2002) which started its operations in July 2001, to cover all formal sector employees for inpatient and outpatient health care services. The aim for the establishment of the scheme is to institute a permanent and reliable system for the provision of health services to Tanzanians especially the low income earners. Also it aims to improve accessibilityand quality of health services by introducing competition among accredited health services providers (NHIF, 2011).

Despite the schemes tries to improve customer care services and improve service quality, there are complaints from clients who are not satisfied by services offered through accreditation (USAID, 2012).Satisfaction is an important element as far as quality of health services is concerned in the ideal situation of the health services provided through NHIF accredited health facilities should be friendly , easy accessible, less time consuming, affordable to everyone and adequate number of health personnel which will lead to clients satisfaction (MOHSW, 2009).

The fund has been operating thirteen years now since its implementation in Tanzania. Within this period of time a lot of study have been conducted concerning NHIF in different areas with different objectives (Kontarygyris, 2010). Therefore this study

intended to assess NHIF client's satisfaction on curative services through accredited health facilities.

1.3 Objectives of the Study

1.3.1 General objective

To investigate NHIF clients' satisfaction on services provided to them by accredited health facilities.

1.3.2 Specific Objective

Specifically, the study intended:

i. To determine NHIF clients' perception on NHIF services
ii. To analyze problems faced by NHIF when providing services to customers.
iii. To analyze problem faced by clients when seeking services provided by NHIF
iv. To assess the extent the problems have been faced by NHIF and clients.

1.4 Research Questions

The study was guided by the following questions:

i. How NHIF clients' perceive NHIF services?
ii. What are the problems faced by NHIF when providing services to customers?
iii. What are the problems faced by clients when seeking services provided by NHIF?
iv. To what extent the problems have been faced by NHIF and clients?
v. To what extent the problems have been solved?

1.5 Significance of the Study

The study inline with Millennium Goals Development (MDGs), which try to find better health for all people, the study will establish strategies that can enhance services provided by NHIF and Accredited Health Facilities (AHF). Conducting this type of study it's essential, because the study will reveal attributes to client's

satisfaction and dissatisfactions and also perception of clients on the quality of curative services provided by NHIF accredited health facilities.

The study makers commendations, which will be used in formulation of policy to ensure people are in good health to enable them in participating in economic activities. Moreover, the study provides useful literature and knowledge for future reviews based on the theoretical views and opinions of several cited authors.

The study mayhelp NHIF to increase their performances in development of health system in Tanzania. This is because findings indicate areas for improvement in health provision of health services.

1.6 Limitation of the Study

The study faced different limitations as discussed below:

Time was one of the obstacles that contribute to delaying of finishing of the study, and constrained the study in various stages, especially during proposal write up, data collection and final report write up. In fact, two month period for data collection were not sufficient.

A research fund was another factor which limits the study. Researcher movement from one place to another during data collection, communications and materials was limited by the lack of research funds.

Another constraint was willingness of respondents to respond to questionnaire for some they took long time to answer and return the questionnaires, and others lost the questionnaires also other respondents gave biased answers as the problem touched their personal interest and people's area of specialization.

Usage of English language to questionnaires was another constraint that the researcher faced, as for some of respondents were not fluent in English language and English is a second language to Tanzanians.

1.7 De-Limitation of the Study

Due to lack of fund and time schedule, the researcher decided to conduct the study in Dar esSalaam. Also the researcher was able to solve the fund constraints by help of her parents who supported her financially.

The researcher was able to overcome biased answers by emphasizing on honest and assuring respondent that the researcher is solely for academic purposes, and all answers were confidential. A researcher explained the significance of the study to the respondents and the country overall. This boost the participation of respondents to the study, moreover, the study used online source instead of text books from the library.

Also English language was one of the constraints that researcher faced, the researcher was able to overcome this constraint by using interview method by translating English to Kiswahili for words that were not easily understood by respondents.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents literature review in line with the research objectives. The chapter gives theoretical and empirical literature review. The chapter starts by defining the key concepts.

2.2 Theoretical Literature Review

2.2.1 Definition of the Key Terms

Health

Health is a complex notion to define because different groups or individuals can mean different things depending on their state of health needs and individual perceptions (Mundi, 2011; Gobah, 2011). Health is a state of complete physical, mental, and social well being not merely the absence of infirmity in an individual (Chee*et al.*, 2002).

Insurance

Insurance is defined as the financial arrangement that redistribute as the cost of an expected loss (Karinga,2010). It involves the transfer of losses to an insurance pool; the pool combined the predicted losses back to those exposed. Thus insurance is the method that provides security and fearlessness to the insured (Bennett *et al.*, 2008).

Health Insurance

Health insurance may be defined as a group of persons contributing Funds to a common pool, usually tiled by a third part. These funds are then used to pay for part of all of the costs of a defined set of health services for the members of the pool. This third part can either be a government social security a public insurance fund pool, employer sponsored pool or private insurance pool (Agyepong and Agyei, 2008).

Accredited

Accredited is the process of assessing health institutions against a commonly accepted set of standards for the purpose of ensure and improve quality of health services (MOHSW, 2009). The main aim insure with accreditation is to insure that providers, both institutions such as hospitals and health centers and care givers such as physicians and nurses provide good quality care (Humba, 2012).

Curative Services

Curative services is the process of affecting correction services concerning how the health provider treat patient including prescribing drugs, referring giving consultation and taking physical examination and investigates history of illness (Owusu, 2010).

Satisfaction

Satisfaction is defined as an important element of quality of health care often determining patient's willingness to comply with treatment and influencing the effectiveness of care (WHO, 2010). According to the author perceived problems of health care on structural and interpersonal failure of skills and therefore deteriorate client's satisfaction on provision of health care (Sukumar, 2007).

Client's Satisfaction

Client's satisfaction is the complex situation worldwide (Oliver and Mossialos, 2004). In other words client's satisfaction is not reached due to different perceptions of the clients in different health facilities. Recent research in health services canters shows that there is improvement in quality of care but still clients are not totally satisfied (Stephen *et al.,* 2011).

2.2.2 Concept of Client's Satisfaction on Curative Services Provided by NHIF

Accessibility

Accessibility to the clients means that health care systems are unrestricted by barriers such as geographical, economical or language. Finally, amenities refer to client's perceptions of the physical health facility as well as medical supplies and

equipmentswithin the facility (NIMR, 2006).Mshana (2007) said it is useful to distinguish between location accessibility an effective accessibility depends on having ability, mobility, and time to reach a health service. In health terms provision of facility of a given type within a specified distance of an intended user population is frequently considered to give more or less access to all potential accessibility. Accessibility is one of the greatest challenges to meet client's satisfaction (Oliver and Mossialos, 2004).

Competence of health care provider

Provider competence and training care required, clients are particularly concerned with the qualifications and professional of the services provider (Carrin, 2003).The quality of health care study discovered that clients often expected facilities to have well qualified medical doctors and laboratory technicians. Specifically, clients wanted a provider to conduct a proper examination, identity the problems and prescribe treatment (Bai*et al.,* 2012).

Quality of health care

Improving quality of health care for clients means understanding their cultural values to meet client's satisfaction on curative services, previous experience and perceptions of the role of the health system (Gobah, 2011). Similarly, enhancing quality of health care for care providers required identification of their motivations, addressing their needs and helping them to better understand the concept of quality. Karinga,(2010) study found that's perception on quality of health care services affects their behavior both before and during the time of services.

Waiting time

Most literature suggests that clients would like to receive health services or medical care within a short waiting period after arrival to the health facility. Majority of clients who are waiting for a long period of time are likely to be dissatisfied with the services they receive from a health facility (MOHSW, 2009).

According to the study in Muheza and Lushoto shows that there is a common complaint about CHF and NHIF that has not benefited rural residents. People in rural urged that HI (health insurance) has not been as beneficiaries as expected since civil servants such as teachers whose salaries are deducted to contribute to the NHIF have been complaining about the excessive bureaucracy experienced when following up claims of their insurance entitlements (USAID, 2012).

There were some dissatisfaction expressed by member of community and their local development committee leaders/representatives that CHF and NHIF schemes were initiated without adequate community sensitization for people to understand and agree on the objectives and practically (Sukumar, 2007).

Employees of Morogoro municipal council once threatened to terminate their membership with NHIF because it does not benefit them that it adds inconveniences. Employees said that the operations of the fund were not transparent especially in the medical treatment as the deductions did not demote the value for services. Operations of the fund were seen as a problematic by some of formal sector employees (Sukumar, 2007).

2.2.3 Social Health Insurance in Tanzania

Features of the social health insurance are to ensure that many people get access to health care because of the social and economic status of the population as Gobah (2010) mentioned. In fact, many people cannot afford to pay for individual health insurance due to limited individual income that will help them to serve and set aside amount for health service. The policy therefore, has the focus of making sure that a large number of people especially employed get medical services through subscription from their monthly gain (NHIF, 2009).

Currently NHIF is a compulsory or mandatory scheme and serves for the public service employees, private sector companies and private individuals including their spouses and four children /legal dependants. For private sectors and private individuals they enter in the scheme by choice. It extended its coverage from 4.5 of

2009 to 10.6% in 2010 out of the population in Tanzania inclusion of police force, prisons immigration, fire and rescue brigade who were not covered before (Humba, 2012).

Policy makers are well aware that a country's economic development is closely linked with the health status of its population. Improving access to affordable health care is therefore central to boosting growth and helping break the vicious cycle of poverty and ill-health (Social health Insurance, 2013 & UTR-MOHSW 2009) (NHIF, 2009).

Social health insurance must be viewed as a policy tool, rather than an end in itself. This means that the goals of health policy must be set clearly so that the new funding arrangements can be seen to help meet them. If social insurance is introduced into a country without careful consideration of the objectives and without proper preparation, it will fail or may lead many problems. The effort and resource will be wasted and this may be difficult in the implementation of the scheme (Agyepong and Agyei, 2008).

Tanzania like other African countries does face the issue of clients dissatisfaction regarding social health insurance, most of the clients who get services in different National Health Insurance Fund (NHIF) accredited health facilities are not satisfied with the quality of health services provided to them (Mundi, 2011).

NHIF was formed to resolve the uncertainty in accessing health services among public servants. At the first place it was a great idea to the servants and some members of their families (dependants) to have access to health services whenever it was needed. Indeed, this transformed the culture of public servants of uncertainty when it comes to the accessibility of health services. Basically, the contribution of the services is made by deducting 3 percent of the salary of an employee and 3% of the employer to subscribe to NHIF to carter for health services among members (Mwendo, 2001).

However, there have been a lot of complaints among member (customers) of NHIF. Health centers especially in rural areas are very far from where members of national insurance live and work(NHIF, 2009).

The national policy on health has outlined areas of priority that at every village must have its dispensary in order to create access to medical facilities. But this has not been attained so far as resources allocated do not meet all the requirements. Human resource training and development have not been done in accordance to real needs and demands of the community members (Mwendo, 2001). Surprisingly, those medical centers available, have failed to offer full services.

2.2.4 Accessibility to Health Insurance

Access to health care is a major development and health issue. Most governments declare that their citizens should enjoy universal and equitable access to good quality care. However, even within the developed world, this goal is difficult to achieve, and there are no internationally recognized standards on how to define and measure equitable access (Gobah , 2011).

Health-seeking studies provide a deeper understanding of why, when, and how individuals, social groups, and communities seek access to health care services. In this perspective, social actors are the potential driving force for improving access to effective and affordable healthcare, but they are often constrained by politics and the economy on national and international levels. Health service studies availability, affordability, accessibility, adequacy, and acceptability to pay more attention to the supply than the demand side (Kontarygyris, 2010).

Across the global, health care is the fastest growing sector of spending especially in developed countries. In addition, the costs of basic services, people and society pay huge price when so many citizens go without the care they need (Carrin, 2003). Individuals suffer preventable illness, pain, complications, bankruptcy, family disruptions, job loss, disability, and even premature death, others pay a lot. infection rates increase, public health and safety are compromised, children miss school, adults

miss work, productivity drops, crime and homelessness increase, social agencies are drained. Health care rates and insurance premiums climb as a consequence of cost shifting. Employers drop benefits for workers or buy policies so lean that even their insured employees can't afford necessary care (Kitzhaber, 2004).

Furthermore, Kitzhaber (2004) argue thattruly accessible health care means three basic things: First, Care is available this means people are diagnosed and treated promptly, and can obtain quality preventive care early enough to avoid illness or complications. Services are offered within a reasonable distance from where people live.

Second, Care is appropriatein the contest thatthe right mix of health care professionals exists to attend to people's most frequent needs. Cultural and linguistic barriers are addressed in such a way that patients get proper diagnoses and can communicate effectively with their providers (Mshana, 2007).
Third, Care is affordable this means basic health insurance wider covered. Accessibility for heath care is provided for all. Additional, out-of-pocket costs are adjusted for those with low incomes. In fact, those are the key expectations a health insurance needs to have (Humba, 2012).

2.2.5 Health Insurance Scheme

Health insurance: A form of health financing that pools risks across patients and a cross time. The objective is to increase equity and protect against catastrophically expensive illness (WHO, 2000).

Health Insurance Schemes (HIS) are voluntary membership schemes that have been developed and promoted as mechanisms to offer protection to poor households from the risk of ill-health, death and loss of assets (Agyepong and Agyei, 2008). These schemes are typically owned, designed and managed by the community that they serve and 'provide financial protection from the cost of seeking health care (Carrin, 2003).

It has three main features: prepayment for health services by community members; community control, and voluntary membership (Kontarygyris, 2010). What is more characteristic about them is that 'they often come out with premiums which are small, paid on regular basis and are often meant to off-set the catastrophic health expenditures incurred in the case of illness, injury, childbirth, or any other event that requires expensive medical care (Diop*et al*., 2006).

Health insurance can be defined as a way to distribute the financial risk associated with the variation of individuals' health care expenditures by pooling costs over time through pre-payment and over people by risk pooling (WHO 2006).

If universal healthcare coverage is to be financed through insurance, the risk pool needs the following characteristics: compulsory contributions to the risk pool (otherwise the rich and healthy will opt out); the risk pool has to have large numbers of people, as pools with a small number cannot spread risk sufficiently and are too small to handle large health costs; and where there is large number of poor, pooled funds will generally be subsidized from government revenue (WHO 2000).

Social health insurance schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations. Recently, apart from governments, several non-government organizations at the community level provide social health insurance in developing countries (Kontarygyris, 2010).

Social health insurance pools both the health risks of its members, on the one hand, and the contributions of enterprises, households and government, on the other, and is generally organized by national governments (Carrin, 2003, WHO 2000). Most social health insurance schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay themselves (WHO 2000). Social health insurance differs from 'tax based financing' which typically entitles all citizens (and sometimes residents) to services thereby giving universal

coverage. However, social health insurance entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population (WHO 2006).

Social health insurance can bring about welfare improvement through improved health status and maintenance of non-health consumption goods through ensuring that health expenditures are smoothed over time and that there is no significant decline in household labour supply (Agyepong and Agyei, 2008).

Health insurance schemes at a subsidized cost target the poorest section of society but we will include both low and middle income populations, especially those in the informal sector, as our study units (Humba, 2012). Since the definition of low and middle income population varies across countries, we will use the official definition used by respective countries as well as the definitions adopted by the individual studies.

Social health insurance is classified into two groups: government based and community based and further classify on the basis of Sources of financing (premium subsidized or not), nature of enrolment (compulsory or voluntary), benefit packages covered (comprehensive or partial; total amount monetary amount of coverage) etc. for e.g. Some SHI cover only hospitalization benefit while some other covers both hospitalization and non-hospitalization; some offer monetary cap and Cost-sharing where the beneficiaries have to pay certain portion of health expenditure (Humba, 2012).

The primary purpose of insurance is to smooth out expenditure on a good for which the need arises unexpectedly; in the case of health insurance the good is health care over a life time. A further purpose is to provide subsidies across people as the particular need may not arise for some of the people who pay into a financial pool. Thus insurance provides risk pooling across time and people due to differentials in risk across time and people (Carrin, 2003).

Social insurance seeks to remove financial barriers to receiving an acceptable level of health care and requires the healthy to share in the cost of care of the sick; the element of cross-subsidy is essential (Ekman, 2004).

SHI has also been mandated for formal-sector workers in a number of developing countries (Humba, 2012). In order to achieve universal healthcare coverage, the institutional structure that emphasizes payment to providers for services delivered has been offered to those beyond the formal workforce (Vietnam 1993 and 2003, Nigeria 1997, Tanzania 2001, Ghana 2005, India2008, China 2003) as an alternative to direct tax-based financing of providers and out-of pocket payments(Carrin, 2003).

The prime welfare objectives of social health insurance are to: prevent large out-of-pocket expenditure; provide universal healthcare coverage; increase appropriate utilization of health services; and improve health status (WHO 2000). Social health insurance can improve welfare through better health status and maintenance of non-health consumption goods by smoothing health expenditure over time and by preventing a decline in household labor supply (Gobah , 2011).

However, financial costs are only one of the potential barriers to access to healthcare; the severity of non-price barriers can also play a major role in LMICs, which results in variation of the impact of health insurance on healthcare utilization for some population groups (Gobah , 2011). For example, health insurance coverage may be of limited value to households living in remote areas where the roads linking them to health facilities are poor and transport options are limited; these physical disadvantages may be compounded by low levels of education and skepticism over the benefits of Western medicine (Agyepong and Agyei, 2008).

Even with insurance, barriers in accessing healthcare include: distance to the nearest healthcare facility; lack of knowledge, skills and capabilities in filling forms and filing claims, lack of money to pay initial registration fees; and indifferent attitudes of doctors related to actual and perceived quality of care (Karinga,2010).

The first area of consensus is that out-of-pocket payments are the least desirable way of funding health services. Out-of-pocket payments place the full burden of paying for health services on the individual who needs to use a health service at the time of need; it does not allow for any income or risk cross-subsidies. It constitutes a major barrier to health services, particularly for poor households (Bai et *al.,* 2012).

This review also recommended more systematic evaluation of initiatives. Broader use of non-branded generic medicines would also help reduce costs. The implementation of effective generic medicines policies in this context would require a comprehensive approach including quality assurance and testing, consumer and professional education and advocacy, and generic substitution policies. However, the most important challenge to rational prescribing is modifying provider payment systems to delink physician and facility income with prescribing practice (Mwendo,2001; WHO, 2000).

The national health reform aims for a patient centered approach, and systems that promote the primary health care utilization, including incentives such as higher reimbursement rates for primary level care. Large-scale investments have been made to strengthen village and township levels, and community health service centers to promote utilization at primary levels. However, the supply of hospitals increased rapidly since 2000 and they remain the dominant source of outpatient consultations, many of which could be seen at lower levels of the health system (WHO, 2000).

Promoting utilization at primary level requires shifting qualified human resources and technology to primary level and increasing quality of care, particularly for the management of chronic conditions that require more qualified staff and stronger referral systems. While the numbers of physicians has increased, the deployment of qualified practitioners to peripheral levels of the health system could be strengthened. Once the primary care level is strengthened, it would be feasible for it to function as a gatekeeper system. A prior study demonstrated improved performance by using salaried staff at village levels and centralized drug procurement (WHO, 2010).

A question that remains of paramount importance in a majority of the world's countries is how their health financing systems can provide sufficient financial risk protection to all of the population against the costs of healthcare. The latter objective is tantamount to the aim of universal coverage, which is to secure access to adequate healthcare for all at an affordable price. That is, universal coverage incorporates two different coverage dimensions: healthcare coverage (adequate healthcare) and population coverage (healthcare for all) (Sukumar, 2007).

A crucial concept in health financing policy towards universal coverage is that of society risk pooling, whereby all individuals and households share the financing of total healthcare costs. The larger the degree of risk pooling in a health financing system, the less people will have to bear the financial consequences of their own health risks, and the more they are likely to have access to the care they need (Ranson, 2007).

There are essentially two main options for achieving universal coverage. One is a health financing system whereby general tax revenue is the main source of financing health services. These health services are usually provided by a network of public and contracted private providers, often referred to as a national health service (Sukumar, 2007).

Second, there is SHI, which in principle involves compulsory membership among all of the population. Workers, self-employed, enterprises and government pay contributions into a social health insurance fund. The base for workers' and enterprises' contributions is usually the worker's salary. The contributions of self-employed persons are either flat-rate or based on estimated income. Government may provide contributions for those who otherwise would not be able to pay, such as unemployed people and low-income informal economy workers. SHI owns its own provider networks, works with accredited public and private healthcare providers, or uses a combination of both. Within SHI, a number of functions (for example registration, collection of contributions, contracting and reimbursement of providers)

may also be executed by parastatal or non- governmental institutions, often referred to as sickness funds (Sukumar, 2007).

However, which use a mix of the two main options. Thus, there are mixed health financing systems that have some part of the population partially covered via general tax revenue, and clearly (Owusu, 2010).

This insurance can be provided by one or a number of parastatal health insurance schemes that function according to SHI principles. Alternatively, a system of private health insurers may also be in place, but one that is subject to government regulatory powers, especially ensuring a specified benefit package of care (Owusu, 2010).

Note finally that within each of the options referred to above, private health insurance can also play a supplementary role. It typically covers extra healthcare services that are not covered in a basic package of care (of one of the three systems), arranges for a reduction in waiting time, or covers some of the cost of patient repayments. Indeed, in reality no health financing system is entirely financed by general taxation, SHI or the mixed health financing system described above. However, these options are useful for describing what is the principal method driving a health financing system towards universal coverage (Kontarygyris, 2010).

A gradual approach as in Germany was adopted. A first Industrial Accident and Health Insurance scheme for enterprise workers was established in 1887-88. Leading up to this scheme were the early regulatory provisions in the early nineteenth century for employers to pay for hospital care and care of sick employees. In 1859, an Industrial Code came to regulate the creation of benevolent funds and cooperative health insurance funds. However, so far these provisions and regulations had been mostly ignored. Then came the 1867 Associations Act that authorized the creation of association-based funds. As a result, the associations for general workers' health and the invalidity relief funds were established in 1868 and 1873, respectively (Kontarygyris, 2010).

The initial 1887-88 scheme was further expanded in the early twentieth century, by systematically enrolling all categories of white-collar workers, blue-collar workers and agricultural workers. The final expansion of coverage came in 1965 and 1967 with the Farmers' Health Insurance Act and the Civil Servants' Health Insurance Act, respectively. By 1980, a population coverage level of 96 per cent had been achieved. Note that there were 79 years between the first law in 1888 and the last major law, the Civil Servants' Health Insurance Act of 1967 (Kitzhaber,2004).

In 1851, a special law officially acknowledged the sickness funds, often referred to as mutual health funds. These were based on different occupational groups and were rather small-scale. Later on, in 1894, more extensive legislation provided the legal foundation of these funds for almost a century: a broader scope of activities was recognized, while they could henceforth benefit from government subsidies. Subsequently, mutual health funds from the same political or ideological background combined into national alliances or unions (Gobah, 2011).

Until the early 1940s, membership in these mutual health funds had been voluntary. Towards the end of the Second World War, on 28 December 1944, a decree was adopted to make health insurance compulsory for all salaried workers. A National Fund for Sickness and Invalidity (embedded in a National Office of Social Security) would collect contributions and distribute them to the mutual health funds that would be in charge of administering compulsory health insurance. The next important steps were the laws of 1964, 1965, 1967, 1968 and 1969 that would expand compulsory health insurance coverage to self-employed workers (but for major health risks only), civil servants, people with physical disabilities, those with learning difficulties, and the remaining uninsured population, respectively. Thus, at the time of universal coverage, 118 years had elapsed since the 1851 law (Owusu, 2010).

In 1901, compulsory health insurance was established for manufacturing and industrial workers. It was also inspired by the earlier 1883 law in Germany. Health insurance developed and, by 1903, 73 sickness funds were operating. Later on, in

1925, legislation was introduced to regulate the health insurance sector, which had become increasingly complex. As in other European countries, SHI further developed after the Second World War. Retirees were the first new group to become covered. Then in 1952, health insurance became compulsory for civil servants and other public sector workers. In 1958, 1963 and 1964, compulsory insurance laws were introduced for the independent professions (businesspeople, craftspeople), farmers, and the independent intellectual professions (doctors, architects, lawyers), respectively. By 1973, the whole population was covered by SHI. Thus, the transition period had taken 72 years since the first law in 1901 (WHO, 2006).

2.2.6 Impact of Health Insurance Scheme

The effects of different social health insurance schemes have in recent years been evaluated including trials looking into specific effects of these schemes (Owusu, 2010). Moreover, social health insurance does not provide complete insurance even if it covers the health care costs (Mwamoto, 2013).Other barriers exist in accessing healthcare including distance to the nearest healthcare facility, lack of knowledge, skills and capabilities in filling forms and filing claims, lack of money to pay admission fees (WHO 2000;Gobah, 2010).

Management of risk within the household may well imply that even with the presence of social health insurance, a substantial amount of borrowing enhances the ability to smooth consumption over the period of major illnesses (Karinga,2010).

The social health insurance literature has reported multiple outcome measures including utilization of health care, reduction in health care expenditure by income class, use of health care by income class (WHO 2000). Which outcome is reported may depend on what administrative data were collected or the surveys used to carry out a study.

Social health insurance allows health care to be accessed free or at low prices at the point of contact with the provider which may lead to an increase in inappropriate utilization as the cost of receiving any service is small after one has paid the

insurance premium; this is known as moral hazard of insurance. This type utilization has no impact on health. Healthcare providers can offer guidance to patients to receive services that may also have no health effect, as patients may readily accept any particular care at a low or zero cost (Carrin, 2003).

Since people in developing countries are already ‘under utilizing’ healthcare, an increase in uptake of healthcare utilization should not necessarily be considered a moral hazard but could be a ‘welfare gain’ (Mundi, 2011). This dilemma, whether over utilization of healthcare due to health insurance coverage is a moral hazard or not is a potential limitation for assessing the impact of health insurance on ‘changes in utilization’ if additional data on appropriateness of utilization are not available.

Studies indicate that the uptake of any type of insurance in developing countries is low; thus an important element of impact of insurance is its rate of enrolment (Ekman, 2004). However, the enrolment in voluntary health insurance schemes is subject to the problem of selection bias through adverse selection the practice of more unhealthy people joining health insurance, and cream skimming a practice by insurers enrolling only the healthy people and conveniently excluding the high risk population group consisting of aged, poor, and women from the insurance program (Mwamoto, 2013). Adverse selection arises when asymmetric information exists between insurers and consumers about individual health risk. People who insure themselves are those who are increasingly certain that they will need health insurance (high risk individuals) and hence they buy more insurance (Kitzhaber, 2004).

Social health insurance is one method of finding for health services, as either the main or supplementary funding mechanism. According to Ekman, (2004), the main reasons choosing the social health insurance finding are:-

It can provide a stable source of revenue for health service the flow of funds into the health sector is visible. It can combines risk pooling with mutual support, by allocating service to pay. It can operate in pursuance of government health policy

goals, but it can maintain degree of autonomous from the government (Ranson, 2007).

It can be associated with efficient provision of health services. The main disadvantages of social health insurance are: there are high administrative costs and there is a problem of cost containment (Mwamoto, 2013).

In order to measure the impact of SHI, one seeks to determine whether there is greater access to health care and a reduction in out-of-pocket expenditure. The welfare impact of social health insurance should be judged in terms of some measure of utilization of health care for treatment, take-up of preventive care, avoidance of large one-off expenditures and improvement in health through being able to receive adequate care (Mwamoto, 2013).

The developed and developing world is currently the midst of a lively debate about the relative merits of social health insurance (SHI) and tax-financed health systems. SHI argue that SHI discourages firms from hiring workers, and hence reduces employment and encourages informal labor markets. They also point to lack of coverage among certain groups during the often long period between establishing SHI and achieving universal coverage, and systematic variations in benefit packages and quality of care across subpopulations. By contrast, SHI advocates argue that it can provide an important additional source of revenue for the health system, and that by separating the purchasing of health care from its provision and encouraging selective contracting between providers (including private sector ones), SHI systems are able to Like many intriguing and important debates, this one is being conducted on a flimsy evidence base (USAID, 2005).

The most basic question still only partially answered is how, on average, SHI and tax-financed systems perform in terms of key health sector and labor market outcomes. Of course, no two SHI systems are exactly alike, and no two tax-financed systems are alike; indeed, the health systems in one camp are increasingly borrowing ideas from the other. Nonetheless, each system still has certain hallmarks, and trying

to establish the system-wide impacts of choosing one system over another is a useful exercise. Such impacts are unlikely, however, to be accurately estimated simply by comparing countries that finance their health care through SHI with countries that do so through general revenues, the reason being that whether a country has a SHI system or a tax-financed system in place is likely to be endogenous unobservable factors correlated with the outcome of interest are also likely to be correlated with the choice of system (USAID, 2012).

The collection of earnings-related contributions in SHI systems is typically done within the SHI system, while a tax-financed system's revenues are collected via the tax system. Other things equal, this is likely to make a SHI system more costly. These extra costs are often seen as a price worth paying by SHI advocates who see earnings-related contributions as more stable and more reliable than tax revenues: people may be willing to contribute more if they know their contributions are going to provide health insurance coverage for them and other contributors than if the monies end up in a large pool of tax revenues whose allocation between the health sectors and other sectors is left to the whims of policymakers. In practice, evasion and avoidance of SHI contributions is a major issue in many SHI countries, and some ministries of finance reduce the tax revenues they assign to the health sector as SHI revenues grow, so SHI revenues are not necessarily additional (Malcolm, 2008).

In 2004, reforms in provider payment mechanisms became more systematic. In recognition that user fee systems provided strong incentives for over utilization of services and medicines, more systematic experimentation began in alternative provider payment mechanisms including diagnostic-related groups (DRGs) for hospitals, capitation at primary level, and prepayment for maternal and child (MCH) services. In 2004, the MoH started experiments across seven provinces in hospital case based payments, many of which established fixed payment rates for specific diseases, based on data about prior years' health care costs. Usually, however, case-based payment systems were initiated by hospitals that wanted to attract more patients by capping their out-of-pocket costs (Malcolm, 2008).

A recent review has emphasized a more comprehensive approach in addressing provider payment reform in conjunction with strengthening the service delivery system and effective referral, improving provider practice norms, and Health facilities have relied on user fees to cover their operational costs, including salaries and bonuses for health providers, since the 1980s. In addition, the government allocates funds to facilities as line-item budgets based on numbers of staff and beds. The accumulated evidence has demonstrated that these incentives have led to over utilization of medicines and services (Malcolm, 2008).

The 2009-10 work plan of the national reform explicitly aims to improve payment methods such as capitation, diagnosis related groups (DRGs), global budgeting; and to develop DRG pilot programs based on about 50 diseases with clear clinical pathways. There is a special need to continue to develop alternative and mixed methods for paying health care providers to replace the fee for service system that remains predominant, and delink the volume of services provided from health providers' incomes. Some experience with prospective payment mechanisms in the urban programs has demonstrated associations with declines in rates of expenditures and use of unnecessary technologies and medicines (Gobah, 2011).

2.2.7 Importance of Health Insurance Schemes

Health insurance schemes are supposed to reduce unforeseeable or unaffordable health care costs through calculable and regularly paid premiums. In contrast to the history of social health insurance in most developed countries, where health insurance schemes were first introduced for formal sector employees in urban areas, recently emerging health insurance schemes have taken the form of local initiatives of a rather small size that are often community based with voluntary membership. They have either been initiated by health facilities, member-based organizations, local communities or cooperatives and can be owned and run by any of these organizations (Gobah , 2011). Health insurance schemes have three effects (Kitzhaber, 2004).

Effect on Members, First of all, insured members no longer have to search for credit or sell assets. They also recover more quickly from their illness since there are no delays in seeking care (Humba, 2012). Considering the fact that people in rural areas rely mainly on their labor productivity and on assets such as livestock for income generation, a serious decline of income can be prevented as productive assets are protected and people can return to work sooner. Income is stabilized and may even counting the sum throughout the year be increased. Consumption will be more stable and probably even higher, thereby positively affecting the health of all household members. Both increased consumption and better health contribute to overall income. In the mid- to long-term, the positive experience of some households or community members with health insurance in terms of immediate access to care and benefits for their health may create trust in the new institution. It also encourages people to prolong their membership and convince others to join the scheme (Karinga,2010).

2.2.8 Health Strategies

Tanzania is currently implementing its Health Sector Strategic Plan phase III. The strategic plan has been developed in line with the goals of the National Strategy for Growth and Poverty Reduction (MKUKUTA). The National Health Policy 2007, and the Millennium Development Goals (MDGs), both recognize the improvement of people's quality of life as essential to their ability to participate fully in the country's production that will contribute significantly to National GDP (Humba, 2012).

This is also true when one makes comparison with the compulsory health insurance, many people would like to have health insurance covers for medical care risks if there were employed in formal sector. But limitations occur when majority are informal sector workers who are not sure of their real income which is used for health insurance NHIF, (2013) revealed by June 2013 only 18% of populations have been covered. For this case, it is not for this people to have health insurance covers due to lack of consistent income (Humba, 2012).

In Tanzania, many people still depend on the public financing in health. Different issues arise in the case of public and private engagement in health care financing and service delivery. A strong government action in health care financing is a must but difficult. Many people working under the private sectors get good health facilities and services in big hospitals as incentives by their employers to motivate them. Employees in private institutions get health services through health insurance covers paid by the employers. For Tanzania many private companies have health insurance policies with big hospitals like Aga Khan, Hindu Mandal, Regency and Mikocheni hospitals which are well staffed professionally and aim at satisfying their customers to maximum level (Carrin, 2003).

Assurance of access to health services at all times to the clients of fund and also contributing to the health sector development as a component of health financing .It has changed health system from free services to contributions and form cash payments to use of cards also from laisser-faire to ownership by members and it brings health services close to its members Most literature suggests that clients would like to receive health services or medical care within a short waiting period after arrive to the health facility. Majority of clients who are waiting for a long period of time is likely to be dissatisfied with the services they have received from a health facility (Gobah, 2011; Karinga, 2010).

According to Karinga, (2010) on his study showed that there is a common complaint about CHF and NHIF that has not benefited rural residents. People in rural urged that HI (health insurance) has not been as beneficiaries as expected since civil servants such as teachers whose salaries are deducted to contribute to the NHIF have been complaining about the excessive bureaucracy experienced when following up claims of their insurance entitlements.

There was some dissatisfaction expressed by member of community and their local development committee leaders/representatives that CHF and NHIF schemes were initiated without adequate community sensitization for people to understand and agree on the objectives and practically (Kontarygyris, 2010).

The Ministry of Health and social welfare Tanzania conceptualizes health care insurance Fund as the coverage of people or an individual to access the health services that those are employed in different government institutions, household or a community experiencing a decline in accessing health service (Karinga, 2010).

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement (Mshana, 2007).

The individuals afford to get accesses to health care when becomes sick or her/his dependant on health centre of his or her contribution to health insurance membership (NHIF) as available to that individual (NHIF, 2013). It covers the risk of illness at a very small cost during illness.

Sukumar (2007) mentioned in his study thatfundamentals of risks pooling and sharing depend on to what extent both the risks and incomes related cross subsidization that is risk solidarity and income solidarity are prevalent. This realized achieved between groups, for example, pooling the health risk between rich and poor, young and old, and employed and unemployed.

Moreover, Sukumar (2007) insist an efficient insurance system is based on the law of large numbers, that is, it requires large risk pools. What is unpredictable to an individual is predictable to a group of individuals. Health care expenses are not only expensive but highly random in nature. Health Insurance mechanism provides a way by which risk sharing within a society may take place.

However, majority of the Tanzanians have health insurance covers which are paid under the private institutions which have health insurance contracts with private insurance companies for their employees. But there are few people who have their own individual health insurance under the private insurance companies depending in

specialist on health services or facilities and health centre for both rural and urban people in Tanzania to access when they are sick (MOHSW, 2009).

Features of the social health insurance are to ensure that a lot of people get access to health care because of the social and economic status of the population as Gobah (2010) mentioned. In fact, many people cannot afford to pay for individual health insurance due to limited individual income that will help them to serve and set aside amount for health service. The policy therefore, has the focus of making sure that a large number of people especially employed get medical services through subscription from their monthly gain (NHIF, 2009).

Currently the NHIF is a compulsory or mandatory scheme and serves for the public service employees including their spouses and four children /legal dependants. It extended its coverage from 4.5 of 2009 to 10.6% in 2010 out of the population in Tanzania inclusion of police force, prisons immigration, fire and rescue brigade who were not covered before.

Policy makers are well aware that a country's economic development is closely linked with the health status of its population. Improving access to affordable health care is therefore central to boosting growth and helping break the vicious cycle of poverty and ill health (Social health Insurance, 2013 & UTR-MOHSW 2009).

Social health insurance must be viewed as a policy tool, rather than an end in itself. This means that the goals of health policy must be set clearly so that the new funding arrangements can be seen to help meet them. If social insurance is introduced into a country without careful consideration of the objectives and without proper preparation, it will fail or may lead many problems. The effort and resource will be wasted and this may be difficult in the implementation of the scheme (MOHSW, 2009).

2.2.9 Equity in Health Care

Justice in the social health care depends on the social health system which a country has adopted in order to help its people to have access to health. In normal circumstances, for example, many people are covered under the general system of health care in which the government pays the larger portion of their health expenses. Therefore, health insurance is meant to assist as many people possible (WHO, 2008). Equality in health services accessibility is highly questionable. Many people not only in rural but also in urban areas is a bit limited in accessing these health services.

The equity in provision of health services as the first health care system to distribute the majority of its revenue resource between geographical areas in relation to population need, the national health services (NHS) international attention. A central aim of the current resource allocation system is to promote equal opportunity of access for equal needs. Using statistically formulae that based on transparent, empirical models, there is a strong assumption on the part of the British government that health resource allocation in England is technically excellent and results in all areas getting their fair share (Sukumar, 2007).

It is important to note that most of the indicators that are used to examine geographical variation in health are measures of relatives' health status. Standardize measures, for example control out difference in the age and sex structure of population, to reveal the impact of non demographic factors on health such as deprivation This is entirely valid and important with respect to identify health inequality (Sukumar, 2007).

2.2.10 Problems facing Health Insurance

Kenya provides a good example of health care provided by health insurance. The funds motive is based on client's satisfaction by providing quality health services and to be easily accessible to everyone. The available literature shows that health insurance pose several problems for government, one of the major drawbacks is its limited coverage .National hospital insurance fund covers only those who are in the

public sector and the current insurance covered only few of the Kenyans households that use insurance to pay for medical care (Gobah, 2011).

Due to the limited coverage and long delay in reimbursement from the NHIF several patients were less likely to use insurance to pay for medical care in public hospitals. Also were reported that patients who use insurance were generally dissatisfied with the health services they receive from accredited health facilities (Mshana, 2007).

The Fund is currently overseen by a board of directors with a mandate of enabling as many Kenyans as possible to have access to quality and affordable health care services. However, despite the transformation of the fund into State Corporation it has continued to face several challenges. The amendment provided for both in patients outpatients as beneficiaries, however, outpatient services are not yet operational. The mechanism for members to influence its decisions, representations from the grassroots level is adequate. As a result, members who contribute to the fund do not have say in the management and operation of the fund. Instead NHIF is perceived as being bureaucratic and insufficient in its medical coverage, with rising health care costs. NHIF does not provide for reimbursements to members. As a result, beneficiaries claim to be not satisfied with the services provided by the fund (Karinga, 2010).

Denmark faces a number of health care challenges including increasing public and political expectations around the continuity of care; increased specialization in the hospital sector, which typically translates into shorter stays and earlier discharge back into the community; and a rise in the number of elderly patients with multiple long-term conditions, requiring safe and effective co-ordination of care and avoiding unnecessary hospitalization (Karinga, 2010)

2.2.11 Delivering of Health Insurance Services in other counties

Gobah, (2011) in his study identify that, although there are strong arguments in favor of universal coverage of health insurance that can be brought about by mandatory

membership, but this type of health insurance is not feasible in an environment where most people are either self-employed or informal sector workers.

That concept for all is contentious and ambiguous because the traditional health care system for instance has not been fully tapped into. Besides, some districts or areas lack health care facilities and/or resources including health care personnel. Despite the obvious reasons for NHIS implementation, what the state and the new scheme do not explain is how the health insurance can encourage all Ghanaians to seek care when poor quality of care and the shortage of health professionals have triggered a loss of confidence in modern health care system. The introduction of the new healthcare scheme has not put an end to the sporadic strikes by physicians and other health personnel. These, coupled with delays in reimbursement of physicians and health facilities for services render has negatively impacted the sustainability of the scheme (USAID, 2005).

In East Africa, with the notable exception of Kenya; several studies have been done on the feasibility of using social insurance in health care delivery. A Study conducted on Kenyans use of Social health insurance suggest that health insurance has not covered a considerable number of people in relation to national population and the people who need heath care most. The Fund finds itself facing contrasting positive and negative public views by the wider audience and health sector stakeholders (NHIF, 2011).

Health care service offerings" and "health care services" refer to the services and programs that you offer in the marketplace. Health care service offerings should consider all the important characteristics of services that patients and stakeholders receive in each stage of their relationship with you. focus should be on features that affect patients' and stakeholders' preferences and loyalty—for example, those that affect their view of clinical and service quality and differentiate your services from competing offerings or those of organizations offering similar health care services. Beyond specific health care provisions leading to desired health care outcomes, those features might include extended hours, family support services, ease of access to and

use of your services, timeliness, cost, and assistance with billing/paperwork processes and transportation. Key health care service features also might take into account how transactions occur and factors such as the confidentiality and security of patient and stakeholder data. Your results on performance relative to the key service features should be reported in item and those concerning patients' and stakeholders' perceptions and actions (outcomes) should be reported in item goal of patient and stakeholder support is to make your organization easy to obtain health care from and responsive to your patients' and stakeholders' expectations. Building patient and stakeholder relationships might include the development of partnerships or alliances with stakeholders Malcolm, (2008).

Singapore has attained one of the most successful systems in terms of delivery of excellent healthcare services as well as the efficiency and effectiveness. It is achieved through the joint responsibilities among government, individuals and employers. It is indisputable that Singapore Government has made great efforts to improve the health care system. Government performs an active role in regulating to be replicated in other countries as the system is constructed on many unique features. Perfection is awaited as some of the problems can be solved in the future enhancements Bai at el, (2012)

2.2.12 Client's Satisfaction on Curative Services Provided by NHIF

Access becomes an issue once illness is recognized and treatment seeking is initiated. The dimensions of access influence the course of the health-seeking process are availability, accessibility, affordability, adequacy, and acceptability (Mshana, 2007).

A review of literature from Tanzania found, for instance, that people considered the availability of essential drugs a prerequisite to the credibility of health services. Problems of accessibility, including long distances to nearest dispensary or health centers special in rural areas, scarce public transport, and lack of bicycles and other private means continued to be major access barriers. Issues related to affordability were also major obstacles: complaints about fees were frequent, and even if official fees were exempted (for children under five) or waived (for person temporarily

unable to pay), people often ended up paying for drugs, small charges, kerosene, and even ambulance transport. Poor people had to resort to short-term coping strategies like selling critical assets such as crops to pay for health care, especially in times of emergencies. Adequacy and acceptability in terms of people's judgment of quality of care also played an important role (Mshana, 2007).

Provider competence and training care required, clients are particularly concerned with the qualifications and professional of the services provider. The quality of health care study Kizber, (2004) discovered that clients often expected facilities to have well qualified medical doctors and laboratory technicians. Specifically, clients wanted a provider to conduct a proper examination, identity the problems and prescribe treatment.

The accessibility to the clients means that health care systems are unrestricted by barriers such as geographical, economical or language. Finally, amenities refer to client's perceptions of the physical health facility as well as medical supplies and equipments within the facility. Kontarygyris, (2010) said it is useful to distinguish between location accessibility an effective accessibility depends on having ability, mobility, and time to reach a health service. In health terms provision of facility of a given type within a specified distance of an intended user population is frequently considered to give more or less access to all potential accessibility. Accessibility is one of the greatest challenges to meet client's satisfaction (Gobah, 2011).

2.3 Empirical Literature Review

Mshana (2007), made a study on access to health care in contexts of livelihood insecurity, The study use case study design the study found that given the fact that people may be willing to spend more money on securing access to health care than they can actually pay as user fees at the time of illness and that the healthy carry the financial burden of illness together with the sick via the insurance scheme, additional resources may be mobilized for health care provision. Utilization of health facilities will probably increase a desirable effect if one considers currently prevailing underutilization in developing countries.

More over, the study found that, a part of these resources could then be used up to expand access. Under the assumption that there is net revenue generation in spite of higher utilization rates, the hospitals or health facilities will utilize the financial means to improve the quality of Care for example, by increasing drug availability and purchasing extra necessary medical equipment Mshana (2007) concluded that better quality of care will increase people's expectations of getting value for money in the case of illness, and will again enhance demand for insurance.

Also,Brugiavini and Pace (2010) made a study on the Effects of the National Health Insurance Scheme in Ghana. The study found majority of the clients were not satisfied with the health services offered by health insurance scheme. Moreover, the study found lower premiums will probably once again increase demand for insurance and coverage rates. Besides acting as an agency that expresses the interests and needs of its members, the CBHI can try to promote the use of preventive care and healthy behavior.

The study concluded that, health education and awareness of health problems would improve public health outcomes and counteract cost escalation. Risk pooling is therefore enhanced as more people participate. Consequently, risks become more calculable. Though the idea of rising demand usually suggests rising prices, in this case it could result in reduced premiums due to economies of scale.

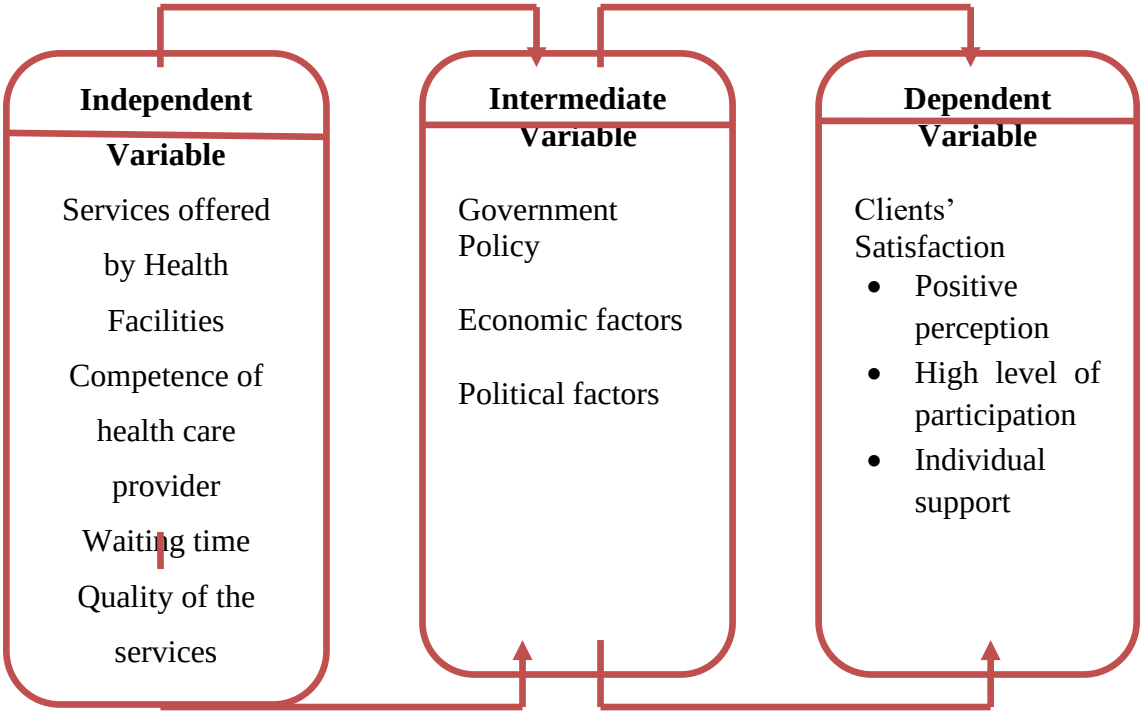
2.4 Conceptual Framework

The study assumes that, there are dependant, intermediate and independent variables. Also, the study assumes that, independent variable is services offered by health facilities. These services influence client satisfaction when offered with satisfactory quality.

Moreover, the study assumes that there are intermediate factors that influence clients' satisfaction. These involve government policy, economic and political factors. Furthermore, the study assumes dependent variable is derived from the research general objective. Therefore, the dependent variable is clients' satisfaction;

this is characterized by positive perception, high level of participation and individual support. These assumptions are summarized in Figure 2.1

Figure 2.1: Conceptual Framework



Source: Research Own Construct, 2014

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents methodology of the study. The first section of the chapter gives research design whereas area of the study is explained in section threeof the chapter. Section four of the chapter contains population of the study while sample size is elaborated in section five. The last section of the chapter gives the validity of data collection instrument.

3.2 Research Design

A case study deign was used,at NHIF offices located in Dar es Salaam, was selected as a case study. The case study design frequently makes use of qualitative data and place emphasis on a full contextual analysis of fewer events and conditions and their interrelations. This involve in depth contextual analysis of similar situations in the organizations, where the nature and definition of the problem happen to be the same as experienced in the current situation.

The main advantage of using a case study design is its ability to draw information from many different sources such as interviews, observations and documentary review including historical findings/data (Kothari, 2004). The use of case study facilitates the use multiple sources of evidence; and thus avoid the bias. A case study examines the problem by exploring the views of different sets of respondents, as well as by exploring different literatures related with the study.

3.3 Study Area

The study was conducted at Tanzania National Health Insurance Fund (NHIF) in Dar es Salaam. NHIF is a statutory health insurance scheme which is a compulsory for public servants. In fact, it was established in 1999 by a parliamentary Act No. 8 of 1999 (NHIF, 2013). The reasons for choosing NHIF, is due to fact that the scheme has sufficient number of health insurance professionals.

3.4 Population of the Study

According to Adam and Kamuzora, (2007), a population in research is the totality of the objects under investigation while a sample is a part of the population. Saunders *et al.,* (2007) suggests that population is the complete set of cases or group members while a sample are a subgroup or part of a larger population.

The targeted population included officials fromNHIF. The fund has a total of 529 staffs. Also, the population of the study involved clients who benefits from the fund accredited health facilities at Dar es Salaam. The study included both gender aged from 18 years and above.

3.5 Sample Size

A sample is a small group or subject of the population which a study selects from the purpose of the study and from which generalization is made about the characteristics of the population (Saunders *et al.,* 2005).

The researcher included about five (5) NHIF accredited health facilities of three from the government facilities and two (2) from private health facilities, where about 20clientswere taken in each health facility that gave a total of 100 clients. Also the study involved 20 staffs from NHIF headquarters.The researcher acquired the total of about 120 respondents as the sample size of the study. Equal number of respondents was taken so that to avoid bias and the sample size included all age and sex in the study. Therefore, a sample size contained 20 NHIF officials and 100 customers, as presented in Table 3.1

Table 3.1: Sample Distribution

Respondents	**Sample size**	**Percentage**
NHIF officials	20	16.7
NHIF clients	100	83.3
Total	**120**	**100.0**

Source: Researcher Own Construct, 2014

3.6 Sampling Procedures

Purposive sampling was used to NHIF officials to participate in the sample, this is because some officials were too busy during data collection.Also the researcher used purposive sampling to select different officials in order to get the intended information. Purposive sampling is a form of non probability sampling in which decisions concerned individuals to be included in a sample are taken by the researcher, based on the criteria which may include specialist knowledge. In selecting the sample officials of NHIF were interviewed together with clients who benefits from the NHIF accredited health facilities at Dar es Salaam.

3.7 Sources of Data

This study collected both primary and secondary data. In order the study to be reliable data, the study use primary and secondary data.

3.7.1 Primary Data

According to Kothari (2004) primary data are those which are collected fresh and for the first time and thus happen to be original in character. In collecting the primary data the study uses questionnaire and in-depth interview.

3.7.2 Secondary Data

According to Kombo and Tromp (2006), secondary data is collected through review of published data and information Articles, reports, journals, newspaper abstracting, theoretical reviews of the citation of other work. Secondary data were obtained from documentation available in libraries, study review of other authors in the same issues in the study.

Secondary data were collected through documentary analysis. Documentary review refers to the analysis of documents that contain information about the phenomenon we wish to study (Saunders and Thornhill, 2009). Documents are important in research because bridges the information obtained from data collected through the use of other research methods such as observations and interviews.

3.8 Data Collection Methods and Instruments

According to Krinshnaswami (1998), data collection is two way systematic conversations between the investigator and the respondent. Data in a simple meaning is information, statistics, facts, figures, numbers or records. Data are categorized into two types, primary and secondary.

3.8.1.1 Questionnaire

The questionnaire was designed in such a manner that helps to minimize open-ended questions so as to get well-structured responses. This approach helps in capturing information and subsequently analysis of the same. Self-administered questionnaires weredesigned.

3.8.1.2 In-depth Interview and Interview Questions

The study conducted an in-depth interview which involved some selected NHIF officials. The purpose of in-depth interview was to get additional information that could not be covered by the questionnaire. In order to acquire information relevant to the research problem; an interview was conducted with few respondents. Interview questions were used to facilitate interview. Closed and open ended questions were used during interview.

3.8.1.3 Document Review and Documentary Review Schedule

Document review consists of analyzing the contents of documentary materials such as company's policy, company performance reports and the contents of all other verbal materials, which can be either spoken or printed. Documentary review schedule was used in reviewing documents. This is a statement that indicates how documents were reviewed.

3.9 Data Processing and AnalysisProcedure

The collected datawere coded; a coding sheet assigning a number then were assigned to each answer in the questionnaire with a corresponding number on the coding sheet. The processeddata were aided by the use of Microsoft Excel. This is computer applicable software, and the software is preferred because of its consistency and

virtues of providing compatibility mode in problems analysis. Then the information that will be coded from the questionnaire, were transformed to the Ms-excel, which help in drawing diagram that helps in analysis and discussions of findings.

Being a qualitative analysis, the study use collected information to provide explanation and clarifications of information were appropriate by using quotation where necessary. Frequency tables, and graphs were worked out basing on the data entered into excel. The tables and graphs were used for presentation of findings.

3.10 Reliability and Validity of Research Instruments

Reliability is the ability of research instruments to consistently yield the same results when repeated measurements are taken under the same conditions (Kothari, 2004). The questionnaire was pre-tested through pilot study to ascertain reliability of instrument in collecting required information for the study. Reliability of the data collection instrument was established through test re-test method.

Validity refers to the degree of success of an instrument in measuring what it is set out to measure so that differences in individual scores can be taken as representing true references in the characteristics under study, also noted that validity is the extend to which instruments capture what they purport to measure (Kothari, 2004). The content validity was used in determining the validity of the instruments.

CHAPER FOUR

PRESENTATION AND DISCUSSION OF RESEARCH FINDINGS

4.1 Introduction

This chapter provides presentation and discussion of the findings. The first section of the chapter gives background characteristics in terms of age gender and level of education. Second section of the chapter gives NHIF clients' perception on NHIF services whereas services offered by NHIF are discussed in section three. Section four presents problems faced by NHIF when providing services while problem faced by clients when seeking services provided by NHIF are explained in section five. The last section of the chapter put down the extent the problems have been faced by NHIF and clients. This chapter analyzes, interpret and present data based on the stated research objectives, the chapter discuses findings through statistical analysis.

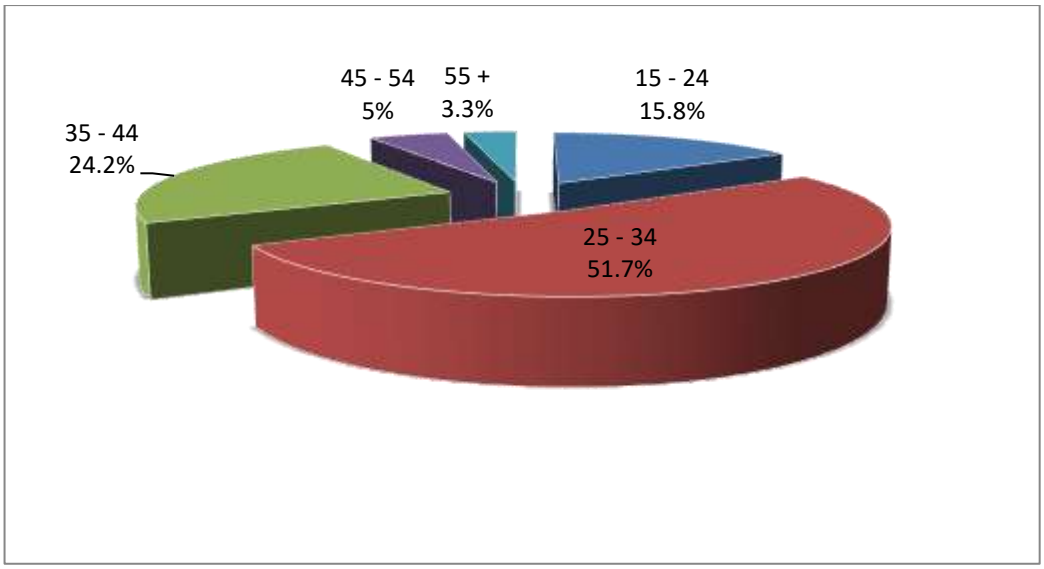
4.2 Characteristics of the Respondents

This section presents background characteristics of the respondents; it presents respondents variability in their profiles based on questions asked. This section intended to explore respondents' composition in terms of age gender and level of education.

4.2.1 Respondents Distribution by Age

The study found age of the respondents contains more or less balanced composition of all age groups as illustrated in Figure 4.1. Its found majority of the respondents (51.7%) were aged between 25 to 34 years. The results also show that only a tiny portion(15.8%) was between 15 to 24 years old. Generally minority (48.33%) of the respondents were in age group (15-24), (35-44), 45 to 54 years old and over 55 years.

Figure 4.1: Age Distribution of the Respondents



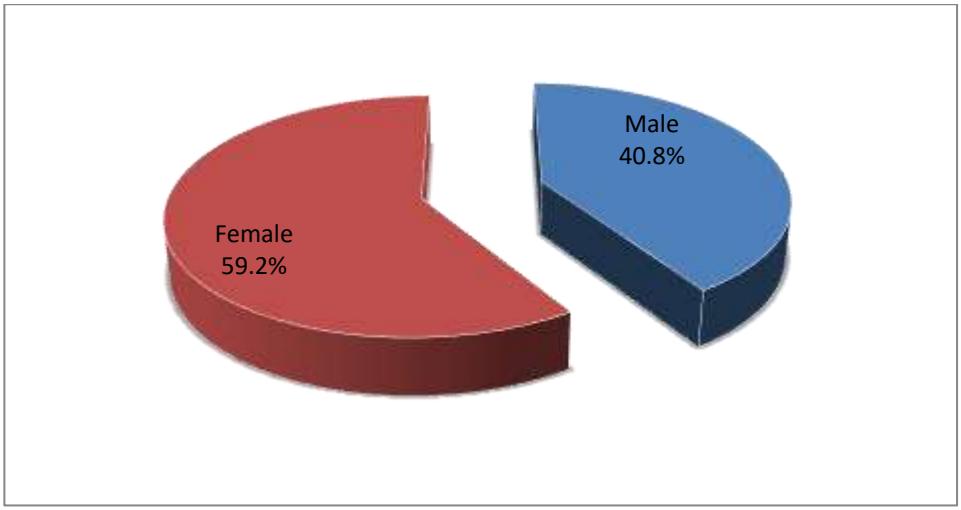
Source: Field Data, 2014

Figure 4.1 illustrate age distribution of the respondents. The study found out of 120 respondents, 62 (51.7%) were aged between 25-34 years. This indicates respondents were capable to participate in the study.

4.2.2 Respondents Distribution by Gender

The study examines gender of the respondents. The study contacted both males and females, it was found by both male and female as the percentage composition was slightly equal. The study found out of 120 respondents, (59.2%) were females whereas minorities of the respondents (40.8%) were males. Figure 4.2 illustrate gender distribution of the respondents.

Figure 4.2: Gender Mix of the Respondents



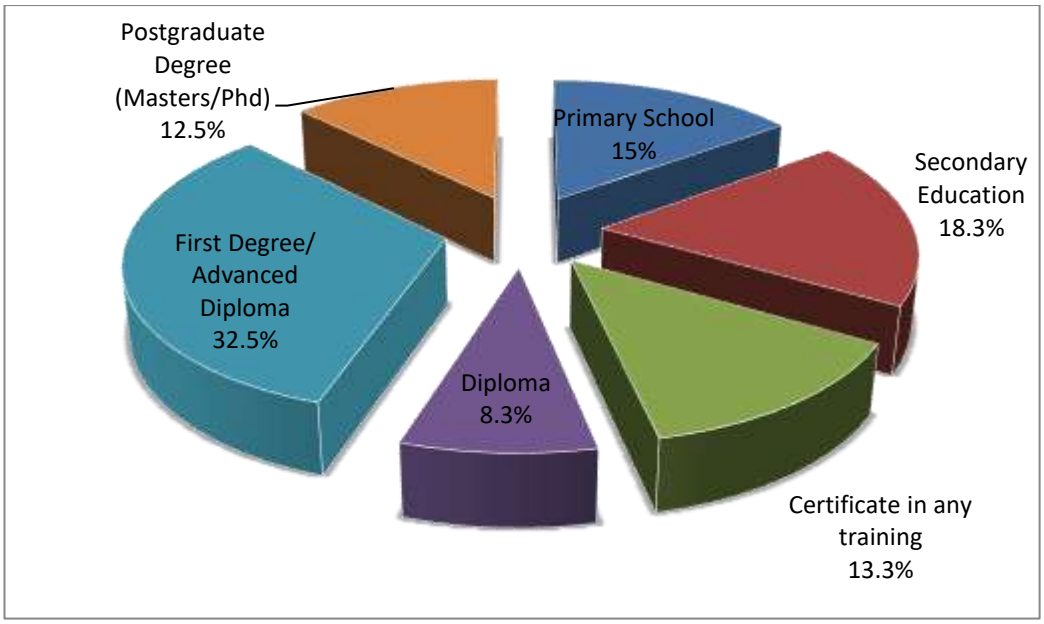
Source: Field Data, 2014

Figure 4.2 shows gender mix of the respondents. It can be observed vividly that, majority of the respondents (59.2%) were females.

4.2.3 Respondents Distribution by Level of Education

The study examines level of education of the respondents. The study found majority of the respondents (66.6%) had tertiary level of education this include diploma, first degree/advanced diploma, postgraduate diploma and masters. Also, the study found out of 120 respondents, 18(15%) had primary education whereas (18.3%) of the respondents had secondary education. Figure 4.3 presents respondents distribution by level of education. It's observed that, the large portion of the respondents (32.5%) identified had first degree/advanced diploma.

Figure 4.3: Level of Education Attained by Respondents



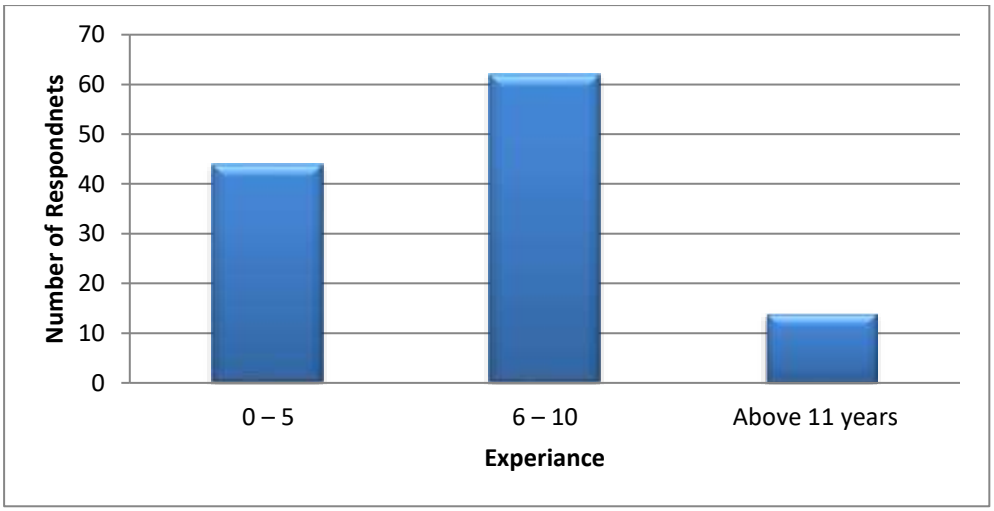
Source: Field Data, 2014

Figure 4.3 illustrate the highest level of education attained by respondents. The study found the large number of the respondents had first degree/advanced diploma. Also, significant number of the respondents (18.3%) and (15%) had secondary and primary education respectively.

4.2.4 Types of Experiences

The study intended to get overview of the respondents' experience in time as members to the fund (NHIF). Respondents were asked for how long they become a part of NHIF. The findings shows that majority of the respondents (51.6%) have the experience of 6 to 10 years. This implies that majority of the respondents have sufficient experience to participate for the study. Also, the study found out of 120 respondents, 44 (36.7%) have the experience of 0 to 5 years, as presented in Figure 4.4

Figure 4.4: Experience



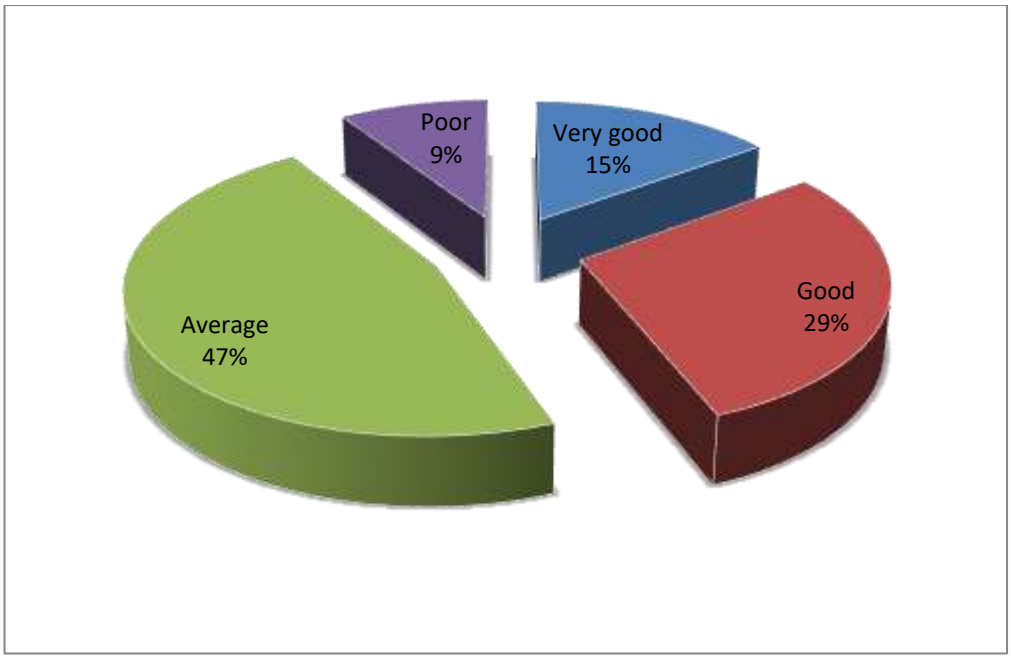
Source: Field Data, 2014

Figure 4.4 shows experience of the respondents. The large number of the respondents (51.6%) has the experience of 6 to 10 years.

4.3 NHIF Clients' Perception on NHIF Services

Respondents were asked to identify their perception of services offered by NHIF. Respondents when responding to questionnaires showed their perception on services offered by NHIF. The study found small number of the respondents (9.2%) perceived NHIF services offer poor services. This implies that, despite NHIF tries to improve its health care services some of the clients were not satisfied with services provided by NHIF. Also, the study found significant number of respondents (29.2%) and (46.6%) identified good services and average respectively. This indicates majority of the respondents were satisfied with the services offered by the scheme. Table 4.5 presents clients' perception on services offered through accreditation by NHIF

Figure 4.5: Clients' Perceptionon NHIF Services



Source: Field Data, 2014

Responses presented in Table 4.5 revealed that respondents were satisfied with the services provided by the scheme. This is similar to responses obtained during interview, one of the interviewed clients revealed that

> *"Although we face some challenges in services offered by NHIF, we are satisfied with services, but a major step should be taken to ensure drugs and medical equipments are available when needed by clients"*

This indicates NHIF provide good services, the large number of the respondents have good perception concerning the services provided by NHIF. The findings of this study is slightly contrary to the one conducted by Carrin, (2003), the study reported that availability of drugs and medical equipment supplies are significantly related to clients satisfactions, most of the patients that were treated and not prescribed with any drug were not satisfied.

The study found important number of the respondents (29.2%) suggested NHIF provide good services. this is similar to the study made by Owusu, (2010), the study

found NHIF offer good services despite of shortage of drugs and medical equipments reported by some of the respondents. This is similar to responses obtained during interview. One respondent stated that:

> *"In fact NHIF offer good services. Although I am not satisfied with availability of drugs in government health facilities this is not a new experience in government facilities due to lack of responsibility and accountability of management"*

4.5 Problems faced by NHIF when Providing Services

The study examines problems faced by NHIF when providing services. The study found majority of the respondents (95.8%) were aware of the existence of problems facing NHIF. This is similar to the study made by Chee*et al.*, (2002) the study found in developing countries social health insurance schemes face a series of problems. These challenges are; political interference, lack of proper health policy, corruption, and lack of experts.

Moreover, the study examines major problems facing NHIF when providing services to customers. Respondents were asked to identify major problems facing NHIF when providing services. The study found majority of the respondents identified social health insurance scheme are facing fraud, as presented in Table 4.1

Table 4.1: Major Problems faced by NHIF

Option	Frequency	Percentage (%)
Low awareness	19	16.5
Forgery/fraud	67	58.3
Low compliance	29	25.2
Total	**115**	**100.0**

Source: Field Data, 2014

Table 4.1presents major problems facing social health insurance scheme. The study found small number of the respondents (16.5%) identified low awareness as a major

problem facing NHIF, low awareness of NHIF clients to services offered to them, most clients don't know about the fund, their rights when attended in the accredited facilities, benefits offered by NHIF. Also, the study found the large number of the respondents (58.3%) and (25.2%) suggest fraud and low compliance respectively. This is slightly contrary to the study made by Gobah, (2011) the study found the major problem facing social health insurance schemes is fraud. Fraud has been the biggest challenge that NHIF faces, fraud in terms of fault claims from accredited facilities also fraud from members that have tendencies to duplicate NHIF membership card s or give their membership cards to relatives and friends that are not listed as members to NHIF.

4.6 Problems faced by Clients when Seeking Services

The study found examines problems faced by clients when seeking services. Respondents were asked to identify problems faced by clients when seeking services. The study found there are different problems facing NHIF clients. It's observed that out of 120 respondents, 49 (40.8%) identified shortage of medicine is a major problem facing NHIF clients, as presented in Table 4.2

Table 4.2: Problems faced by Clients

Option	Frequency	Percentage (%)
Queuing	29	24.2
Bureaucracy	7	5.8
Poor services	10	8.3
Shortage of medicine	49	40.8
Poor customer care	25	20.8
Total	**120**	**100.0**

Source: Field Data, 2014

From Table 4.2 it's evident that, NHIF clients face different problems when seeking health services. this is similar to the study made by Mundi, (2011), the study found NHIF clients have complained on the process in the provision of health services from NHIF accredited health facilities that it has long process, also funds claim forms that

takes more time to be filled and sometimes the health providers concentrate on filling them instead of listening to patients.

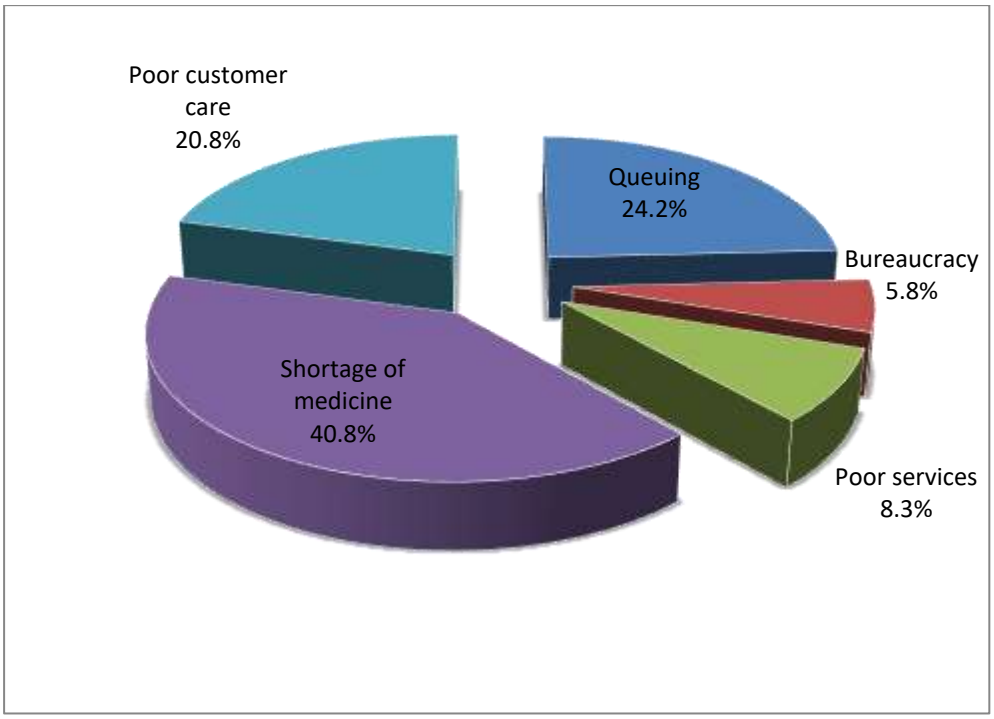
Karinga,(2010) found clients face problems of X-rays and ultra sound because of technical problems of the equipment and they are required to seek for other alternatives like to find the health facility that provide such services and sometimes they have to pay for it.NHIF claims form required a lot to be filled by the health providers which as the result become boring to its clients, sometimes the health providers concentrate on filling them to avoid mistake due to the fact that if they appear they are going to be deducted during payments.

Queuing also is among problems that face clients when seeking services from accredited facilities, queuing is brought about having few medical staffs and also few hospitals, people have to line up and wait for services.

Shortage of medicine has been a major challenge to clients when seeking services from accredited facilities,NHIF A s health fund provides generic medicine to its clients, so when there is shortage of generic type of medicine, doctors prescribes patients with alternative medicine which are brand names medicines to which customers have to pay from their own pockets.

The study found small number of the respondents (5.8%) and (8.3%) identified bureaucracy and poor services respectively. Significant number of respondents (20.8%) identified poor customer services, as illustrated in Figure 4.6

Figure 4.6: Problems faced by Clients



Source: Field Data, 2014

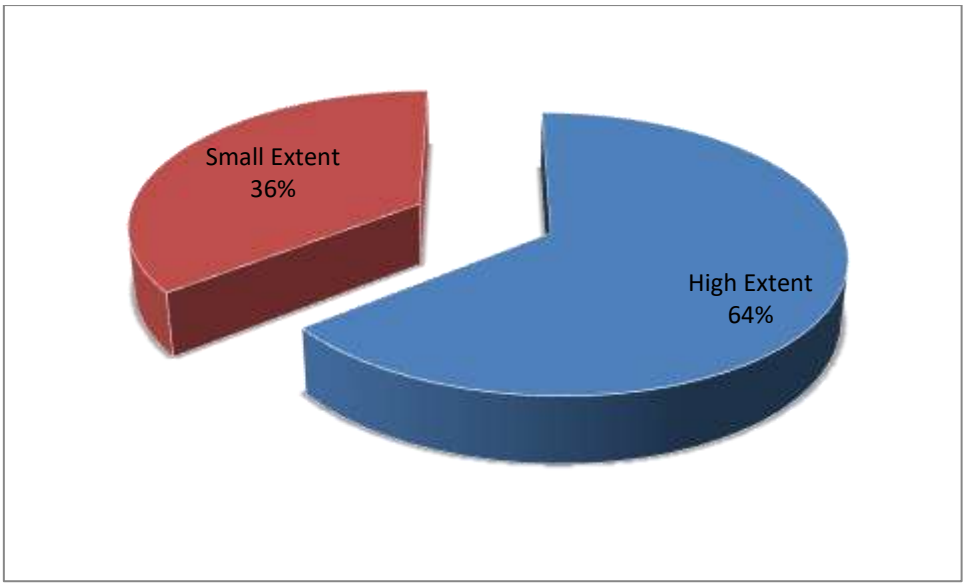
Figure 4.6 illustrates problem faced by clients when seeking servicers. Its found NHIF clients are facing a range of challenges when seeking health services. The major challenge facing clients is shortage of medicine

4.7 The Extent of Problems Faced by NHIF and Clients

The study investigates the respondents were aware of the extents problems faced by NHIF and clients. Respondents were asked to identify if they are aware of the extents the problems faced by NHIF and clients. Its found majority of the respondents were aware.

Respondents were asked to identify the extent of problems have been faced by NHIF and clients. The study found majority of the respondents (64%) identified the problem face clients and NHIF for large extent, as presented in Figure 4.7

Figure 4.7: The Extent the Problems Have Been Faced



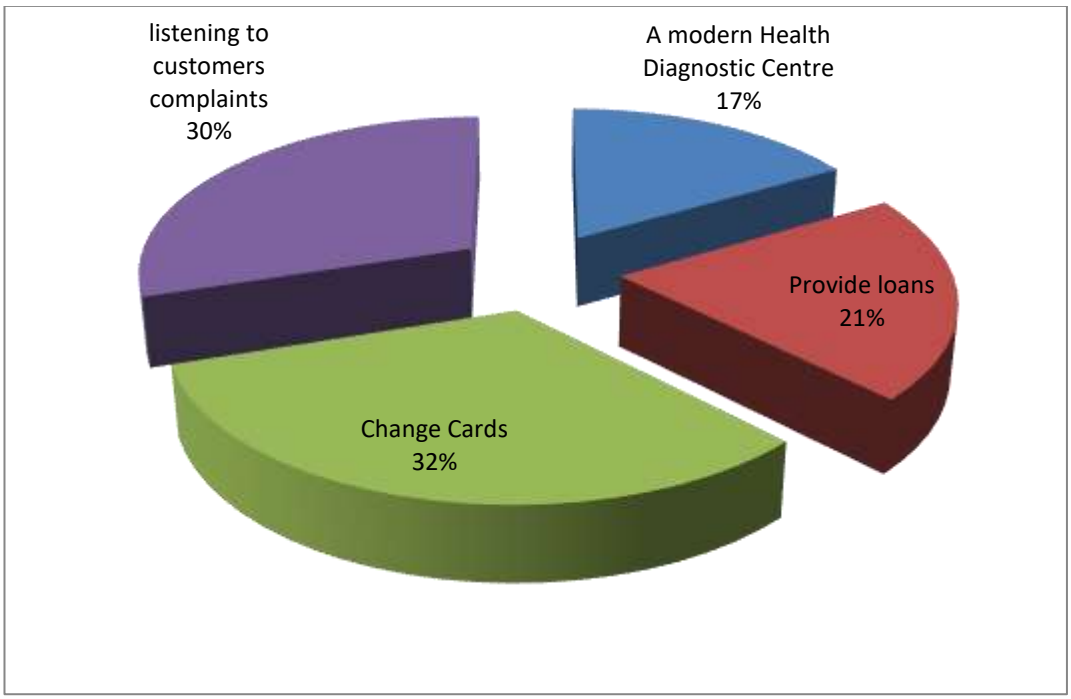
Source: Field Data, 2014

From Figure 4.7 it's observed that, for high extent problems are facing NHIF and clients. This study is related to the study done by (Gobah, 2011), which found the clients of health insurance schemes face the problem of lack of health personnel for high extents. Lack of health personnel at health facilities had negative impact on client's perceptions on quality of health care because of untrained health providers were delivering services which in most cases were poorly handled. Availability of adequate number of health personnel is very important in the provision of quality services because they are the one who are responsible for the treatment, if they are few in number they will be overloaded and exhausted due to many patients that may result to poor service provision that positively contribute to patients dissatisfaction.

Moreover, the study examines extent the problems have been solved. Respondents were asked to identify the extent the problem have been solved. The study found majority of the respondents (67.4%) identified the problem have been solved for large extent. Also, the study found significant number of respondents (32%)

identified the scheme plan to change cards, this help in controlling fault claims and misuse of the cards by members, Figure 4.8 presents initiatives taken by management of the fund to overcome problems.

Figure 4.8: Initiatives taken to solve the Problems



Source: Field Data, 2014

Figure 4.8 presets initiatives taken to solve the problems. The study found the large number of the respondents (32%) identified the scheme plan to change cards. The study found NHIF plan to change cards from simple cards that are current being used to smart cards which will help in controlling fault claims from accredited facilities and misuse of membershipcards by members.

Listening to customers complaints has been continuously strategy to NHIF through this strategy its easy for the fund to be aware of problems that are facing customers and know how to eradicate them,the study found (30%) of respondents suggested that NHIF do listen to customers.

Moreover, the study found (17%) of respondents suggest that the fund is constructing a modern health diagnostic center at the University of Dodoma (UDOM).

Finally, the study found NHIF as a fund provides loans to accredited health facilities that can help to purchase medical equipments and to take on necessaryreconstruction or upgradingprojects that will help to offer better medical services to its clients, these loans commenced to be offered in2007/08, the medical equipment and facility improvement loan program is an intentionally efforts by NHIF to improve delivering of health service in the country.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter providessummary, conclusion and recommendations of the study. The first section of the chapter provides summary of the study. Section two of the chapter gives conclusion while recommendations of the study are discussed in section three. The last section of the chapter gives areas for further studies.

5.2 Summary of the Study

Generally, the intended to investigate clients' satisfaction on services offered by accredited health facilities. Specifically, the study aimed; to determine NHIF clients' perception on NHIF services; to analyze problems faced by NHIF when providing services to customers; to analyze problem faced by clients when seeking services provided by NHIF and to assess the extent the problems have been faced by NHIF and clients.

A case study design was used whereas a sample of 120 was involved. In collecting primary data the study used questionnaire and in-depth interview. Secondary data were collected through documentary analysis. Data were analyses by using Microsoft Excel, tables and figures were used to present data.

It was revealed from the study that, NHIF clients' were satisfied by services provided by the fund. The study found majority of the respondents (95.8%) were aware of the existence of problems facing NHIF. Also, the study found there are different problems facing NHIF clients. It's observed that out of 120 respondents, 49 (40.8%) identified shortage of medicine is a major problem facing NHIF clients. Moreover, the study found majority of the respondents (64%) identified the problem face clients and NHIF for large extent

The study concluded that NHIF members are satisfied with the services offered by the scheme despite members not being satisfied by availability of drugs/medical equipments and health care providers' attitudes. Furthermore, it's concluded that, the major problem for NHIF clients involves; queuing, bureaucracy, poor services, shortage of medicine and poor customer care. Finally, the study concluded that, to high extent NHIF and clients are faced with problems. The study recommended that strategic strength on the provision of education about the fund, on its objectives and benefit package offered during regular supervision to clients and service providers.

5.3Conclusion

Based on the objectives of the study, it's concluded that NHIF members are satisfied with the services offered by the scheme despite members not being satisfied by availability of drugs/medical equipments and health care providers' attitudes. Moreover, the study concluded that, NHIF faced different problems; these include low awareness, forgery/fraud and low compliance. Furthermore, it's concluded that, the major problem for NHIF clients involves; queuing, bureaucracy, poor services, shortage of medicine and poor customer care. Finally, the study concluded that, to high extent NHIF and clients are facing problems.

It is concluded that NHIF has tried to improve health services delivery to its clients though there are some problems such as inadequate availability of drugs and medical supplies as well as lack of qualified staff especially in government health facilities that need to be solved.NHIF have improved the provision of curative services in its accredited health facilities to provide education on the benefit packages offered by them to clients and also to motivate accredited facilities to take loan so that they can offer better health services to NHIF clients.

5.4 Recommendations

Based on the findings of the study, the following recommendations were made:

There should be improvement in its system of reimbursing the money to service providers either by making the process computerized and decentralizing its power of

authority to zonal offices, this should be the collaborated to all stakeholders so as to improve the of the quality of health services provided.

Strategic strength on the provision of education about the fund, on its objectives and benefit package offered during regular supervision to clients and service providers.

All stake holders should facilitate the involvement of clients in decision making so that they can contribute to matters they are concerned, this will help to maintain the provision of quality health services particularly curative services.

The fund should have at least one qualityassurance co-coordinator from each district hospital that will be responsible on making sure that all accredited health facilities in district provide quality services to its clients as indicated by funds plan.

Inspections and evaluation of accredited health facilities should be done regularly so to remind the health care providers on the health services required to be provided to the clients.

The scheme should provide education to people concerning social security matters in regards to its benefit provided and how the scheme act as poverty eradication the schemes in its operation should match with science and technology which facilitates effectiveness and better performance especially in providing adequate health services to its clients.
The find should look into ways to eradicate constraints of shortage of medicine, the fund should provide both generic and brand names medicine so when generic medicine are not available it will be easy for clients to switch to alternative medicines (brand names medicine).

Also social protection experts in the existing social securities industry are very important in the extension of social protection particularly curative health services to its members.

In the long run the fund must plan to invest building its own capacity by owing its own hospital in each region that will encompass laboratories for diagnostics test and pharmacies for its beneficiaries. Public owned health personnel are rigid to change that do not bear their interest, thus acting as stumbling blocks health service provision under the fund. Bureaucracy and corruption are quite common challenges facing service providers in most public health facilities. The private sector is after making profit therefore every private hospital health provider will ensure health services are of best quality since there are in competitive market which improve the quality and increase the choice to beneficiaries.

Ministry of health and the fund management now should consider motivation and attractive atmosphere for the private sectors to invest more in heath service and enter into contract to provide services for the fund beneficiaries, more involvement of private sector will make the health services more competitive and lead to improve the quality of services provided.

Training health facilities staff on the scheme through seminars, workshops and provide the government health facilities with training manual on how insurance is operated and introduce special section to government hospital who will deal with medical schemes only. This will improve the awareness of medical insurance.

6.5 Areas for Further Studies

Future studies should try to examine measures that can be used to overcome fraud from health care providers and clients. Also, there is a need to identify strategies that can be used to overcome problems faced by NHIF when providing services. The impeding studies should differentiate the level of clients' satisfaction from private health care providers and public health care providers.It would particularly be interesting to study the behavior of providers in the private sector since they are profit-oriented. Further research should also be carried out to determine if non-medical costs in terms of transportation, meals, affect health seeking among the population, apart from removing payments at the point of service use.

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APPENDICES

Appendix I: Questionnaire

My name isEvaristaMkwizu, a Masters Student from Mzumbe University**.** I am conducting a research on **Clients Satisfaction on Services Offered by Accredited Health Facilities.** Your participation on answering this questionnaire could make this research be effective and complete. Therefore I am kindly requesting your attention to read and answer the question below to the best of your knowledge and ability.

General Instruction: Please encircle the correct answer and fill the blanks.

Part A:Demographic characteristics

1. What is your age?
    a.) 15 - 24
    b.) 25 - 34
    c.) 35 – 44
    d.) Older Than 44
2. Gender
    a.) Male
    b.) Female

3. What is your level of education?
    a.) Primary school
    b.) Secondary education
    c.) Certificate in any training
    d.) Diploma
    e.) First Degree/ advanced Diploma
    f.) Postgraduate Degree (Masters/Phd)
4. How long have you been a member of NHIF?
    a.) 0 – 5
    b.) 6 – 10

c.) Above 11 years

Part B: Clients' Perceiveon NHIF Services

1. How do you perceive NHIF services?

a) Very good

b) Good

c) Average

d) Poor

2. How long do you wait to receive curative services in health facilities accredited by NHIF?

a.) Immediately

b.) Less than 30 minutes

c.) More than 30 minutes

3. What should be done to improve services provided by NHIF?

a.) Improve ethics in service provision

b.) Transparency

c.) Responsiveness

4. Apart from the above, identify other initiatives that can improve services provided by NHIF? Please mention

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PART C: NHIF Services'

1. What are the services offered by NHIF?

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2. Mention medical services offered by NHIF to its members

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3. What are the excluded medical services to NHIF members?

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PART D: Problems faced by NHIF

1. Do you think NHIF face anyproblems when providing services to its members?

a) Yes
b) No

2. If yes, what are the problems faced by NHIF when providing services to its members?

a) Low awareness
b) Forgery
c) Low compliance
d) All of the above

3. Apart from the above, identify other problems faced by NHIF when providing services. Please mention

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PART E: Problems faced by Clients

1. What are the problems faced by clients when seeking services provided by NHIF?

a) Queuing
b) Bureaucracy
c) Poor services
d) All of the above

2. What are other problems faced by clients when seeking services provided by NHIF? Please mention

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3. What should be done to overcome the above problems?

a) Increase number of health facilities
b) Provide Training to officials
c) Improve monitoring

4. Identify other initiatives that should be done to overcome problems faced by NHIF clients'. Please mention

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Part F: The Extent

1. Do you understand the extent the problems have been faced by NHIF and clients?

a.) Yes

b.) No

2. If yes, to what extent the problems have been faced by NHIF and clients? Please explain

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Appendix II: Interview Guide

1. How do you perceive NHIF services?

2. What are the services offered by NHIF?

3. What are the problems faced by NHIF when providing services?

4. What are the problems faced by clients when seeking services provided by NHIF?

5. To what extent the problems have been faced by NHIF and clients?

6. To what extent the problems have been solved?