THE EFFICIENCY OF NATIONAL HEALTH INSURANCE FUND IN HEALTH PROVISION TO THE BENEFICIARIES THE CASE STUDY OF MOROGORO MUNICIPALITY

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By

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A Thesis submitted to the school of Public Administration and Management of the Mzumbe University in Partial Fulfillment of the Requirements for Award of the Master of Public Administration (MPA) of Mzumbe University

JULY 2013

CERTIFICATION

We, the undersigned, certify that we have read and hereby recommend for acceptance by the Mzumbe University, a dissertation/thesis entitled The Efficiency of National Health Insurance Fund in Health Provision to the Beneficiaries- The case study of Morogoro Municipality, in partial/fulfilment of the requirement for award of the degree of Master of Public Administration of Mzumbe University.

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Internal Supervisor

Accepted for the Board of school of Public Administration and Management

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Chairperson, School Board

DECLARATION AND COPYRIGHT

I, **Sibilina Joseph Msaki,** declare that this thesis is my own original work and that has not been presented and will not be presented to any other university for a similar or any other degree award.

Signature _____

Date _____

ACKNOWLEDGEMENTS

Primarily, I wish to acknowledge and propel a word of thanks to Almighty Lord for his mercy that had fostered my existence in sound mind and good health during the entire period set for field work.

The work has been possible with the support of individual and groups of people whom I would like to extend my appreciation.

First and foremost I would like to thank the Management of NHIF in Morogoro Municipality, clinical providers and all NHIF members for the support and cooperation that they rendered to me during my study period.

Secondly, I wish to thank the University of Mzumbe and the school of Public Administration and Management for making it possible for me to accomplish this study.

Thirdly, special thanks go to Major Supervisor Mr. Venance Shillingi for his dedication and tireless encouragement throughout the preparation of this report. I have gained immensely from his rich experience in research and constructive criticism that have resulted to this report.

Fourthly, I would like to extend my heartfelt appreciation to my brother Richard Msaki for his motivation into my decision for further studies and the family for encouragement and support during my study period.

I also would like to thank my fellow colleagues in the MPA 2011-2012 for their cooperation and support throughout my studies. Lastly, there are many other who have not mentioned, but their contribution cannot be neglected; together I say thank you.

DEDICATION

To all the people who have supported Women in attaining their education.

LIST OF ABBREVIATIONS

CCSS	Costa Rica Social Security System *(Caja Costarricense de Seguro Social)*
EHIF	Estonian Health Insurance Fund
FONASA	National Health Insurance Fund *(Fondo Nacional de Salud)*
GDP	Gross Domestic Product
GES	Explicit Health Guarantees (*garantías explícitas de salud*)
GP	General Practitioner
GTZ	Deutsche Gesellschaft fürTechnische Zusammenarbeit
HSR	Health Sector Reforms
HMO	Health Management Organization
ILO	International Labour Organization
ISAPREs	Health Insurance Funds (*instituciones de salud previsional*)
ISSA	International Social Security Association
MHI	Mandatory Health Insurance
MOHSW	Tanzania Ministry of Health and Social Welfare
NGO	None Governmental Organization
NHIF	Tanzania National Health Insurance Scheme
NHIS	National Health Insurance Scheme
NHIC	National Health Insurance Council
OECD	Organization for Economic Co-operation and Development
SHI	Statutory Health Insurance
SIS	Superintendancy of Health *(Superintendencia de Salud)*
VHI	Voluntary Health Insurance
WHO	World Health Organization

ABSTRACT

The study investigates the efficiency of National Health Insurance Fund in health provision to the beneficiaries a case in Morogoro Municipality and 242 respondents participated in the study.

The overall purpose of the study is to enhance efficiency in the provision of health services to the beneficiaries at all levels from dispensary to referral hospital. The study intended to answer the following questions; what are the operations of the NHIF in implementing its policies and terms, what are the operations of the accredited health facilities in implementing the NHIF policies and terms, what is the essence of the members' complaints, what are the existing mechanisms of flow of information to and fro between the members and the Fund, to what extent do the members have knowledge on their entitlements from the scheme and what extent knowledge on entitlements of the members do the primary service/care givers at the hospitals, pharmacies and NHIF offices have. The case study research design was employed during the study and research methods used included interviews, questionnaires, survey and documentary review schedules. The Statistical Package for Social Sciences (SPSS) was used to analyze data. By using descriptive analysis with simple quantitative technique the findings revealed that the operations of the NHIF in implementing its policies and terms. Accredited of health facilities and flow of information to and fro between members and fund are well planned. Also the findings indicated that both NHIF members and their entitlements have the knowledge about the rights and benefits package provided by the Fund. The findings showed that NHIF faces the following challenges in providing health services: late of payments from the fund to care providers ,lack of education to members, category of some services, low quality of services, poor communication, and improper facility inspection and supervision.

It is recommended that NHIF should be sensitive to provide education to the beneficiaries and care providers which are the major obstacle to majority.

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CHAPTER ONE

INTRODUCTION

1.0 Introduction

The chapter gives about the background of the study, statement of the problem, research objectives, significance of the study as well as scope and limitation of the study.

1.1 Background of the Study

The Health Insurance is increasingly given attention both, it's overall financing aspect and its contribution towards universal coverage and promoting health services delivery. In Tanzania during 1990's faced with severe economic crisis which forced government to reduce expenditure in social services including health services .Its impacts was deterioration of both quality and quantity of medical services and poorly motivated medical staff. This made the government formed health insurance schemes.

The National Health Insurance Fund (NHIF) is a statutory health insurance scheme which was established by Parliamentary Act No.8 of 1999 Chapter 395 of 2002 in order to facilitate access to health services by the principal members and their dependants.

It is the outcome of a 1990-1992 study on the long-term options for financing health services in Tanzania. The scheme commenced its operations on 1st July 2001 by members (employees) and their respective government employer starting to contribute. The principles applied in establishing the NHIF were: Strengthening cost sharing in government health facilities by providing an opportunity for formal sector employees to contribute; Providing health insurance to employees in the formal sector especially after the introduction of user-fees; Allowing free choice of

providers to civil servants who were previously restricted to government health facilities; Enhancing health equity among employees in the health sector; and Providing an environment for the growth and participation of the private sector(NHIF,2005).

NHIF is an autonomous institution. Its main objectives are to administer the scheme, and to formulate and promulgate policies for sound administration of the scheme. Its management and administration is vested on the Board. There is also the Director General who is appointed by the Board. Below the Director General are the Directors and other officers (NHIF Act, 1999).

The Board is the sole authority of the Fund to grant accreditation to health care provider. The accredited health care provider is obliged to take part in programmes of quality assurance utilization review and technology assessment to ensure that: the quality of health care services is delivered in accordance with the standards specified by the Ministry Health from time to time; and acquisition and use of scarce and expensive medical technology and equipment are in consonance with the actual needs and standards of the medical practice and that the performance of medical procedure and administration of drugs are appropriate and consistent with accepted standards of medical practice and ethics and are respectful of the Tanzania Standard Guidelines for Treatment(NHIF Act, 1999).

The Fund enters a contract with each health care provider to ensure that there are monitoring mechanisms to safeguard against: over-utilization of health care services; under-utilization of health care services; unnecessary diagnostic and therapeutic procedures and intervention; irrational medication and prescription; and inappropriate referral practices.

Nevertheless, up to now, the Fund has gone through three phases in the accreditation process. In the first phase, all public health facilities were automatically accredited through Government circular of September 18, 2001. This accreditation considered

the fact that Tanzania is one of the countries with the best health service networks in Sub-Saharan Africa. Members were frustrated when they could not obtain prescribed medicines, which should have been covered in the benefits package because of stock-outs in public facilities. In an effort to alleviate that problem of out of stock drug, the Fund entered in the second phase of accreditation. The second phase involved the Faith Based and NGO health facilities where the problem of out of stock rate is low. A total of 519health facilities were accredited in this phase. The third phase involved the private for-profit health facilities. This phase is implemented as part of the strategy to minimize problems of drug shortages, and the government emphasis to strengthen public-private partnership in service delivery. Pharmacies have also been accredited in all regions (NHIF, 2005).

The membership terms as per the Act, require employers and employees in the public sector to register themselves and contribute to the Fund a total of six percent, whereby three percent comes from the employee's gross salary and the other three percent from the employer on the base of that employee's gross salary. The Act provides for a penalty of 5% to the Employer who delays in remitting contribution to the Fund.

However, extension of membership coverage has been made possible through the amendments of the NHIF Act, which extended the coverage to include all public servants instead of the previous Central Government employees. The following groups were taken on board namely public servants, councillors, and members of the Police force, Prisons, Immigrations, Fire and Rescue as well as other groups of persons. As the scope of membership and beneficiaries increases, the Scheme is expected to ultimately assume its national role as the major social health insurance provider in the country. The statistics shows that, beneficiaries have been increasing gradually from 1,830,375 in June 2009 to 1,971,251 as of 30th June 2010, equivalent to an increase of 7.7% http;//*www.nhif.go.ke/.* Thus, the Fund is obliged to provide for its members the benefits package comprising of Registration and Consultation

Fees, Outpatient Services, Medicines, Diagnostic Tests, Inpatient Services, Surgical Services, Physiotherapy and Optical Services. These services are provided to beneficiaries through the Fund's accredited health facilities which include Government, Faith Based and Private facilities that are located throughout the country. The Fund covers for the members, their spouses and up to four children or dependants (NHIF Act, 1999).

The scheme is compulsory, and it covers all public sector employees. However on the first two years of operations the Fund covered only Central Government employees. The membership base was extended to cover all public servants in 2002 in a move to widen coverage until all formal sector employees are covered. The membership includes principal members their spouses and up to four children or legal dependants. Where both a couple (man and woman) both workers in the public service have equal rights to register four different children or dependants. The scheme has no option for opting out. The Minister of Health has been empowered under existing legislation to determine any other category of workers to become members of the scheme with a view of enhancing the Fund's members.

The NHIF Act section 30 (j) empowers the Board of Directors to review and make some improvements to the benefit package, including are view of the rates used to reimburse the health care providers. Currently the benefits package includes: Registration fees fixed per visit per level of health facility; Basic diagnostic tests; Outpatient services which include payment of examinations and all drugs prescribed for its beneficiaries in both private and public hospitals provided that the hospitals or health facilities are accredited by the Fund. The drugs prescribed should be from the list of essential drugs. The prescriptions should be generic where available; In-patient services include accommodation, medication, examinations, investigations and surgeries which range from minor to super specialized surgeries.

Under section 15 (1) of the NHIF Act, the Fund is obliged to issue an identity card to every registered member. However, in order for the identity card to be issued, members are required to properly fill NHIF registration forms and pass them to the employers for certification before being sent to the Fund offices. Likewise the Fund is required to produce identity cards and distribute them to employers so that they can be handled over to members. The Fund devised a special NHIF "sick sheet" to be used with the employers' identity cards whenever members' require accessing services from the accredited health facilities in absence of the NHIF identity card.

1.2 Statement of the problem

The National Health Insurance Fund/Scheme is well organized in terms of providing services to its members. The scheme has various levels of authority to make decisions on various issues pertaining to the fund and services. Yet, the Fund in every month of the year receives the contributions or premiums from the member employees and the employers. The health facilities served by the fund are abundantly spread throughout the country. The facilities are in diverse ownership as some are owned by government and others privately by NGOs and individual persons. The Scheme purposely enrolled by accrediting the private health facilities so as to increase the ease reach to the services by its members as well as giving them assurance of getting even the services which are not available in the government hospitals. Despite the fact that, the Fund strives to expand its services in every corner in Tanzania, still the members of the Scheme raise claims of not getting some services from the health facilities though listed in the benefits package. From this point of view, requiring answers as to why the members claim lacking some important health services contrary to the terms of Fund membership, this study wants diagnose the governance efficiency of the Scheme so as later to fix out the faucets leading to members' complaints.

1.3 Research Objectives

1.3.1 Main Objective

i. To diagnose the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries.

1.3.2 Specific Objectives

i. To find out the operations of the NHIF in implementing its policies and terms.
ii. To assess the operations of the accredited health facilities in implementing policies and terms.
iii. To examine the essence of the members complains
iv. To determine the existing mechanism of flow of information to and fro between the members and the Fund.
v. To determine the extent of members knowledge on their entitlements from the Scheme
vi. To investigate the extent of knowledge on entitlements of the members do the primary service/care givers at the hospitals, pharmacies, and NHIF offices have.

1.4 Research Questions

1.4.1 General Question

i. To what extent is the National Health Insurance Fund governance efficient?

1.4.2 Specific Questions

i. What are the operations of the NHIF in implementing its policies and terms?
ii. What are the operations of the accredited health facilities in implementing the NHIF policies and terms?
iii. What is the essence of the members' complaints?

iv. What are the existing mechanisms of flow of information to and fro between the members and the Fund?

v. To what extent do the members have knowledge on their entitlements from the Scheme?

vi. What extent of knowledge on entitlements of the members do the primary service/care givers at the hospitals, pharmacies, and NHIF offices have?

1.5. Significance of the study

The study provides for the clue to the NHIF on the source of prevailing complaints and hence fixes them. The study provides answers that can eliminate the doubts of the members on their Fund as the problem will have eradicated hence leaving the members enjoying fully their entitlements. The revelations of the study would influence improvement in customer care from the NHIF officers and health care facilities in Tanzania. The study can provide essential information to the policy makers to work with, in their plans to improve the health insurance business in the country.

The study is a useful material of reference in various academic and non-academic matters relating to health insurance schemes, within the country and even outside the country. The study would enhance the partial fulfilment of the requirements to achieve the Masters degree in Public Administration by this study researcher.

1.6. Scope and Limitation of the study

The research was conducted in Morogoro region. The researcher specifically chose Morogoro Municipality as the case study. The study was confined to the efficiency of NHIF in health provision to the beneficiaries. The study measured the operations of the NHIF in implementing its policies and terms, to assess the operations of the accredited health givers in implementing policies and terms, to examine the essence of members complains, determine the mechanism of flow of information to and fro

and investigate the knowledge of both members and entitlements towards to the benefits package provided by the fund. In this study the researcher collected information from various categories of respondents: NHIF members, NHIF staff and care providers. The information was gathered through questionnaires, interviews and documentary review.

However, in terms of study theories, the researcher is guided by only one theory. Predominantly, the Explanatory Theory guides this study because it can well explain something whole by its constituting parts as long as the study is about diagnosis of the NHIF governance leading to its efficiency.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

The chapter brings forth the various literatures reviewed relating to the study topic on health insurance schemes efficiency. This part presents the review on the key concepts of the study, empirical studies relating to the study, as well as the conceptual framework of the study.

2.1 Conceptual reviews

2.1.1 Health Insurance Scheme

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 (OECD, 2004). Tanzania is in the process to meet the commitment under the Millennium Development Goal and the Abuja Declaration of extending health services to the citizens. The main objective is to cover 45% of population with sufficient Health Insurance by the year 2015 (Health Sector Strategy Plan 2009 -2015).

2.1.2 Social health insurance

Social health insurance is a mechanism of health financing to enables the burden of cost of health services to be spread on a time to the people who share costs and risks. It is a system of national social security and health insurance introduced into the nineteenth century German empire under then Chancellor Bismarck. This system is a legally mandatory system for the majority or the whole population to obtain health insurance with a designated (statutory) third-party payer through non-risk related contributions which are kept separate from taxes or other legally mandated payments" (Saltman, R. B. 2004).

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 (ILO 2008; WHO 2010). 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 (Townsend, 1994). Insurance should at least allow those insured greater care with a reduced financial burden through risk sharing across people and across time to help smooth consumption for those who fall ill.

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 (Enthoven 1988). Yet, in reality, 'when a society considers providing for health care by offering health insurance, to some significant degree, at the public's expense, such insurance programmes provided through taxes or regulations are called social insurance programs' (Folland,*et al*. 2004; Carrin& James, 2004; WHO 2010).

Social health insurance differs from a tax-based system where the Ministry of Health, through general revenues, finances its own network of facilities which are paid for through a mixture of budgets and salaries (Wagstaff, 2009). Although some of the operating costs may come from earmarked tax revenues, social health insurance operates an institutional separation between the 'purchasers' of care from the providers of care with the beneficiaries having to enrol into the insurance system. The payment for the service to the provider is conditional upon delivery of a service or through enrolment of recipients into a specific programme.

In order for universal healthcare coverage to be financed through insurance, the risk pool needs the following characteristics: compulsory contributions to the risk pool; 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 2010).

Social Health Insurance systems are generally characterized by independent or quasi-independent insurance funds, a reliance on mandatory earmarked payroll contributions (usually from individuals and employers) and a clear link between these contributions and the right to a defined package of health benefits (Gottret&Schieber, 2006). Social health insurance mandates enrolment for both those in the workplace and those outside it; various levels of subsidies for the population from different socio-economic levels are also provided.

However, financial costs are only one of the potential barriers to access to health care; the severity of non-price barriers can also play a major role, which results in variation of the impact of health insurance on healthcare utilization for some population groups (Wagstaff, 2009; Basinga, et. al 2010; Toonen, et. al 2009). 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 scepticism over the benefits of Western medicine (Wagstaff, 2009). 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 (Sinha,*et al*. 2006).

Social health insurance systems have been established in more than 60 countries in the world, beginning with Germany at the end of the nineteenth century. Twenty-seven have reached universal coverage through social health insurance (Carrin& James, 2004). Social health insurance is particularly widespread among OECD countries, but is also in use in developing countries, mainly in Latin America (Argentina, Bolivia, Brazil, Chile, Colombia, Costa Rica, the Dominican Republic, Ecuador, Peru, Uruguay, República, Bolivariana de Venezuela, and others) and to a

lesser extent in other parts of the world (Algeria, Kenya, Lebanon, and Tunisia). Today, many low and middle-income countries have instituted, or are considering starting, social health insurance systems (Bosnia and Herzegovina, China, Croatia, Estonia, Ghana, Hungary, Indonesia, the Kyrgyz Republic, Macedonia, Moldova, Morocco, Nigeria, the Philippines, Poland, the Russian Federation, Serbia, Slovenia, Tanzania, and Vietnam).

Very often, policy makers view social health insurance as an effective way to raise additional resources for health and as a means for decreasing the financing burden of health care coverage (Carrin, 2002). There is also a strong presumption that individuals may be more willing to be taxed (pay payroll taxes) if there is a specific individual entitlement that accompanies the tax (a benefit tax). In some cases, especially in countries that experienced communist rule, social health.

Insurance provides an opportunity to reduce the role of the state or to build democratic and participatory institutions (as in China, Estonia, and Hungary). Finally, countries that used to have National Health Service systems or "Beveridgean" systems may experiment with social health insurance as a way to improve the efficiency of the health care system by "outsourcing" health insurance coverage (as in Jamaica, Kenya, and Malaysia).

In order to measure the impact of social health insurance, 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 (Wagstaff, 2010).

2.1.3 Social Health Insurance in Tanzania

Until 1993, health services in Tanzania were provided free of charge. This proved to be unsustainable and the quality of health care declined rapidly as a consequence. Due to that alternative health care financing addressed the following health care reform; establishment of National Health Insurance, introduction of Cost-sharing arrangements in public hospitals through user fees ,establishment of Community Health Fund, introduction of an indent system to replace gradually the" Kit System" and establishment of the private for profit sector.

2.1.4 Health care financing in Tanzania

The government of Tanzania adopted health sector reform strategy in 1995 particularly on health care financing which is the firs step in introducing user fees in public hospitals. Several other alternatives of funding option were explored of which government introduced two new major ones in line with the principle of social security in health sector (MoH budget speech, 2003). Firstly, the National Health Insurance Fund (NHIF), a compulsory health insurance scheme for formal sector employees, and secondly, the voluntary Community Health Fund (CHF) which aimed to cover the informal sector. In additional to the government programmes, there are ranges of private health insurance initiatives (Tanzania NHA, 2001). These are either in form of micro, local communities and provider-based health financing projects. The country was pushed to opt for such financing mechanisms according to the general trend of economic policies towards increasing the role of private sectors.

2.1.5 National Health Insurance Fund (NHIF)

National Health Insurance Fund is a mandatory health insurance fund due to the Act of the parliament to make it compulsory to those in the formal employment from central to local government. The contribution are made by both employees and their employers making a total of 6% which done directly from employees' payroll.

Under equity perspective, social health insurance (mandatory) is progressive. The contributions are proportional related to the income of the beneficiaries. These beneficiaries receive the same benefit packages. Financial burden fall under those who are formally employed .In addition, SHI create two tier systems that result into one system funded by mandatory health insurance for those with specified income and they can purchase comprehensive health services.

Efficiently, the scheme has defined benefit package (outpatients and hospitalization services). The members are free to access services at any accredited health faculty of their choice. The fund accredited all government facilities, few private pharmacies and some few faith based organisations. The scheme provides quick and quality of services to its members to promote technical efficiency. The costs of administrative are high. National Health Insurance Fund revenue is reliable as the contributions are directly deducted from payroll.

2.1.6 The Basic Functions of NHIF

National Health Insurance Fund has been created with the view of providing members of the public services with the health insurance coverage. The functions are; to collect monthly contributions and process providers' claims, to register members and issue identity cards, undertake the process of quality assurance, to provide health assurance education to the public and enhance public relations, to account for the funds so collected and invested to accredit and inspect health givers and broaden accessibility to health particularly in rural areas of the country and investigate fund so collected order to earn income, inspect employers to check compliance and carry out an actuarial assessment and evaluation.

National Health Insurance Fund does no provide health services directly to the ownership, rather it facilitate access to such services through a tripartite arrangements (this is an internationally system in social security scheme) involving beneficiaries/ members, accredited service givers and the fund itself.

2.1.7 The Fund governance

The administration and management of the fund is governed by ten members of the Board of Directors. The Board is composed of 10 members from key stakeholders of health sector namely Association of Private Hospitals, Ministry of Health and Social Welfare (MoHSW), Trade Unions, the Treasury, the ICT's representative, Employers and Experts within the field of health Insurance and Economics. The NHIF's Board is appointed by the Minister responsible for health .The day to day activities are carried out under the supervision of the Director General who is the Chief Executive and Secretary to the Board. In additional to the Head Office, the fund engineers its operations through a decentralized process using established zone offices to facilitate service to and communication with members, care providers and other stakeholders.

2.1.8 The Vision of the Fund

National Health Insurance Fund envisions becoming the leading health insurance scheme of choice in Sub-Saharan Region in terms of providing sustainability and quality of services.

2.1.9 Mission of the Fund

The NHIF is accountable in providing support to beneficiaries to access health services through a wide network of accredited quality health facilities all over the country. The core values of the Fund towards to service provision include providing high quality services to its members, be accountable to the stakeholders of the fund, promote responsiveness and innovation towards evolving needs of the members and work through teamwork.

2.1.10. The source of income

The major source of income is contributions from the members. Increase in collections is generally expected each year due to more employed persons, salary increments and improvement of compliance activities. As the reserves increase the investment income become a significant source of income, as its rate of increase out of the total income exceed the expenditure rate of set for operations of the scheme and this ensure the future obligations of the scheme in terms of the benefit payment in yearly basis are made. Other sources of income received from donors such as World Bank through Basket funds, replacement of identity cards, adverts on members' identity cards, accreditation fees, and interest from Staff loan, fees collected from tender document and charges to employee defaulter through penalties.

2.2 National Health Insurance as a Global Phenomenon

National health care is a broad concept that has been implemented in several ways. The common denominator for all such program is some form of government action aimed at extending access to health care as widely as possible. Most countries implement health care through legislation, regulation and taxation. Legislation and regulation direct what care must be provided, to whom and what basis. Usually some costs are borne by the patient at the time of consumption but the bulk of costs come from a combination of compulsory insurance and tax revenues. Some programs are paid for entirely out of tax revenues. In some cases, government involvement also includes directly managing the health care system, but many countries use mixed private public private systems to deliver health services.

2.2.1 The National Health Insurance in Germany

Statutory health insurance (SHI) covers about 85 percent of the population of Germany. Around 10 percent of the population is covered by private health insurance, with civil servants and the self-employed being the largest groups. The remainder (e.g., soldiers, policemen, and others) are covered under special regimes. Undocumented immigrants are covered by social security in case of illness. Since 2009, health insurance has been mandatory for all citizens and permanent residents, either in the statutory or the private health insurance scheme (Thomson, S. & Reed, S. J.2011).

SHI covers preventive services, inpatient and outpatient hospital care, physician services, mental health care, dental care, prescription drugs, medical aids, rehabilitation, hospice care, and sick leave compensation. SHI preventive services include regular dental check-ups, well-child check-ups, basic immunizations, check-ups for chronic diseases, and cancer screening at certain ages. All prescription drugs, including newly licensed ones, are covered unless explicitly excluded by law (applies to so-called lifestyle drugs) or following evaluation.

The various levels of government have virtually no role in the direct delivery of health care. However, states own the vast majority of university hospitals and municipalities play a role in public health activities and own around half of hospital beds. A large degree of regulation is delegated to the self-governing corporatist bodies of both the sickness funds and the provider associations. The most important body is the Federal Joint Committee (G-BA), which was created in 2004.

2.2.2 The National Health Insurance Scheme in Japan

Japan operates a universal social health insurance system with more than 3,500 insurers. Employees and their families (60 percent of the population) are required to enroll in the health insurance offered through their employers, and the remaining 40

percent (unemployed, self-employed, and retired) are covered through plans administered by their local municipality or prefecture. All plans cover the same statutory benefit package. Individuals cannot choose their plans. Those who evade enrolling must pay back up to two years of premiums when they re-enter the system (although public assistance will cover them if they are unable to pay this fee). Permanent residents and long-term visitors are also required to obtain coverage; undocumented immigrants are not covered.

The statutory national benefit package covers hospital care, ambulatory care, and approved prescription drugs, and covers most dental care; it does not cover eyeglasses. Since 2000, long-term care has been covered under its own insurance system, administered by local governments. A number of preventive measures are publicly provided to those aged 40 and older, including screening, health education, and counseling. Mental health care is also covered under the statutory benefit package (Thomson, S. & Reed, S. J.2011).

In Japan, primary and specialist care are not held apart as distinct disciplines, as they are in other countries; rather, specialists generally operate in community-based clinics, provide many primary care functions, and can be easily accessed without referral. Very few clinics have a formal scheduling system; rather, patients wait in the waiting room until they can be seen. Outpatient visits are typically very short, yet common—in 2009, physician visits per year (13.9 per capita) were more than twice as frequent as the OECD median (6.2) and three times as frequent as in the U.S. (3.9). Virtually all clinics used to dispense medication (which doctors can provide directly to patients), but only a minority do so now. Clinics are mostly physician-led, with nurses playing less of a role in caring for patients than in some other countries, such as the U.S. Outpatient care is also provided at hospitals. After-hours care is usually provided by on-call physicians; there are few emergency departments in Japan. Hospital-based physicians are paid fixed salaries.

The health care system has to be evaluated based on its effectiveness, efficiency, and equity. There are three determinants of effectiveness: accessibility, quality, and integration. Integration means that the system functions well in ensuring that a patient receives care in facilities that are appropriate for the seriousness of the disease (Fukawa, T. 2002). In other words, it means there is a good referral system. Evaluating Japan based on these determinants, we find that the accessibility of the health care system is excellent; its quality is not known because there is no official data on this aspect or a system that monitors and ensures the quality of medical care; and integration is poor because there is no explicit referral system (Gunji, 1994).

2.2.3 The National Health Insurance Scheme in Netherlands

The National Health Insurance Scheme (NHIS) is funded primarily by contributions from members based on income. For the Formal Sector Social Health Insurance Program contributions are premiums that make up 15% of an individual's basic salary, with the employer contributing 10% while the employee pays 5% for coverage of themselves, their spouse, and up to 4 children. An employer may negotiate with an HMO for coverage of additional supplementary benefits and pay the extra contributions required. Participants in the Informal Sector Program are expected to make a monthly contribution based on the benefits package of their choice as well as other factors. The poor, elderly, veterans, and disabled are exempted from paying membership premiums.

Since January 1, 2006, all residents of the Netherlands, as well as nonresidents who pay Dutch income tax, are required to purchase health insurance coverage, except those with conscientious objections and active members of the armed forces. Coverage is statutory under the Health Insurance Act (*Zorgverzekeringswet*, or ZVW), but is provided by private health insurers and regulated under private law. In 2009, roughly 152,000 persons (1% of the Dutch population) were uninsured. That figure has remained stable since 2007.

Approximately 50 percent of the uninsured are in their twenties or thirties. In addition to those who should be insured but are not, there is a category of the uninsured who failed to pay their premium for at least six months (so-called defaulters).

Insurers are legally required to provide a standard benefit package (per the Health Insurance Act) covering the following: medical care, including care provided by general practitioners (GPs), hospitals, specialists, and midwives; hospitalization; dental care (up to the age of 18; coverage after age 18 is confined to specialist dental care and dentures); medical aids and devices; pharmaceutical care; maternity care; ambulance and patient transport services; paramedical care (limited physiotherapy/remedial therapy, speech therapy, occupational therapy, and dietary advice); ambulatory mental care (primary care psychologist, eight sessions); and outpatient and inpatient mental care for the first year. Insurers may decide by whom and how this care is delivered, giving the insured a choice of policies based on quality and costs (Thomson, S. & Reed, S. J. 2011).

At the health system level, quality of care is ensured through legislation governing professional performance, quality in health care institutions, patient rights, and health technologies.

2.2.4 The National Health Insurance Scheme in Switzerland

Coverage is universal, with residents mandated under the 1996 Health Insurance Law to purchase statutory health insurance (SHI) from competing insurers. There are virtually no uninsured residents. Every individual is required to take out an insurance policy within three months of arrival in the country, which is then applied retroactively to the date of arrival.

The SHI benefits package covers most general practitioner (GP) and specialist services, as well as an extensive list of pharmaceuticals, physiotherapy (if commissioned by a physician), and some preventive measures. It also covers outpatient and inpatient out-of-canton services in case of medical need, even though many residents purchase voluntary health insurance (VHI) for nationwide coverage of inpatient care (Cantons are like states, in that they are sovereign in all matters that are not specifically designated the responsibility of the Swiss Confederation by the federal constitution. Each canton and demi-canton has its own constitution and a comprehensive body of legislation stemming from its constitution.) Starting in 2012, the SHI benefits package will also include certain forms of complementary medicine (Thomson, S. & Reed, S. J.2011).

The SHI benefits package also covers mental illnesses on the condition that certified physicians provide treatment. Services from nonmedical professionals (e.g. psychotherapy by psychologists) are only covered when prescribed by a qualified specialist. If this is not the case, these services must be covered by VHI or paid for out-of-pocket by patients.

SHI covers the costs of selected vaccinations, selected general health examinations, and early detection of disease among certain risk groups and for certain diseases (e.g., one mammogram a year if a woman has a family history of breast cancer). Once again, additional services have to be paid for by patients themselves unless they have VHI to cover these costs.

Two-thirds of the costs of long-term inpatient care (nursing homes and institutions for disabled and chronically ill persons) are funded by contributions from private households (out-of-pocket and cost sharing). SHI funds only 15 percent of such services (nursing care), with the rest paid for by state subsidies and disability insurance.

For long-term outpatient care (called Spitex in Switzerland), SHI also covers the cost of home nursing care; this makes up roughly a third of Spitex's total expenditure. The other two-thirds, devoted mainly to support and household services, are paid for by customers and via state subsidies.

Dental care is largely excluded from the SHI benefits package. More than 90 percent of all expenditure on dental treatment is paid for by households.

Residents generally have free choice of GPs and access without a referral to specialists in private practice (unless enrolled with a gate-keeping managed care plan). Outpatient care tends to be physician-cantered with nurses playing a relatively small role. The majority of private medical practices in Switzerland only have one practicing medical doctor. Apart from some managed care plans, where physician groups are paid on a capitation basis, ambulatory physicians are paid according to a national fee-for-service scale. Here the corresponding cost rate values are negotiated between insurers and providers or their organizations at the cantonal level. Hospital-based physicians are normally paid a salary. Fee-for-service remuneration is possible for the treatment of privately insured patients.

The Federal Law on Health Insurance (KVG) of 1996 brought about a fundamental change in the health system. The law introduced regulated competition among health insurers and among service providers to achieve a series of key objectives such as containing costs; guaranteeing high-quality, comprehensive health care; and establishing greater solidarity among the insured. While scientific analyses and public perception have been particularly critical of competition's ability to cut or control health care costs, the other objectives are generally regarded as having been successfully achieved.

A system of risk equalization is designed to encourage insurers to compete on cost and quality rather than via risk selection, employing the power of market forces to improve efficiency. However, observers generally acknowledge that risk selection is widespread under the current risk equalization formula, which only considers canton,

age, and gender. As previously mentioned, in 2012 the formula will be refined to include hospital and nursing home stays of more than three days in the previous year. This should bolster insurers' incentives to improve efficiency.

2.2.5 The National Health Insurance Scheme in Nigeria

The effort of re-designed National Health Insurance System was adopted in 2006; seek to establish a realistic health financing system that has capacity of meeting health system of improved health status of Nigerians, financial protection of citizens against cost of illness, fair financing of health services and responsiveness to the citizen's expectations.

The National Health Insurance Scheme (NHIS) is the body responsible for regulation of the system and the different health insurance schemes. The Governing Board of the National Health Insurance Scheme is the National Health Insurance Council (NHIC). NHIC works to regulate the scheme (including setting standards, determining contribution rates, providing technical support, etc), license HMOs and providers, train health care providers, and manage the National Health Insurance Fund (NHIF).

Patients are allowed to choose their primary provider from the list of accredited facilities, which includes both public and private providers. The provider network is used for access and secondary referrals, which acts to control costs and maintain viability of the system. Provider payment mechanisms are primarily determined by the National Health Insurance System (NHIS) Governing Council.

The National Health Insurance Scheme (NHIS) is funded primarily by contributions from members based on income. For the Formal Sector Social Health Insurance Program contributions are premiums that make up 15% of an individual's basic salary, with the employer contributing 10% while the employee pays 5% for coverage of themselves, their spouse, and up to 4 children. An employer may

negotiate with an HMO for coverage of additional supplementary benefits and pay the extra contributions required. Participants in the Informal Sector Program are expected to make a monthly contribution based on the benefits package of their choice as well as other factors. The poor, elderly, veterans, and disabled are exempted from paying membership premiums.

Health insurance is obtained either through private insurers or the National Health Insurance Scheme (NHIS). About 5 million people are enrolled in the 3 NHIS Programs, which represents just about 3% of the population. In the Formal Sector Program, employees in the formal sector who pay premiums are covered, in addition to their spouse and up to 4 dependants. Companies that employ more than 10 workers are responsible for enrollment of their employees.

The benefits package for the National Health Insurance Scheme for workers in the formal sector is pre-determined and includes: Out-patient care, including necessary consumables prescribed drugs, pharmaceutical care and diagnostic tests on the National Essential Drugs List and Diagnostic Test Lists, maternity care for up to 4 live births for every insured contributor, Preventive care, including immunization, health education, family planning, antenatal and post-natal care ,consultation with specialists with a referral ,hospital in-patient care in a standard ward for a 15 cumulative days per year, eye examination and care, excluding the provision of spectacles and contact lenses, a range of prostheses (limited to artificial limbs produced in Nigeria) and preventive dental care and pain relief (including consultation, dental health education, amalgam filling, and simple extraction).

Patients are allowed to choose their primary provider from the list of accredited facilities, which includes both public and private providers. The provider network is used for access and secondary referrals, which acts to control costs and maintain viability of the system. Provider payment mechanisms are primarily determined by the National Health Insurance System (NHIS) Governing Council.

2.2.6 The National Health Insurance Scheme in Ghana

The National Health Insurance Scheme (NHIS) was established under the Act 650 of 2003 by the government of Ghana to provide basic health care services to persons residents in the country through mutual and private health Insurance Scheme (Ghana Website).

The District Mutual, Private Mutual and Private Commercial Schemes are regulated by the National Health Insurance Council (NHIC) to provide Health services to the community. The National Health Insurance Policy was set up to allow everybody to make contributions into a fund so that in the event of illness contributors could be supported by the fund to receive affordable healthcare.

The NHIS covered all 138 districts, Municipal and Sub-Metro contributions. The contributors are grouped according to the levels of Income; there is a specific premium that ought to be paid. This was done since the socio-income condition scheme contributors is not the same and the contributions was to be affordable for all to ensure that nobody is forced to remain in Cash and Carry System.

The above contributions are after 13 months, after the time is over the contributor will renew the contract and continue to enjoy the national health services provided.
Workers in formal sector join the District Wide Health Insurance Scheme through the enacted law on Health Insurance. The law makes it mandatory for 2.5% of workers social security contributions to be put into the National Health fund to be subsequently disbursed to the district mutual health Insurance Scheme as their contributions to the schemes. Children under 18 years of formal sector workers will also be exempted from paying any contributions provided workers spouses in the informal sector. The package covered about 95% of diseases in Ghana including Malaria, Asthma, Diabetes, Diarrhea, Hearing aids, Dentures, Beautification, Supply of Aids drugs and treatment of chronic reveal failure.

2.2.7 The National Health Insurance Scheme in Kenya.

As revealed by the (Kenya website), the National Hospital Insurance Fund is a State Parastatal that was established in 1966 as a department under the Ministry of Health. The original Act of Parliament that set up this Fund in 1966 has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. Currently the National Hospital Insurance Fund Act No 9 of 1998 governs the scheme.

The transformation of National Hospital Insurance Fund from a department of the Ministry of Health to a state of corporation was aimed at improving effectiveness and efficiency. The Fund's core mandate is to provide medical insurance cover to all its members and their declared dependants (spouse and children). The National Hospital Insurance Fund membership is open to all Kenyans. Each of these branches offers all National Hospital Insurance Fund services including payment of benefits to hospitals or members or employers. Smaller satellite offices and service points in district hospitals also serve these branches.

National Hospital Insurance Fund operations have been computerized and decentralized, enhancing efficiency in settling claims and effective management of membership database. The Fund also increased its service accessibility through the current networked 23 fully-fledged branches, 7 satellite offices and service points at most district hospitals countrywide. The branches function independently to offer services similar to any other office across the country.

2.2.8 The National Health Insurance Scheme in Uganda

As per (CHMI website), a study (2008) by WHO revealed that Ugandans spend 22 percent of their earnings on health care, and six percent of the poorest who have the highest number of health bills have to sell their assets to meet medical bills. The National Social Health Insurance Scheme was expected to take off in July 2007, but was tabled before the Parliament of Uganda in March 2009. The National Health

Insurance Fund failed to make it to through the parliament because of resistance from employers, trade unions and worker representatives. They were skeptical about the government's ability to guarantee efficient service delivery given the poor state of health facilities in the country.

Despite the fact of the above case studies, Savedoff, W. D. &Gottret, P.(2008) potray the other case studies based on governance of the scheme as follows.

2.2.9 The National Health Insurance Scheme in Costa Rica

Costa Rica performs very well in two of the five dimensions, namely *Consistency and stability* and *Stakeholder participation*. With regard to *Consistency and stability*, the objectives of the health insurance system have remained unaltered since the creation of the system in 1941. The Constitutive Law (Ley Constitutiva) of the Costa Rica Social Security System (CCSS) has been basically the same since its promulgation in 1943, with only few amendments, and the main components of the MHI system remained unaltered.

For example, the package of benefits stayed practically the same and changed only when the Constitutional Court forced the Costa Rica Social Security System (CCSS) to include particular treatments (such as AIDS antiretroviral) as part of the benefits. The core legislation for the basic drugs list dates from 1989, and is another example of the stability of the system.

Consistency and stability is also evident at the management level—since 1974only two executive presidents did not complete their term, one because of death and the other because of a corruption scandal. In terms of *Stakeholder participation*, the board of directors—which is the main body for regulatory oversight and institutional governance—is a tripartite body with representatives from employees, employers, and government? Within each group the range of key stakeholders, including medical doctors is ample and diverse. However, some experts felt that, despite the balance of powers in the board of directors, clients were underrepresented.

The weakest dimensions were *Supervision and regulation* and *Coherent decision-making structures*. The low rating for *Supervision and regulation* is driven, in part, by the evidence that, in spite of explicit legal competencies to sanction individuals and organizations that fail to comply with their responsibilities, such sanctions are rare in practice. Situations covered by the legislation are either obsolete or lack specificity, and associated sanctions are not clear and objective. Furthermore, most of the supervisory regulations are applied ex post, with little provision for preventing such problems in the first place. In cases where sanctions are clearly defined, the penalty is inadequate. For instance, those who evade their responsibility to make social security contributions, if caught and punished, are assessed fines of US$350 irrespective of the size of the unpaid debt. Also, even if the sanction is correctly specified, administrative problems and processes tend to complicate the work of the institutions.

Other aspects of *Supervision and regulation* have similar weaknesses. For example, financial management rules with respect to reserves clearly assign responsibility to the board of directors. Nevertheless, the law is vague with respect to how these reserves should be managed and what kinds of investments are permitted. For "ongoing supervision and monitoring," the Costa Rica Social Security System has created specific departments for on-site and off-site inspections, such as the Procurement Department and the Medical Management Department. However, the capacity to effectively carry out inspections is limited by the amount of resources allocated to these activities, by the weak scope of responsibilities and powers defined by law, and by the low priority given to inspection activities by the Costa Rica Social Security System. Finally, financial information is provided to the public via Web sites, but both financial and clinical data generally lag by a year or more.

Regarding the dimension of *Coherent decision-making structures*, the Costa Rica Social Security System (CCSS) has the power to alter contribution rates, implement new health plans, and redefine the package of benefits and essential drugs. In fact, according to experts, the board of directors of the CCSS has such power that its

regulations have the same effect as an Act approved by Congress. In other words, the board of director's is not tied to most regulations that affect the performance of other similar autonomous institutions. Despite these comprehensive decision-making powers, the CCSS lacks routine risk assessment and management strategies. It has no permanent program or capacity to analyze and manage risk, although it tracks the evolution of revenues and expenditures and has a department of Actuarial Studies and Economic Planning.

Relative to the other dimensions, *Transparency and information* performance is average. The code of ethics for CCSS personnel adopted by the CCSS board in1999 attempted to establish standards of conduct. However, the code has failed to prevent some major scandals in the areas of, for example, purchase of medical services at inflated prices, procurement of medicines and equipment, provision of private training courses and medical research, construction of hospitals, and management of the CCSS pensions system. There are limited provisions to address conflicts of interest and check the power of the executive president and board of directors. These issues became especially apparent in 2004 when almostUS$9 million from a Finnish loan was used for bribes and other illegal payments.

2.2.10. The National Health Insurance Scheme in Estonia

Estonia's mandatory health insurance (MHI) system seems to be well governed and performs well to very good on all five dimensions. It performed best with regard to *Consistency and stability*, receiving the maximum rating due to the ongoing commitment to its original objectives and basic values and principles. While the establishment of the current health insurance system in 1992 was a very radical change, the system since then has not been changed significantly. For example, the contribution rate has remained at 13 percent since it began, and there have been only minor changes in entitlement rules. Legislative changes have largely focused on developing the system further. Moreover, changes in political power have not unduly influenced important characteristics of the health insurance system.

Stakeholder participation performed nearly as well. Stakeholders are represented in the governing bodies of the Estonian Health Insurance Fund (EHIF) in ways that appear quite effective. The highest body of the EHIF is the tripartite supervisory board with 15 members: five representatives chosen by the government, five by employers, and five by beneficiaries. Although provider representatives are not explicitly included in the EHIF's supervisory board, they play an important role indecision-making because all questions related to the benefits package and contra conditions are negotiated with provider associations. Providers' involvement is important to the EHIF and progress is measured by provider satisfaction surveys, which currently are conducted every year. In 2006 the general satisfaction with partnership with the EHIF was quite high—76 percent of contracting partners considered it very good or good.

Supervision and regulation is one of the slightly weaker areas, largely because sanctions and corrective actions are not generally applied, despite rules allowing for them. For this reason, it is difficult to assess the quality of corrective actions, the capacity for execution of these sanctions and actions, and whether they would be publicized or otherwise publicly discussed.

Estonia scores well for *Transparency and information* for several reasons. Financial management rules for the EHIF are quite explicit and the system has good structures for supervision and monitoring. In addition, financial performance of the EHIF is monitored quarterly by the supervisory board. In addition to financial information, quarterly reports include an overview of EHIF performance in terms of strategic objectives and yearly action plans. All quarterly reports are publicized on the EHIF's Web page and those who have no access to the Internet can get this Information on request in hard copy. (Beneficiaries also have the right to get more detailed information on themselves from the EHIF's database, for example, treatment costs.)

The EHIF's annual report is more detailed and audited by an external auditor; it is also public, and has gained the best public reporting award for four consecutive years. (Thomson, S. & Reed, S. J.2011).

However, there is room for improvement on *Transparency and information* because consumer protection is relatively weak. Currently there is no separate patient/insured protection legislation other than the Law of Obligations, which regulates all contractual relationships. According to insured satisfaction surveys (annual population-based surveys), beneficiaries' awareness of their rights and of changes in health insurance system (benefits, copayments, etc.) is relatively limited.
Also, beneficiaries have the right to put their complaints to the EHIF, but procedures are not established or clear. If the EHIF receives a complaint and no agreement is reached, then the complaint goes directly to an administrative court according to general procedures. However, the number of court cases is limited and this is uncommon.

A *Coherent decision-making structure* is another important dimension for Estonia. Given the impact of different decision-making bodies, the creation of separate financial reserve accounts is potentially useful. The financial reserve fund of the EHIF is accessible to the supervisory board for covering normal commercial risks and management problems associated with managing the EHIF. The additional reserve can be released only by the government and is meant to cover the costs of government decisions affecting EHIF finances. In addition, the consolidation of health insurance entities may make operational performance more efficient, particularly for smaller populations. Estonia appears to have substantially reduced administrative costs by consolidating 22 regional insurers into a single fund covering the country's entire population of 1.3 million.

2.2.11. The National Health Insurance Scheme in Netherlands

Governance of MHI in the Netherlands is rated quite high. It scored well in most of the governance dimensions. The score was highest for *Consistency and stability*, followed by *Supervision and regulation.* Although the institutional and legal framework of MHI legislation was substantially reformed in 2006, the broad objectives and instruments of legislation for the MHI system have remained substantially the same since the 1960s (even though less fundamental changes did occur, such as the extension of the population covered and the benefits package). MHI has remained unaffected by political changes.

With regard to *Supervision and regulation*, rules on compliance and sanctions are clearly defined in legal texts and the Supervisory Board for Health Care Insurance has imposed corrective actions (mainly financial). All regulatory agents publish annual reports with information on cases of rule violation and subsequent actions.
For *Transparency and information*, the Netherlands performs less well because disclosure rules regarding business activities, ownership, and finances were not in place until recently. A new disclosure arrangement states that each health insurer (or provider) must annually publish information on the salary of its chief executive. Frequent efforts are made to measure the performance of health insurers and provider organizations, and to disclose information to the general public through the Internet. In addition to formal information requirements, a number of social factors, including citizen groups and the press, play a role in reporting information, such as the salaries of chief executives of sickness funds, as they do for other publicans semi-public institutions. The Netherlands also has consumer protection regulations related to consumer information, responsibilities, grievance procedures, and appeal mechanisms. However the complaints and appeals mechanisms are relatively weak and rarely used. An ombudsman exists, and the insured have the right to appeal decisions made by their sickness fund to this officer.

Stakeholder participation was good. In the past, representatives of employers, unions, provider, and insurers sat on the semi-public independent agencies that regulate the sector. However, recent reform of these bodies has put an end to this "representative model." At present, their boards consist of independent experts, appointed by the minister of health. Reporting to the board are usually various working groups. Stakeholders often have representatives in these working groups and such representation is generally effective. Also, there is a tradition in the Netherlands of decision-making by consensus and shared responsibility. Thus, for example, the minister of health is expected to negotiate with interest groups when problems arise, rather than acting unilaterally.

Regarding *Coherent decision-making structures,* improvements in efficiency may not be achieved, despite the existence of multiple competing health insurers, if fundamental pricing and service decisions are imposed by the government. The Netherlands' recent health reform seeks to structure competition so that health insurers will suffer financially for poor management but not for insuring a disproportionately high-risk population. The government has the authority to regulate the benefits package but there is flexibility by insurers to complement packages. The supervisory authority is independent and periodically assesses the risk borne by insurers.

2.2.12. The National Health Insurance Scheme in Chile

The assessment of Chile's mandatory health insurance (MHI) governance performance included both, National Health Insurance Fund (*FondoNacional de Salud*-FONASA) and the private health insurers; Health insurance funds (*instituciones de saludprovisional*-ISAPREs). Although the two kinds of insurers are quite different, they both operate within the context of a single MHI system.

Therefore, the assessment for each dimension was made on the basis of information for both types of insurers, and a combined rating was then given. Generally the ISAPREs are regulated much more comprehensively than FONASA. Consequently the overall results are more variable than in the other three countries.

The divergence between the two systems can be illustrated with *Supervision and regulation*, in regard to rules on compliance, enforcement, and sanctions. The Superintendence of Health (*Superintendence de Salud*-SIS) has no power to sanction the public insurer, FONASA, if it fails to meet its obligations; the SIS has the right to audit FONASA's activities, but not to directly impose sanctions; there is no information regarding corrective actions based on clear and objective criteria for FONASA that are publicly disclosed; and finally, no rule violations have been documented in the case of FONASA.

In contrast, SIS has substantial authority to impose sanctions on the ISAPREs—specific regulations govern their oversight and imposition; sanctions take the form of legislative investigations against the institution involved; the new laws allow SIS to impose financial sanctions on ISAPREs; the SIS Web site publishes he sanctions imposed on private insurers, as well as the cause of the sanction and the fee levied; and finally, SIS publishes the sanctions imposed against ISAPREs on its Web page and in other media.

Chile's MHI governance system performs very well in terms of *Consistency and stability*. For FONASA and the ISAPREs, the system's basic objectives have remained the same. Fundamental characteristics of the MHI system, including the minimum benefits package, contribution requirements, and basic institutional requirements for operators, are defined in different laws. The current system was established in 1981, and legislators have since sought to improve it: in 2004 are form process was initiated, including new laws and new rights that apply to all beneficiaries, regardless of the insurance system, but changes have largely related to expanding the rights and benefits of the insured.

The *Transparency and information* dimension was good, although objectives of the system are not always clearly defined and easily understood by beneficiaries. For example, a SIS opinion survey shows that just over 20 percent of beneficiaries feel that they have enough information, 60 percent feel that they have little information, and the rest feel that they have none. The differences between FONASA and ISAPREs in this regard are small. The legal framework is adequate given the local context, even though key players and beneficiaries did not help establish the framework. Consumer complaint mechanisms exist for both ISAPREs and FONASA, but only the private system has a culture of consumer complaint. The regulatory agency periodically publishes data regarding the nature and rates of complaints for each of the ISAPREs, usually in the form of a ranked list. No complaints data are available for FONASA.

For other MHI governance dimensions there is also room for improvement, especially *Stakeholder participation*, which is very weak. FONASA's stakeholders do not have direct representation in the institution's supervision. Since FONASA reports directly to the government, through the Ministry of Health, no representatives from unions, employers, beneficiaries, or providers meet in an oversight body. FONASA does have 14 user committees (participatory bodies of patient associations and beneficiaries), but these are advisory and have no power to impose or vote on decisions. Similarly, the SIS is a technical body appointed by the government and has no representatives from unions, employers, beneficiaries, or providers. ISAPRE boards of directors are generally chosen by shareholders, leaving beneficiaries, employees, and providers without explicit representation.

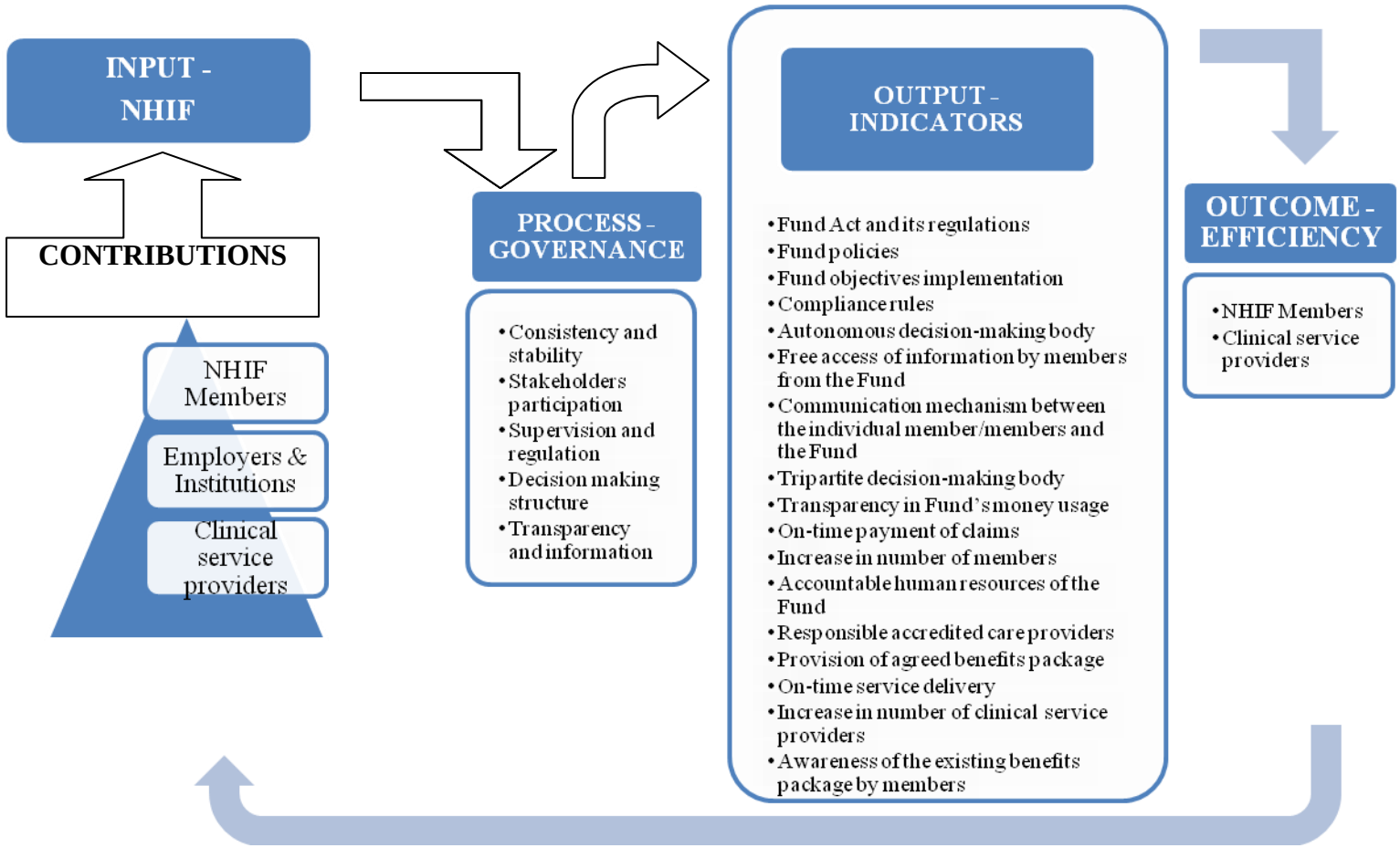
Coherent decision making structures are the weakest dimension in the case of Chile. The ISAPREs have, over time, been able to risk-select the insured population, forcing the transfer of higher risk to the realm of FONASA. Recent changes in regulations imposed explicit health guarantees (*garantíasexplícitas de salud*- GES) on all health insurers, but it is uncertain that this change will affect existing risk selection.

2.3. Conceptual framework of the study

This is the study conceptual framework which diagrammatically shows the whole picture of the study. It gives the boundaries the research is grounded to study about the efficiency of the NHIF, see figure 2.1

Figure 1: The analytical framework of the study

(Source: Researcher's creativity and innovation, 2012)



This framework leads to the answers of the questions of this research whereby, to start its reading; the contributions from the members and their host institutions/employers, and care providers services are collected by the NHIF.

Then, the Fund through its management governs the use of the scheme fund in assuring various things are done in achieving the goals and intents of the Fund.

The NHIF in its governance touches different angles as dimensions in terms of consistency and stability of the scheme, stakeholders participation, supervision and regulation of the services, transparency and information flow, as well as cohering to the decision making structure of the Fund.

As a result of the good governance in terms of the observed dimensions, the following outputs appear as indicators to such governance. They are the prevalence of: the Fund Act and its regulations, Fund policies, Fund objectives implementation, compliance rules, autonomous decision-making body, free access of information by members from the Fund, communication mechanism between the individual member/members and the Fund, tripartite decision-making body, transparency in Fund's money usage, on-time payment of claims, increase in number of members, accountable human resources of the Fund, responsible accredited care providers, provision of agreed benefits package, on-time service delivery, increase in the number of clinical service providers, and awareness of the existing benefits package by members.

Finally, the outcome of the whole thing of governance done well by the NHIF is efficiency attainment as judged by the members and their host institutions, as well as the accredited care providers.

If the NHIF collects the contributions and in turn governs not well the scheme, in adherence to the above mentioned dimensions, automatically the output results would be the negative of the above mentioned outputs, and ultimately the outcome would the inefficient Fund, as per the perceptions of the care providers, members and their host institutions/employers.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter answers the procedural question of the research. It addresses the research design, area of study and population of the study .The part will also briefly explain on the sample and sampling procedures employed. In this part the researcher will tray to elaborate on the data collection methods.

3.1 Research design

This study used a case study design. This type of study design was adopted because it gave the researcher on opportunity to intensively explorer and analyze information over the life of single unit (Tripath 2002). For the case of this study Morogoro Municipality was picked as a case study.

3.2 Area of the study

The area of study is in Morogoro region within only one district which is Morogoro Municipality. This area is studied because it consisted of many NHIF members compared to other districts in Morogoro region; it has a good means of communication that enabled the researcher to visit different places to access data easily.

3.3 Target population

The population of the study was divided into three main groups. These are NHIF Staff, Health care providers, (hospitals and pharmacies) and NHIF members. The whole population is 1652. The total number of NHIF Staff is 15, the NHIF members' is1436 and 201 health care providers all in Morogoro Municipality.

Table 3.1: Population of the study

S/N	Participant category	Total Population	Sample Size	Sample Percentage
1.	NHIF Staff	15	03	20%
2.	Members	1436	200	14%
3.	Hospitals	183	30	16%
4.	Pharmacies	18	09	50%
	Total	**1652**	**242**	**100%**

Source: (NHIF, Morogoro Municipality Dec 2012

3.4 Sampling Procedures and techniques

This study involved both purposive and convenience sampling techniques to obtain the suitable institutions and clients to be engaged in the study

3.4.1 Purposive Sampling

Purposive sampling according to the words of Kombo and Tromp (2006; 82) the researcher uses his/her expert judgement based on available information to choose the sample of the study. The purposive sampling techniques was used in this study as it offered an opportunity to select participants on the basis of their experience and administrative power, as well as responsibilities assigned to them on the provision of services through NHIF. Therefore this technique was applied to get respondents from NHIF office in selecting regional director, middle cadre officer, and junior cadre officer. Furthermore purposive technique was also employed to select respondents from the selected hospitals and pharmacies particularly medical officers in charge, pharmacists in charge as well as middle and junior cadre of the institutions table 3.2, 3.3, as well as 3.4 indicated.

Table 3.2 NHIF Office Respondents

S/N	Officer Rank	Total Number of Respondents	Sample taken
1.	Regional Director	1	1
2.	Middle cadre officer	9	1
3.	Junior cadre officer	5	1
	Total of Respondents	**15**	**3**

Source ;(NHIF, Morogoro Municipality, Dec 2012)

Table 3.3; Selected Hospitals Respondents

S/N	Name of Hospital	Respondents Rank	Sample taken	Total
1.	Morogoro Regional Hospital	Chief Medical Officer	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
2.	Mazimbu Hospital	Medical officer In charge	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
3.	Sabasaba Health Centre	Medical officer In charge	1	
		Middle carder officer	1	
		Junior carder officer	1	3
4.	Mgolole Health Centre	Medical officer In charge	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
5.	Shalom Medical Centre	Medical Officer In charge	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
6.	Kilakala Dispensary	Medical Officer In charge	1	
		Junior cadre officer	1	
		Middle cadre officer	1	3
7.	Kichangani Dispensary	Medical Officer In charge	1	
		Junior cadre officer	1	
		Middle carder officer	1	3
8.	AgakhanDispensarry	Medical Officer In charge	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
9.	St. Thomasi Dispensary	Medical Officer In charge	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
10.	Kihonda Dispensary	Medical Officer In Charge	1	
		Middle cadre officer	1	
		Junior cadre officer	1	3
	Total		**30**	**30**

Source; (NHIF Morogoro Municipality, Dec 2012)

Table 3.4, Selected Pharmacy Respondents

S/N	Name of Pharmacy	Respondent Rank	Sample take	Total
1.	Uluguru Pharmacy	Pharmacist in charge	1	
		Middle cadre pharmacy officer	1	
		Junior cadre pharmacy officer	1	3
2.	Gwami Pharmacy	Pharmacist in charge	1	
		Middle cadre pharmacy officer	1	
		Junior cadre pharmacy officer	1	3
3.	Whitegate Pharmacy	Pharmacist in charge	1	
		Middle cadre pharmacy officer	1	
		Junior cadre pharmacy officer	1	3
	Total Respondents		**9**	**9**

Source; (NHIF, Morogoro Municipality, Dec 2012)

3.4.2 Convenience sampling

Convenience sampling according to Kombo and Tromp (2006) is a non probability sampling method based on using people who are a captive audience, people the researcher meets haphazardly or accidentally. Respondents are people who just happen to be walking by, or show a special interest in research, Therefore under this study the sample involves selecting 200 respondents from a total population of 1436 NHIF members. This category of sample frame is obtained from the different institutions in Morogoro Municipality as table 3.5 indicated.

Tale 3.5: Results for the convenience sampling on NHIF members

S/N	Institution Name	Sample taken	Total
1.	Morogoro Municipal Council	10	10
2.	Immigration	10	10
3.	TAFORI	03	03
4.	Police Post	15	15
5.	MOROWASA	05	05
6.	Post Company	04	04
7.	DAS	03	03
8.	RAS	05	05
9.	Mzinga Corporation	10	10
10..	Tanzania Tree Seeds Agent	03	03
11.	DED Morogoro	05	05
12.	Kigurunyembe TTC	15	15
13.	Magistrate's Court	10	10
14.	Sumeye Secondary School	17	17
15.	Kilakala Secondary School	17	17
16.	Lupanga Secondary School	17	17
17.	Mwande Primary School	17	17
18.	Mchikichini A. Primary School	17	17
19.	Mgolole Primary School	17	17
	Total	**200**	**200**

Source; (NHIF, Morogoro Municipality, Dec 2012)

3.5 Sample Size

The simple size of the study is made up of 242 respondents. The respondents include 3 NHIF staff, 30 respondents from the hospitals, 9 respondents from the pharmacies and 200 NHIF members from different institutions will constitute only paying members with exclusion of dependents of paying members, all above 24 years old.

3.6 Data Collection Methods

According to (Kombo 200) data are grouped into primary and secondary data. Primary data Kombo explains that is the information gathered directly from respondents. The information can be gathered through interviews, questionnaires and observation. On the other hand Secondary data (2006) adds that is the information that is not collected

directly by the user. Secondary data involves gathering data that already been collected by someone else. It includes published and recorded down information.

In this study the researcher used both primary and secondary data. Before data collection the researcher will seek for permission from relevant authorities so as to make the study ethical. For the purpose of objectivity and reducing bias, the researcher will use questionnaires, Interviews and documentary reviews as elaborated below.

3.6.1 Questionnaires

This method has been used to gather different facts from the respondents. The questionnaires w particularly administered to NHIF members, NHIF accredited clinical care providers and the NHIF staff in Morogoro Municipality. A total of 200 questionnaires will be printed and distributed out of 242 to the informants to fill in as attached in appendix 3,4 and 5.There are three types of questionnaires. The first questionnaire intended for NHIF members, the second was for NHIF accredited clinical providers and third for the NHIF staff. The questionnaires were later collected from different respondents for analysis.

3.6.2 Interviews

This is where the researcher identifies the respondents and requests them to answer certain questions (Kombo, 2006). .In this study the number of interviewers was only one person who is the researcher. Whereby, in interviewing technique, the schedule was self administered by the researcher on a face to face interview with the respondents from different institutions. The total number of 42 respondents including heads of department who are the key informants included in the study. The reasons for the choice of interview against questionnaires are; to avoid and reduce –non response rates that, some respondents have no time to fill questionnaire. Most of the sample to be surveyed is not conversant in English language used in the schedule.

The approach ensures that the researcher and the respondents understand each other and perceive the questions to be responded as intended. In most cases, the researcher has to guide the respondents by translating each question into Kiswahili language so as to collect the right answers.

3.7 Data Analysis

In data processing, after collection of data, the schedules were edited to determine the degree of response and the number of usable schedules. The data was coded and then entered into a computer data sheet for analysis. The data analysis was done in the computer application known as, the Statistical Package for Social Sciences (SPSS). The analysis model applied was descriptive statistics involving the measures of central tendency and correlations,

CHAPTER FOUR

PRESENTATION OF THE RESEARCH FINDINGS

4.0 Introduction

This chapter focuses on the discussion based on a study that was conducted in for the purpose of diagnosing the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries. The study involved 200 respondents from NHIF members, 39 respondents from health care givers and 3 staff workers from NHIF making altogether 242 respondents. In collecting opinions from the three different categories of respondents, three different types of questionnaires were used and responses from the three different types of questionnaires are reflected in the six sections of this chapter. This chapter includes seven sections. Section one deliberates on background information of the respondents who were involved in the study while section two on the types of operations of NHIF in implementing its policies and terms. Sections three and four focus on the operations of the accredited health facilities in implementing policies and terms and the essence of the members complains respectively. Section five presents the existing mechanism of flow of information to and fro between the members and the Fund. The last two sections deliberates on the extent of members knowledge on their entitlements from the Scheme and extent of knowledge on entitlements of the members do the primary service and care givers at the hospitals, pharmacies, and NHIF offices have.

4.1 Background and Information of the Respondents.

In diagnosing the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries, considerations' background information is important. In this study, background information includes respondents' sex, age and education.

Table 4.1 Respondents age and sex

Gender of respondents	Frequency	Percent
Female	154	63.6
Male	88	36.4
Total	242	100
Age of respondents	Frequency	Percent
20-30	33	13.6
31-40	88	36.4
41-50	80	33.1
51-60	40	16.5
60 and above	01	04.0
Total	242	100

Source; Field Data, 2013

As far as sex and age of the respondents are concerned, results in table 4.1 show that 63.6% of the respondents who were involved in this study were female while 36.4% were male. In view about age results in table 4.1 show that the majority of the respondents were between 31 to 40 years.

With regards to education, results in table 4.2 show that 50.8% have completed form four, 10.7% have diploma, 21.1% bachelor degree and 3.7% masters' degree. Results in table 4.2 further show that only 2.1% of the respondents have primary education.

Table 4.2; Respondents education

Respondents education	Frequency	Percent
Standard seven	05	2.1
Form four	123	50.8
Form six	12	5.0
Certificate	16	6.6
Diploma	26	10.7
Bachelor Degree	51	21.1
Master Degree	09	3.7
Total	242	100.0

Source; Field Data, 2012

4.2 Types of operations of NHIF in implementing its policies and terms

This section focuses on the types of operations of the National Health Insurance Fund in implementing its policies and terms. In achieving the objective, three NHIF staff workers were involved in answering questions that are related to the operations of the National Health Insurance Fund in implementing its policies and terms. The main questions posed include whether NHIF has scheme objectives, if all terms in the fund act are being implemented and to mention type of legal framework and material that give guide in operating the schemes and types of NHIF operations in implementing policies and terms. Results in table 4.3 show that all the three NHIF staff involved in the study agreed that NHIF has scheme objectives and that all terms in fund act are being implemented.

Table 4.3; Types of operations of NHIF in implementing its policies and terms

Availability of Scheme Objectives	Frequency	Percent
Yes	3	100
No	0	0
Total	3	100
Implementation of the terms in the Fund Act	Frequency	Percent
Yes	3	100
No	0	0
Total	3	100
Type of Legal Frameworks		
Fund guide	Frequency	Percent
Yes	3	100
No	0	0
Total	3	100
Type of Operations	Yes Response	Percent
Entering contract with the health care providers	3	100
Supervision and Inspection	3	100

Source; Field Data, 2013

In view about types of legal framework and material that give guide operating the schemes, results in table 4.3 show that fund guide is the main legal framework that guide in operating the schemes. Finally, the other types of operations that National Health Insurance Fund undertake in implementing its policies and terms include entering contracts with health service providers and supervision and inspection of health care providers in checking about the compliance to NHIF terms and regulation.

4.3 Operations of the accredited health facilities in implementing policies and terms

This section deliberates on the types of operations undertaken by accredited health facilities in the implementation of NHIF policies and terms. In achieving the objective, in the first place, this study tried to establish if accredited health facilities become members on signing a contract with NHIF and the time when the accreditation took place. In the second place this study went further in establishing whether during the accreditation the health facilities were you given NHIF compliance rules, policies and contract terms that facilities will follow during the time of implementation and to which level.

In view about whether health facilities sign contract with NHIF during accreditation or not, results in table 4.4 show that 100% of the health facilities do the exercise.

Table 4.4; If Health Facilities Sign Contract with NHIF during Accreditations

Signing a contract with NHIF during accreditation	Frequency	Percent
Yes	39	100
No	0	0
Total	39	100
Time when the facility accredited by NHIF	Frequency	Percent
2001-2005	8	21
2006-2010	9	23
2011-2013	7	18
Don't know	15	39
Total	39	100

Source; Field Data, 2013

With regard to the time when the exercise started, results in table 4.4 show that the exercise started in 2001 to date.

Table 4.5; Provision of Compliances Rules during Accreditation and Level of Implementation

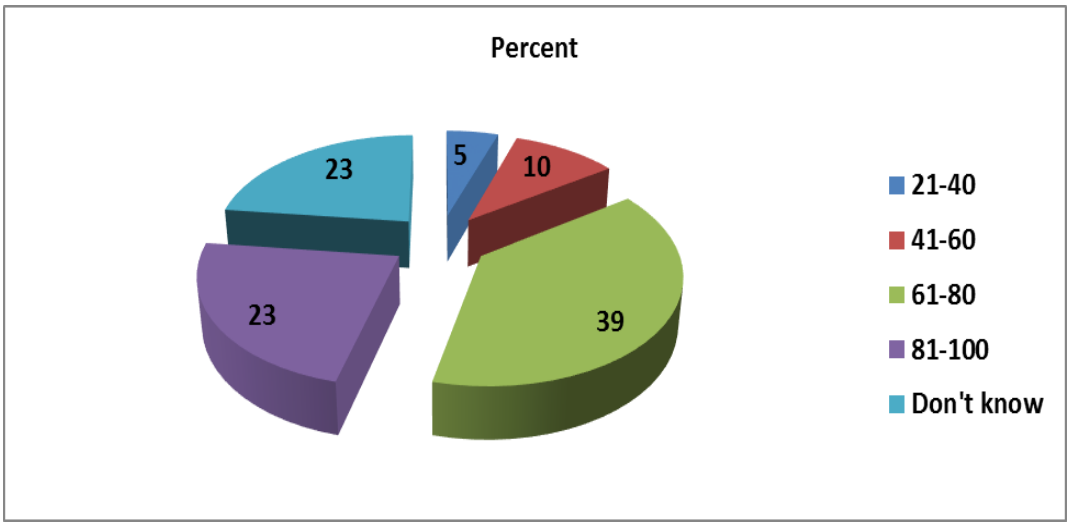
Provision of NHIF Compliances Rules	Frequency	Percent
Yes	37	95
No	2	5
Total	39	100
Level of Implementation	Frequency	Percent
21-40	2	5
41-60	4	10
61-80	15	39
81-100	9	23
Don't know	9	23
Total	39	100

Source; Field Data, 2013

As far as provision of NHIF compliances rules policies and contract terms and level of implementation by health facilities is concerned, results in table 4.4 show that 95% of the health facilities are provided with NHIF compliances rules policies and contract terms.

In view about the level of implantation, results in figure 4.1 show that 62% of the respondents say that the level is between 61-100 percent, 5% in the range 21-40, 10% in the range 41-60 and 23% of the respondents said that are not aware.

Figure 4.1: Level of NHIF Compliances Rules Implementation



Source; Field Data, 2013

4.4 The essence of the members complains

This section focuses on the members complains. The section deliberates on members' opinions on satisfaction of services provided by NHIF fund, if NHIF is really providing the agreed benefits to its members, if NHIF members are denied certain rights to a particular benefit at the health facility.

4.4.1 Members Opinions on Satisfaction of Services Provided by NHIF

In looking at the essence members complains, this study examined members' feelings on the satisfaction about the services that are provided by NHIF. Results in table 6 show that the majority of the members, that is 67% are not satisfied by the service provided by the fund and 33% are satisfied. The major reasons given are based on the types of NHIF cards given, category of medicine and diseases. Other reason mentioned include amount of funds given is higher than the services

provided, poor arrangements of getting health services, not all the time members are sick so the Fund become useless and long process of getting health services through the funding.

Table 4.6: Members Opinions on Satisfaction of Services Provided by NHIF Fund

Response	Frequency	Percent
Yes	66	33
No	134	67
Total	200	100
Reasons for respondents not satisfied with the provided services by the Fund		
Reasons	Frequency	Percent
Not Applicable	65	33
The amount is higher while health services are in low quality	39	20
Types of Membership cards, medicines and diseases	59	39
Poor arrangements health services	28	14
Not all time members are sick	5	2
Long process of getting health services	4	2
Total	200	100

Source; Field Data, 2013

4.5 Existing mechanism of flow of information to and fro between the members and the Fund

This section deliberate on issues related to the existing mechanism of flow of information to and fro between the members and the fund like representation in the top NHIF decision body by the NHIF members and health care providers, mechanism used in receiving individual member's information such as complaints, whether NHIF body give out financial information related to the fund to the public and members and if not what are the reasons. In view about representation in the top NHIF decision body by the NHIF members and health care providers, results show that 100% of the NHIF staff workers involved in this study said that there is representation by the said members. However, on the mechanism NHIF body use in

receiving information such as complains from members, results in table 4.7 show that the body use journals and the media. With regard to whether the NHIF body gives financial information to the public and its members, results in table 4.7 show that 67% of the respondents said that the body does not give such information and the reason being that the fund is not for profit orientation.

Table 4.7: Existing mechanism of flow of information to and fro between the members and the Fund

Representation by NHIF Members	Frequency	Percent
Yes	3	100
No	0	0
Total	3	100
Mechanism for receiving complains	Frequency	Percent
Journals and Media	3	100
Total	3	100
If give financial information	Frequency	Percent
Yes	1	33
No	2	67
Total	3	100
Reason for not giving financial information		
Not Applicable	2	33
The Fund is not for profit orientation	1	67
Total	3	100

Source: Field Data, 2013

4.6 Members Opinions about their entitlements from the Scheme Awareness on Membership Benefits Package

With regards to the way members think about health care givers awareness about membership benefit packages, results in table 4.8 show that 71% of the members know that the health care givers are aware about membership benefit packages and 29% do not know. Reasons given by respondents about lack of awareness by health care givers include low level of education towards NHIF, they provide poor health services, lack of seminars and NHIF is still new programme in Tanzania.

Table 4.8; Members Opinions about Health Care Givers Awareness about Membership Benefit Packages

Response	Frequency	Percent
Yes	140	71
No	58	29
Total	198	100
Reason for being not aware	Frequency	Percent
Not Applicable	140	71
Lack of seminars	5	3
Low level of education towards NHIF	28	14
NHIF is still a new programme in Tanzania	8	4
They provide poor health services	19	9
Total	200	100

Source; Field Data, 2013

4.7 Health Care Givers Knowledge about Membership Benefit Packages

The last section of this chapter deliberates on health care givers knowledge about membership benefit packages. The section focuses on staffs' knowledge at health care centres about the rights and benefits of the NHIF members when they save them, if health care givers serve the NHIF members with all the contracted benefits package at their facilities, reasons for failing to serve NHF members with all contracted benefits and reasons for telling NHIF members that a particular service is not available while the non-NHIF members at the same time are given the same and nature of processing of payment claims and refund by NHIF.

4.7.1 Staffs at Health Care Centres Knowledge about Rights and Benefits of the NHIF Members

This section focuses on staffs at health care centres knowledge about rights and benefits of the NHIF members. Results in table 4.9 show that 95% of the staffs at health care centres involved in this study show that the staffs are aware about the rights and benefits of the NHIF members and 5% are not aware.

Table 4.9; Staffs' knowledge at Health Care Centres about Rights and Benefits of the NHIF Members

Response	Frequency	Percent
Yes	37	95
No	2	5
Total	39	100

Source; Field Data, 2013

4.7.2 If Health Care Givers Serve NHIF Members with All the Contracted Benefits Package

NHIF have contracted benefits package which the contracted health care providers have to provide to its members. Results in table 4.10 show that 51% of the health service providers reported that the NHIF members are provided with all the contracted benefits and 49% say they are not provided with all the contracted benefits. Looking at the reasons as to why the NHIF members are not provided with all the contracted benefits, results in table 4.10 show that the main reason is lack of funds and qualified workers. The other reason given by the health care givers is weakness of NHIF staff and the rest of the staff is not aware.

Table 4.10; If Health Care Givers Serve NHIF Members with All the Contracted Benefits Package

Response	Frequency	Percent
Yes	20	51
No	19	49
Total	39	100
Reason for not serving	Frequency	Percent
Not Applicable	20	51
Lack of fund and qualified workers	10	26
Weakness of the NHIF staff	8	21
Don't know	1	3
Total	39	100

Source; Field Data, 2013

4.7.3 Reasons for not giving some Services to Members while availing the same to Non members

Experience has revealed that some of the services intended for the NHIF members are provided to non NHIF members. Results in table 4.11 show that price of medical services and grade of the hospital contribute to the provision of some of the services to non NHIF members instead of the NHIF members. Other reasons given include late payments of from the Fund, long process in funds acquisition; in some cases the providers need cash instead of cards and use of generic names as well.

Table 4.11 Reasons for not giving some Services to Members while availing the same to Non Members

Reason	Frequency	Percent
Not applicable	20	51
Generic names	1	3
Price and grade of the hospital	7	18
Late payments from the Fund	6	15
They need cash than NHIF cards	2	5
Long process	3	8
Total	39	100

Source; Field Data, 2013

4.7.4 Nature of Processing of Payment Claims and Refund by NHIF

In diagnosing the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries, study about the nature of processing payment claims and refunds becomes important. Results in table 4.12 show that the majority (54%) of the health care providers says that processing of payment claims and refund by NHIF is not on time and 46% say is on time. The main reason given for the late processing of payment claims and refund being long processing arranged by the fund. The other reasons include shortage of competent workers and weakness of the managing NHIF body

Table 4.12 Nature of Processing of Payment Claims and Refund by NHIF

Response	Frequency	Percent
Yes	18	46
No	21	54
Total	39	100
Reason for the delay	Frequency	Percent
Not Applicable	18	46
Weakness of the body of NHIF	1	3
Long process arranged by the Fund	10	26
Shortage of workers	6	15
Total	39	100

Source; Field Data, 2013

CHAPTER FIVE

DISCUSSION OF THE RESEARCH FINDINGS

5.0 Introduction

This chapter presents summary of discussion of the findings obtained from the study. Data collected had been analyzed accordingly.

5.1 Discussion of the Findings

Chapter four has shown the analysis of data in respect of the Efficiency of NHIF in health provision to the beneficiaries a case of Morogoro Municipality. The discussion in this section will be guided by the objectives that mentioned in chapter one.

5.1.1 Awareness in implementing NHIF policies and terms

On the operations of the NHIF in implementing policies and terms, the three NHIF staff workers was involved in answering questions that are related to the operations. Result shows that 100% of the three NHIF staff involved agreed that NHIF has scheme objectives and that all terms in fund act are being implemented. The staff also mentioned the fund guide as the main legal frame work in operating the schemes and the mechanism which are used in operating that scheme include entering the contract with care providers, supervision and making inspection to the care providers.

5.1.2 Accredited of the health facilities in implementing NHIF policies and terms

In view of generating of the accredited health facilities in implementing policies and terms, the results depicted how care providers sign a contract with National Health Insurance Fund. Majority of the health facilities signed the contract in 2001 to date.

In addition this sign of the contract is due to compliance of rules and policies of the NHIF towards to health services provision to the beneficiaries.

The essence of the provision of National Health Insurance Fund compliances rules, policies, contract terms and level of implementation are well done. Furthermore in table 4.4 and figure 4.1 shown that the level of implementation ranged 61-100% which makes NHIF be efficient in health services provision to its beneficiaries.

5.1.3 The essence of members' complains

In the study it was found that in Morogoro Municipality the essence of members complains to the provision of health services raised to the 67%. Members claimed that the Fund categorized members through treatment cards, diseases and some medicines In getting health services with the entire contracted benefit package at the health facilities the care givers provided health services following the NHIF table list and not any other ways, this causes complains to the members why X get such services and Y failed to get with no reasons. The Fund here is luck- efficiency in health provision to its members.

5.1.4 Flow of information to and fro between members and the Fund

In generating the existing mechanism of flow of information to and fro between members of NHIF and the Fund, table 9 shows that 100% of the National Health Insurance Fund staff agreed that the Fund has representatives in top decision making body of NHIF. Both journals and media were mentioned as the mechanism of receiving individuals complains. Further in table 4.7 shown that financial information to the public and its members does not given, the reason behind is that the Fund is for providing health services and not for profit oriented.

5.1.5 Extent of members' knowledge on their entitlements from the Scheme

This part explained the knowledge of the members have about the rights and benefit package provided by NHIF though care givers, the findings depicted that 71% of the members said that care givers have the knowledge towards to the Scheme. In the study also it come out that 29% of care givers are not aware. This unawareness is due to the low level of education towards to the National Health Insurance Scheme in providing health services to its members, results to this is poor services to the members.

5.1.6 Extent of knowledge on entitlements of the members do the primary service and care Givers at the hospitals, pharmacies, and NHIF offices have

The researcher noted that in health services provision the entitlements of the members are well qualified in provision of the health services, results in table 4.9 show that 91% of the care givers know the rights and benefits package of the members. Results also show that only 51% of the health services provide services with the all contracted benefits package and the reasons behind is lack of fund, qualified workers, weakness of the care provider, grade of some health centres lack qualification in distributing some health services use of generic names and some care givers prefer to serve mere in cash than NHIF cards to generate quickly profits. The nature of processing payments claims and refund on time 54% of health services stated that the exercise is not on time because NHIF arranged long process in payments, shortage of qualified workers and weakness of some staffs of care providers in managing the provision of the health services to the beneficiaries.

CHAPTER SIX

SUMMARY, CONCLUSION AND POLICY IMPLICATION

6.0 Introduction

This chapter provides a summary, conclusion and policy implication arising from the study. The chapter is divided into three main sections. The first section gives the summary of the major findings. The second section presents the conclusion based on the chapters obtained in the report. The third section presents the policy implications arising from the study and recommended policy actions.

6.1 Summary of Major Findings

The study focused on Efficiency of National Health Insurance Fund in health provision to the beneficiaries a case study of Morogoro Municipality. Six specific objectives were developed to guide this study. The first objective was to find out the operations of the NHIF in implementing policies and terms. The second objective was to assess the operations of the accredited health facilities in implementing policies and terms. The third objective was to examine the essence of the members complains. The fourth objective was to display the existing mechanism of flow of information to and fro between the members and the fund. The fifth objective was to scrutinize the extent of member's knowledge on the entitlements of the members. The sixth objective was to investigate the extent of knowledge on entitlements of the members do the primary services/care giver at the hospitals, pharmacies and NHIF offices have.

Case study design approach was used in the study where by Morogoro Municipality was taken as case study, the total population of study area was identified to be 1652. This population is made up from government and private sectors in different institutions. Data for this study were collected through questionnaires, interviews and recorded information. The data were collected from a sample size of 242

respondents. The collected information from the field study was coded and entered into a spreadsheet and analyzed using Statistical Package for Social Sciences (SPSS) version 16.0. Quantitative analysis involved generating descriptive statistics included frequencies and their corresponding percentage scores. The qualitative analysis involved categorizing of data from interview and field notes into common themes and presented using percentage in tables and figure.

It was noted that in the study 67% of the members are not satisfied by the service provided by the fund. The major reasons given are based on the types of NHIF cards given, category of medicines and diseases, poor arrangement of getting services and amount of money is high than the services provided .Also it was found that 49% of the care providers not provided health services with all contracted benefits package. The reasons given include lack of fund and qualified workers, weakness of NHIF Staff as well as the late payments from the fund.

6.2 Conclusion

The study focused on the Efficiency of National Health Insurance Fund in health provision to the beneficiaries. The study was conducted in Morogoro Municipality. There were six questions that have obviated answers as follows: On operations of NHIF in implementing its policies and terms, respondents showed that 100% were involved. The exercise of accredited health facilities and sign contract in implementing the NHIF policies and terms, 100% of respondents agreed are being implemented. Essence of members' complaints was at the rate of 67%. The rate of flow of information to and fro between members and fund were 67%.The knowledge of members towards entitlements/caregivers was 71% while Knowledge of entitlements to the members was at the rate of 95%.

In view of the study findings, this research concludes that NHIF lack efficiency and recommended to improve those areas raise claims to the members.

6.3 Policy Implication

Following the different ideas from the study on the efficiency of National Health Insurance Fund in health provision, it shown that, NHIF is really in providing the agreed benefits to its members, the NHIF policy of 1999 under the Ministry of health amend the following areas to improve health services delivery;

6.3.1 Educate Beneficiaries

They advised to provide education to the NHIF members and health facilities both in urban and rural areas beneficiaries /members and some care givers seemed to lack education on what kind of benefit package the Fund provided and what not provided with the reasons. Seminars and workshops should be provided to help NHIF members to know their rights, since the Fund established in 2001 Morogoro Municipality provided only one seminar to its members.

6.3.2 Provide Quality health services

It would be desirable for the Fund to provide quality health services to the beneficiaries. Health services which are provided by the Fund are in low quality to treat some diseases and sometimes care givers told NHIF members that the medicines thought to be better for such diseases are not in the list of NHIF. This also raises complaints to the members to fight extra money for buying such services while contributions are deducted every month. Solution to this is for the government and body of NHIF to include all medicines in the list of NHIF because the amount which are deducted in every month are enough to provide such health services and lack enough not all time members are sick.

6.3.3 Eliminate category of NHIF cards

National Health Insurance Fund categorizes cards; there are members of brown and green cards, members claimed that those who have brown cards enjoyed the cake of National Health in receiving the quality health services compared to those who have green cards in terms of medicines and some diseases, green cards members feel inferior once meet with brown cards members in health centres and they lack information why such situations happened. The National Health Insurance Fund is the Fund for the few especially those who are in top. It is better for the Fund to have the same cards to all NHIF members in provision of health services if not so education is needed members.

6.3.4 Pay Care providers on-time

National Health Insurance Fund supposed to pay care providers on-time in order to work properly and provide better service to NHIF members.

6.3.5 Introduce Representatives to the NHIF members

In improving health services to the members the staff of NHIF agreed that the Fund had representatives from the different occupational associations and from care providers but majority of members and care facilities stated that no representatives from such associations once the members have the problems about the NHIF they didn't get solutions. The NHIF should devise a mechanism of introducing all NHIF representatives to the members and care givers to remove complain and improve health services provision.

6.3.6 Improve Communication

Information and communication is very important in any association/organization to achieve its objectives, National Health Insurance Fund should provide information to its beneficiaries in simple ways such as meetings and journals rather than using websites because majority seemed to be out of website, some members of NHIF in Morogoro

Municipality didn't know even where the NHIF office is and the reasons behind include poor communications and lack of meetings. The staff and body of NHIF should improve this department in both urban and rural areas, the package and benefits which are provided by the Fund is not only health services but also other services such as loan for health treatment tools in all accredited centres.

6.3.7 Properly facility inspection and supervision

The respondents argued that the NHIF has to make serious in inspection and supervision to medical centres in several times to check the efficiency, members said that most of medical centres are defrauding the fund.

6.3.8 NHIF be closely with Stakeholders such as workers Trade Unions

The fund has to work closely with Trade Unions to make sure that accredited health providers are delivering what beneficiaries are expecting to their end. They should listen and take all complaints aired by the members and find lasting solutions from the responsible entity.

6.3.9 The Government

Respondents are recommended that government as the machinery should follow up and take correct measures to health facilities that defraud the fund. It should directive all councils on importance of NHIF as the alternative financing option in the health care mechanism and encourages students to study science subjects including health sciences to overcome shortage of qualified medical personnel**.**

6.4 Areas for further studies/research

The National Health Insurance Fund in providing health services to the beneficiaries are faced with some problems such as lack of knowledge by the public on health insurance schemes, low quality of health services, category of NHIF cards, late of payments from the fund to care givers, poor communication and proper facility inspection and

supervision. These caused complains to the beneficiaries in getting health services to improve manpower of the nation. The government, NHIF, trade unions, care providers and all members/beneficiaries should find solution to the highlighted problems.

The study focused on efficiency of NHIF in health provision to the beneficiaries. Further research should investigate into the following areas so as to find causes and provide solutions to the problems and eradicate the completely**.**

i) The shortage of drugs and other medical supplies in public centres.

ii) How the scheme should be more effective and nearly to the society especially those who are in rural areas and disseminates education to the majority.

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APPENDICES

Appendix 1

THE RESEARCH WORK PLAN

From year 2012 to 2013

Activity/Time	***November 2012***	***December 2012***	***January 2013***	***February 2013***	***March 2013***	***April 2013***	***May 2013***
Consulting Research Supervisor							
Research proposal drafting							
Consulting Research Supervisor							
Research proposal submission							
Consulting Research Supervisor							
Pilot study survey							
Data collection							
Data cleaning							
Data processing and analysis							
Research report drafting							
Consulting Research Supervisor							
Research report submission							
Thesis Defending							

Appendix 2

THE RESEARCH BUDGET

PARTICULARS (Costs)	AMOUNT (Tshs)
1. Transport during data collection 500,000	
2. Meals during data collection	200,000
3. Accommodation during data collection	300,000
4. Stationeries and rim papers	100,000
5. Statistical Package (SPSS)	100,000
6. Laptop	850,000
7. Printer and accessories	350,000
8. Transport & meals in consultation with the Research Supervisor	400,000
9. Contingency	200,000
GRAND TOTAL	***3,000,000***

Appendix 3

MZUMBE UNIVERSITY SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

MASTERS IN PUBLIC ADMINISTRATION PROGRAM (MPA)

Schedule for the NHIF member

Title of the study: ***"THE EFFICIENCY OF THE TANZANIA NATIONAL HEALTH INSURANCE FUND IN HEALTH PROVISION TO THE BENEFICIARIES: A Case Study of Morogoro Municipality***

I, *Sibilina J. Msaki,* conduct this study for academic purposes only. The purpose of this study is to diagnose the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries.

You are among the NHIF members who enjoy the benefits package of the National Health Insurance Fund. I therefore kindly request you to respond to the following questions to the best of your knowledge. I promise and assure you that all the answers will remain confidential and will only be used for the purpose of this study.

THANKING YOU IN ADVANCE FOR YOUR COOPERATION!

Schedule number…… Date data collected……

PERSONAL PARTICULARS

Full names……..

Occupation…….

Occupational institution…….

Sex: MALE or FEMALE (cancel inappropriate)

Age……..

Education level……..

Marital status……

QUESTIONS

1. Are you a member of NHIF?

a) YES b) NO ……

2. Since when have you been a member of NHIF? year……

3. Do you have NHIF membership card?

a) YES b) NO ……

4. Have you ever used one of the benefits package provided by NHIF?

a) YES b) NO ……..

If YES, were you given that service on-time?

a) YES b) NO …….

If NO, why not given on-time?

.....

.....

.....

.....

5. Have ever in any given day in your life been denied your right to a particular benefit at the health facility?

a) YES b) NO ……..

If YES, what was that service?

……

What is the name of that facility?

……

Why do you think you were not given?

……

……

6. Do you think NHIF is really providing the agreed benefits to its members?

a) YES b) NO ……..

If NO, why you think so?

……

……

7. Are you satisfied with the provided services by the Fund commensurately to your premiums?

a) YES b) NO ……

If NO, why?

……

……

……

8. Have you ever tried to find any information about NHIF or benefits package from the NHIF office or website?

a) YES b) NO ……

If YES, did you succeed to get that information?

a) YES b) NO ……..

If YES, how?

……

If NO, why?

……

9. When you have something to tell NHIF you personally, how do tell it to NHIF?

……

10. How would you advise any member of the public wishing to join NHIF today?

a) Ever join it b) Never join it c) Wait a bit ……..

Why such an advice?

……

……

11. Have you ever requested anything in person at the NHIF office?

a) YES b) NO ……

If YES, when still at the office, did the NHIF staff handle you warmly or coldly? ……

In whatever handling, did the staff process or work upon your request on-time?

a) YES b) NO ……

If NO, why?

……

……

12. When you attended to the clinic or pharmacy as an NHIF member, were you handled warmly or coldly? ……

Where you attended on-time like other patients who are none NHIF members?

a) YES b) NO ……..

If NO, why?

……

……

13. Are you aware about the existing membership benefits package from NHIF?

a) YES b) NO ……

If NO, why?

……

……

14. Do you think that, the health care givers are knowledgeable about the rights and benefits package of the member of the NHIF attending the health facility?

a) YES b) NO ……

If NO, why?

……

……

15. Do you have any complaint or problem to NHIF?

a) YES b) NO ……

If YES, mention and state each complaint/problem with its essence as per your thinking below.

……

……

……

16. Why sometimes at the health facility, you are told the particular service is not available while at the same time it is given to the non-NHIF members?

……

17. Have you ever asked the NHIF how is the scheme's money used?

a) YES b) NO ……..

If YES, what were you answered?

……

……

If NO, why?

……

……

18. From your occupational associations, you as members of NHIF, do you have any person representing you in the top decision making body of NHIF?

a) YES b) NO …….

If YES, how many represent you? .....

If NO, why?

……

……

Appendix 4

MZUMBE UNIVERSITY SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

MASTERS IN PUBLIC ADMINISTRATION PROGRAM (MPA)

Schedule for the NHIF accredited clinical care provider

Title of the study: ***"THE EFFICIENCY OF THE TANZANIA NATIONAL HEALTH INSURANCE FUND IN HEALTH PROVISION TO THE BENEFICIARIES: A Case Study of Morogoro Municipality***

I, *Sibilina J. Msaki,* conduct this study for academic purposes only. The purpose of this study is to diagnose the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries.

You are among the NHIF accredited clinical care provider who enjoys the contract of the National Health Insurance Fund. I therefore kindly request you to respond to the following questions to the best of your knowledge. I promise and assure you that all the answers will remain confidential and will only be used for the purpose of this study.

THANKING YOU IN ADVANCE FOR YOUR COOPERATION!

Schedule number…… Date data collected……

PERSONAL PARTICULARS

Full names……..

Occupation…….

Occupational health facility type……

Health facility name ……..

Sex: MALE or FEMALE (cancel inappropriate)

Age……..

Education level……..

QUESTIONS

1. Is your facility accredited by NHIF to provide for its members?

a) YES b) NO ……

2. Since when is your facility accredited by NHIF? year……

3. Was your facility accredited by signing a contract with NHIF?

a) YES b) NO ……

If NO, why?

……

……

4. When facility accredited, were you given by NHIF the compliance rules to the services provision and other particulars, the NHIF policy, and the contract terms?

a) YES b) NO ……..

If NO, why?

……

……

If YES, to what percentage do you work and walk on them? ……

5. Do your all staff at the facility have knowledge about the rights and benefits of the NHIF members when they serve them?

a) YES b) NO ……..

If NO, why?

……

……

6. Does NHIF process your payment claims and refund on-time?

a) YES b) NO ……..

If NO, why?

……

……

7. Do you serve the NHIF members with all the contracted benefits package at your facility?

a) YES b) NO ……

If NO, why?

……

……

8. Do you serve the NHIF members at your facility on-time without delaying compared to non-NHIF members?

a) YES b) NO ……

If NO, why?

……

……

9. Why do you sometimes tell the NHIF members that a particular service is not available while the non-NHIF members at the same time are given it?

……

……

10. What would you advise the new clinical health provider wishing to enter service provision contract with NHIF?

a) Ever to contract b) Never to contract c) Wait a bit ……..

Why such an advice?

……

……

11. Does NHIF at any uninformed time, come to your facility for inspection on your compliance to the rules and terms of the contract and policies?

a) YES b) NO ……

If NO, why?

……

……

12. From your associations of health care providers for NHIF, do you have any person representing you in the top decision making body of NHIF?

a) YES b) NO ……..

If YES, how many represent you? …….

If NO, why?

……

……

Appendix 5

MZUMBE UNIVERSITY

SCHOOL OF PUBLIC ADMINISTRATION AND MANAGEMENT

MASTERS IN PUBLIC ADMINISTRATION PROGRAM (MPA)

Schedule for the NHIF staff

Title of the study: ***"THE EFFICIENCY OF THE TANZANIA NATIONAL HEALTH INSURANCE FUND IN HEALTH PROVISION TO THE BENEFICIARIES: A Case Study of Morogoro Municipality.***

I, *Sibilina J. Msaki,* conduct this study for academic purposes only. The purpose of this study is to diagnose the governance of the National Health Insurance Fund leading to its efficiency in service provision to beneficiaries.

You are among the NHIF staff who is an employee of the National Health Insurance Fund. I therefore kindly request you to respond to the following questions to the best of your knowledge. I promise and assure you that all the answers will remain confidential and will only be used for the purpose of this study.

THANKING YOU IN ADVANCE FOR YOUR COOPERATION!

Schedule number…… Date data collected……..

PERSONAL PARTICULARS

Full names……..

Title …….

Occupational institution…….

Sex: MALE or FEMALE (cancel inappropriate)

Age……..

Education level……..

QUESTIONS

1. Do you have scheme objectives?

a) YES b) NO ……

2. Do you implement all the terms in the Fund Act?

a) YES b) NO ……

If NO, why?

3. What legal frameworks and materials guide you in operating the scheme?

……

……

……

4. Do you enter contract with the health care providers??

a) YES b) NO ……..

If NO, why?

.....

.....

5. Do you go to supervise and inspect without any information the health care providers to check about their compliance to NHIF terms and regulations?

a) YES b) NO ……..

If NO, why?

……

……

6. Why do some health care providers tell the NHIF members some particular services are not available while at the same time are given to non-NHIF members?

……

7. Do you pay the money claims on-time?

a) YES b) NO ……

If NO, why?

……

……

8. In your top decision making body, are there representatives for the NHIF members and health care providers?

a) YES b) NO ……

If NO, why?

……

……

9. What mechanism do you have for receiving individual member's complaints or information?

……

……

10. Do you give out to the public and your members the financial information and other information relating to the Fund?

a) YES b) NO ……..

If NO, why?

……

……

11. Are all NHIF staff knowledgeable about the members' benefits package, NHIF legal frameworks, rules and procedures of the scheme as well as the compliance policy?

a) YES b) NO ……

If NO, why?

……

……

12. Why do NHIF staff not process and solve the problems of its members on-time?

……

……

13. What mechanism do you as NHIF have to control and check for the compliance of the accredited health care providers in serving well the benefits package to your members?

……

……

14. Does NHIF make autonomous decisions without being interfered by other organs of the government in implementing its day to day activities and issues including the goals?

a) YES b) NO ……

If NO, why?

……

……

15. In your views, is the Fund stable financially to cover for the entire benefits package and other management operations for at least ten years to come?

a) YES b) NO ……

If NO, why?

……

……

……

……

16. Looking back two years ago, what can you say in comparison to the current time, are the numbers of members and health care providers increase, decrease, or stagnant in enrolment to NHIF? …….....

Why to such answer?

……

……

17. Do you (NHIF) know your members have some complaints concerning services given to them?

a) YES b) NO ……..

If YES, why you still let the complaints prevail?

……

……

If NO, why?

……

……

18. Is the NHIF Board comprise of the representatives from different members occupational associations as well as health care providers associations?

a) YES b) NO …….

If NO, why?

……

……

Regardless to the above answers, please outline the composition of the NHIF Board with regard also to professionalism requirements!

……

……

……