

**SERVICE PROVIDER'S PERCEPTIONS OF THE QUALITY AND  
ACCESSIBILITY OF HEALTH SERVICES UNDER SOCIAL  
HEALTH INSURANCE IN DAR-ES-SALAAM**

**By**

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A Research Treatise submitted in partial fulfilment of  
The requirements for the degree of Master of Arts in Health and Welfare  
Management in the Faculty of Health Sciences at the Nelson Mandela  
Metropolitan University

**Date of submission: 10<sup>th</sup> January 2007**

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## ACKNOWLEDGEMENTS

With much appreciation I gladly acknowledge those who in some way, provided me with assistance and guidance throughout the research process and writing of this treatise.

I must begin by expressing my sincere appreciation and gratitude to my supervisors, Prof. Juanita Strumpher of NMMU and Dr Phares Mujinja of MUCHS. None of the work I did for this treatise could have been accomplished without their assistance and guidance. Throughout the process of writing the proposal, conducting the research and writing the report, their insightful comments have always inspired me to do better.

To the health workers who participated in this study, I owe my gratitude and respect. They participated in this study willingly and with much enthusiasm, giving me the cooperation that made my work much easier. Although the study focused on the health workers, I cannot forget the assistance that was provided by the directors of the hospitals where the study took place. This study would not have been possible without their permission and cooperation in identifying the participants.

I also wish to acknowledge the Tanzania Commission for Science and Technology and the District Health Official for granting me the necessary permits to conduct this research.

To complete this research entailed a lot of hard work and time away from family. I thank my family, who gave me all their support and assistance, which gave me encouragement throughout my studies. I wish to extend special appreciation to my husband, Chilanga for

his patience, for his challenging remarks and advice throughout the duration of my course, especially during the research.

Finally, I would also like to thank Mrs Barbara Pitt for providing assistance with editing of this report.

## ABSTRACT

Social health insurance is a form of health care financing that has gained increased attention in African countries in the past decade. Tanzania introduced social health insurance by the establishment of the National Health Insurance Fund (NHIF) in 1999 with, *inter alia*, the objective of improvement of the quality and availability of health services.

The goal of this study was to determine the perceptions of services providers on the quality and accessibility of health services following the introduction of social health insurance. A qualitative approach was used to gain an insider's perspective from the service providers of how the services have changed following the introduction of the scheme. Individual interviews, observation and field notes were used to gather information on the quality and accessibility of health services under the policy of social health insurance. Data were analysed using Tesch's method of data analysis.

The health workers generally perceived the fund as being beneficial to its members as it reduced the financial barriers to receiving health care. However, the objectives of the NHIF as a health financing mechanism were not adequately understood by the health workers. Although they perceived the quality of health services as having improved compared to previous years, they did not associate this improvement with the NHIF. The health workers also perceived accessibility of health services as having improved for insured patients but not for non-insured patients.

Based on the findings, the study recommended that more effort be put into informing and educating the health workers about social health insurance and the NHIF and that NHIF staff make regular visits to health facilities and member workplaces to monitor progress. The study also recommended that further research be conducted in the areas of insurance coverage and competition among public providers.

**KEY WORDS:** health workers, social health insurance, quality, accessibility, health services, NHIF.

## TABLE OF CONTENTS

<b>CHAPTER 1</b>	<b>1</b>
<b>OVERVIEW OF THE STUDY</b> .....	
1.1 INTRODUCTION.....	1
1.2 BACKGROUND.....	2
1.3.....LITERATURE STUDY.....	4
1.4 PROBLEM STATEMENT.....	9
1.5 RESEARCH QUESTIONS.....	10
1.6 RESEARCH GOALS.....	11
1.6.1 Research Objectives.....	11
1.7 DEFINITION OF TERMS.....	11
1.8 RESEARCH DESIGN.....	13
1.9 RESEARCH DESIGN.....	15
1.9.1 Study Population.....	15
1.9.2 Sampling Strategy.....	16
1.9.3 Method of Data Gathering.....	16
1.9.4 Data Analysis.....	17
1.9.5 Use of Literature in the Study.....	17
1.9.6 Pilot Study.....	18
1.9.7 Ensuring Rigour (trustworthiness) of the Study.....	18
1.9.8 Ensuring High Ethical Standards.....	19
1.9.9 Role of the Researcher.....	22
1.10 CONCLUSION.....	22
 <b>CHAPTER 2.....</b>	 <b>23</b>
<b>METHODOLOGY</b> .....	
2.1 INTRODUCTION.....	23
2.2 RATIONALE FOR THE STUDY.....	23
2.3 GOAL OF THE STUDY.....	25
2.4 RESEARCH DESIGN.....	25

2.5	RESEARCH METHODOLOGY.....	26
2.5.1	Research Population.....	26
2.5.2	Sampling Strategy.....	26
2.5.3	Contact with Research Population.....	27
2.5.4	Method of Data Gathering.....	28
2.5.5	Data Analysis.....	33
2.5.6	Use of Literature in the Study.....	34
2.5.7	Pilot Study.....	34
2.5.8	Ensuring Rigour (trustworthiness) of the Study.....	36
2.5.9	Ensuring High Ethical Standards.....	39
2.6	CONCLUSION.....	39

### **CHAPTER 3**

	<b>FINDINGS AND INTERPRETATION.....</b>	<b>40</b>
3.1	INTRODUCTION.....	40
3.2	FINDINGS AND INTERPRETATION.....	41
3.2.1	Theme 1: Health Workers' Understanding of the NHIF.....	42
3.2.1a	Sub-theme 1.1: Understanding of the Objectives of the NHIF.....	43
3.2.1b	Sub-theme 1.2: Understanding of the Benefits of the NHIF.....	46
3.2.2	Theme 2: Health Workers' Perceptions Regarding the Quality of Health Services.....	48
3.2.2a	Sub-theme 2.1: Perceptions Regarding the Availability of Drugs, Supplies and Equipment .....	48
3.2.2b	Sub-theme 2.2: Perceptions Regarding Performance of Health Workers.....	52
3.2.2c	Sub-theme 2.3: Perceptions Regarding the Ability to Offer More Services.....	55
3.2.2d	Sub-theme 2.4: Perceptions Regarding the Hospital Environment.....	57
3.2.2e	Sub-theme 2.5: Perceptions Regarding Extra Duties for Health Workers.....	59
3.2.2f	Sub-theme 2.6: Perceptions Regarding the Difference in Services Offered to NHIF Members and non NHIF Members.....	65
3.2.2g	Sub-theme 2.7: Perceptions Regarding the Effect of the NHIF on Quality of Health Services.....	68

3.2.3 Theme 3: Health Workers' Perceptions on the Accessibility of Health Services.....	70
3.2.3a Sub-theme 3.1: Perceptions Regarding Accessibility for NHIF Members.....	71
3.2.3b Sub-theme 3.2: Perceptions Regarding Accessibility for non NHIF Members.....	73
3.3 CONCLUSION.....	75
<b>CHAPTER 4</b> .....	<b>76</b>
<b>DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSION.....</b>	
4.1 INTRODUCTION.....	76
4.1.1 Objectives of the Study.....	76
4.2 DISCUSSION OF FINDINGS.....	77
4.2.1 Understanding of the NHIF.....	77
4.2.2 Quality of Health Services.....	80
4.2.3 Accessibility of Health Services.....	83
4.3 LIMITATIONS OF THE STUDY.....	84
4.4 RECOMMENDATIONS.....	86
4.4.1 Education.....	86
4.4.2 Clinical Practice.....	86
4.4.3 Research.....	88
4.5 CONCLUSION.....	88
BIBLIOGRAPHY.....	89
APPENDIX I: INFORMATION AND INFORMED CONSENT FORM.....	97
APPENDIX II:	
LETTER OF APPROVAL FROM THE ADVANCED DEGREE COMMITTEE.....	101
LETTER OF APPROVAL FROM THE HUMAN ETHICS COMMITTEE.....	102
APPENDIX III- RESEARCH PERMIT FROM COSTECH.....	103
APPENDIX IV: PERMISSION TO CONDUCT RESEARCH IN KINONDONI DISTRICT.....	104
APPENDIX V: PERMISSION TO CONDUCT RESEARCH IN TEMEKE DISTRICT.....	105
APPENDIX VI: INTERVIEW GUIDE.....	106



## **LIST OF TABLES**

Table 3.1: Identified Themes Related to Service Providers' Perceptions of the Quality and Accessibility of Health Services under Social Health Insurance in Dar-Es-Salaam.....	42
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## **LIST OF ABBREVIATIONS**

<b>ADO</b>	<b>ASSISTANT DENTAL OFFICER</b>
<b>AMO</b>	<b>ASSISTANT MEDICAL OFFICER</b>
<b>COSTECH</b>	<b>COMMISSION FOR SCIENCE AND TECHNOLOGY</b>
<b>DC</b>	<b>DISTRICT COMMISSIONER</b>
<b>DFID</b>	<b>DEPARTMENT FOR INTERNATIONAL DEVELOPMENT</b>
<b>DMO</b>	<b>DISTRICT MEDICAL OFFICER</b>
<b>MOH</b>	<b>MINISTRY OF HEALTH</b>
<b>NHIF</b>	<b>NATIONAL HEALTH INSURANCE FUND</b>
<b>RMO</b>	<b>REGIONAL MEDICAL OFFICER</b>
<b>WHO</b>	<b>WORLD HEALTH ORGANIZATION</b>

## **CHAPTER 1**

### **OVERVIEW OF THE STUDY**

#### **1.1 INTRODUCTION**

Tanzania started experimenting with social health insurance in 2001 after the National Health Insurance Act (Act 8 of 1999) was passed in Parliament (United Republic of Tanzania, 1999). This new form of health care financing is part of the ongoing health sector reforms in the country that were instituted to improve, *inter alia*, the quality and accessibility of health services in the country. As in most Sub-Saharan countries where the implementation of this type of system is still in its early stages, the impact of social health insurance on the provision of health services in Tanzania has not yet been adequately documented.

This study aims to explore the views of the service providers regarding the provision of health services following the establishment of the National Health Insurance Fund (NHIF). A qualitative approach will be used, whereby individual interviews, observation and field notes will be used to obtain a thick description the health workers' perceptions concerning provision of health services under social health insurance.

#### **1.2 BACKGROUND**

Social health insurance is a mechanism for financing health care whereby services are paid for by contribution to a health fund that is usually independent of the government

but works within a tight regulatory framework (Bennett and Gilson, 2001:5). It is characterised by solidarity, whereby the rich subsidise the poor, the young the old and the healthy the sick, and is usually government mandated and compulsory. Social health insurance is usually financed through taxes or by contributions from both employer and employees (Carrin and James, 2004:3). Contributions are based on the ability to pay and access to services depends on need (Normand and Weber, 1994:13). Coverage may be universal as in the United Kingdom, Sweden, Finland and Canada or limited to specific groups of the population like the formal sector or the army as in Brazil, Argentina and Chile (Kutzin in Beattie, Doherty, Gilson, Lambo, and Shaw, 1996:61). However, the premise is to promote equity and access for all.

Health insurance received much attention in African countries over the past decade due to the stagnant economies and resultant lack of resources to finance health care. Governments could no longer honour their commitment to provide free health care for all by relying on general taxation and donor support (Beattie *et al*, 1996:1-2; Leighton, 1995:6). Many African countries facing similar problems with health care financing introduced cost recovery measures such as user fees with mixed results. On the one hand, there was improved quality of health services, an increase in availability of drugs, maintenance of health facilities and contribution of user fees to the recurrent budget and non-wage budget for the health sector (Rwechungura, 2003, Msambichaka, 2003 and MOH 1999 in Laterveer, Munga and Schwerzel, 2004:24). On the other hand, there was a negative impact on health service utilization, especially by vulnerable population groups (Bennet and Gilson, 2001:11; Laterveer *et al*, 2004:24; Quaye, 2004:96).

Hence, health insurance became an alternative cost recovery measure to generate additional revenue for financing health care and to complement the existing user fees system. In addition, this form of health care financing was seen as a means to address the problems and challenges facing the health sector such as quality, access, equity, efficiency and sustainability (Kutzin *in* Beattie *et al*, 1996:61).

The same concerns regarding the financial sustainability of the health sector were raised in Tanzania, which resulted in the introduction of user fees as a cost-sharing measure in 1993. After five years of user fee implementation, experience highlighted the need for an alternative means to finance health care, hence the introduction of a national health insurance scheme (Minja, 1999:152; Bituro, 1999:153). The National Health Insurance Fund (NHIF) was introduced following the passing of the National Health Insurance Act, 1999 (Act 8 of 1999) by the Tanzanian parliament (United Republic of Tanzania, 1999).

The objectives of the scheme include to:

- Increase financial resources and reduce the financial gap in the health sector.
- Facilitate private financing in curative care and shift resource allocation to preventive and public health programmes.
- Improve efficiency in the health sector and improve the quality and availability of health services (Bituro, 1999:153; NHIF, 2002).

The fund is mandatory for all civil servants, with benefits extending to their spouses and not more than four children or legal dependants. This coverage is expected to expand gradually to become universal. Funding is obtained mainly from contributions by the employee and the employer; this constitutes an amount of 6% of the employee's salary

(3% as a direct deduction and 3% as a contribution by the employer) (Bituro, 1999:153; NHIF, 2002). The fund was implemented in 2001 and currently has a total of 248,343 members and a total of 1,142,378 beneficiaries (Humba, 2005a:7). The fund has six branches nation-wide, each responsible for a geographical zone consisting of 2-4 regions.

To date, the NHIF has reported a number of achievements. These include improved health services due to the payments being made to service providers from the fund, which have risen from 247.36 million Tanzania Shillings (Tsh) in 2002 to Tsh 3,799.25 million in 2005 (Humba, 2005b:19). These moneys are meant to be used by service providers for curbing of drug shortages, renovation of hospital facilities and motivation of hospital staff. However, the scheme also faces many challenges, which include fraudulent tendencies and non-adherence to Ministry of Health (MOH) standards by service providers (Humba, 2005a:7; Humba, 2005b:24). A preliminary study by Quaye (2004:100) also reported complaints of abuse and inferior services from NHIF members and lack of awareness on the part of service providers about the fund.

### **1.3 LITERATURE STUDY**

Health financing reforms were introduced to address the concerns about problems regarding the quality of health care, financial constraints and the problem of access and equity in health care (Sekwat, 2003:70). Hence, it is not surprising that improvements in quality and access to health care are included in the major goals of these reforms.

According to Leighton (1995:15), health care financing reforms are justifiable and most effective when designed to achieve such goals.

One of the strategies of health financing reforms is to raise revenue through cost recovery, which represents a departure from the traditional view of government as the sole provider of health services in the region (Sekwat, 2003:73). Indeed, raising revenue was found to be the primary objective of cost recovery cited by most countries in a worldwide survey of 26 countries in 1995. Nine countries (Cameroon, China, Honduras, Iran, Kenya, Mexico, Nepal, Thailand and Uganda) also cited improving the quality and extending the coverage of healthcare services through cost recovery strategies (Russell and Gilson 1995 in Leighton, 1995:11). Raising revenue through cost recovery has been the main policy reform chosen by African ministries of health for financing quality and access improvements in health service delivery. The additional funds captured could be used to pay for quality improvements and improving geographical access (Leighton, 1995:11).

Social health insurance seems to be a leading alternative health financing strategy for many Sub-Saharan countries. Ghana introduced a National Health Insurance Program (NHIP) similar to Tanzania's NHIF with the primary objective of assuring equitable universal access for all residents of Ghana to an acceptable quality package of health services. Other countries in the process of introducing social health insurance include Malawi, Nigeria, South Africa, Uganda and Zimbabwe (DFID Health Insurance Workshop Report, 2002:11-15).

Access to health care is closely linked to health service financing in developing countries and is a key challenge to the health systems (Harderman, 2004; Gilson and Lake, 2002). Health insurance can improve access to health services by reducing the financial barriers associated with seeking treatment. According to experts in South East Asia, evidence shows that health insurance has been associated with higher utilization among insured people than among those with less or no insurance (World Health Organization, 2003). Bennett and Gilson (2001:8), in their analysis of different health financing mechanisms, contend that social health insurance promotes access since no payment is required at the point of use. Access to health care can also be improved by freeing up resources that could then be better targeted to subsidise the non-insured, poor population (Leighton, 1995:14).

In Sudan the primary objective for implementing the insurance plan was to increase access. In a study to investigate the different aspects associated with the adoption of health insurance for curative services in Sudan, it was found that the insurance plan contributed greatly to the enhancement of access by reducing the cost of curative services (Suliman, 2002). Similar results were obtained from an Indonesian study where the effects of mandatory health insurance on equity in access to outpatient care were measured and the conclusion drawn that the scheme had a positive impact (Hidayat, Thabrany, Dong and Sauerborn, 2004:332).

Quality of health services can also be improved following the introduction of health insurance by introducing competition among the various health care providers. This can be achieved by giving members of a health insurance fund the choice of health care

provider. The NHIF uses the same strategy to improve quality of health care (Humba, 2005b:14). Health insurance can also improve the quality of health care by providing an additional source of revenue to fund the costs of better services. Leighton (1995:3) points out that,

"Improving quality is a two-way street: cost recovery reforms are most likely to work when fee revenues are ploughed back into the delivery system to improve quality. Thus, the link works both ways: quality improvements generate support for financing reform and financing reform can generate the revenues to sustain quality improvements."

This appears to be the case with the NHIF; quality improvements such as renovations to health facilities and availability of drugs have been attributed to the payments made by the NHIF to health care providers (Humba, 2005b:19). Conversely, the Sudan study reported no significant improvement in quality following implementation of the health insurance scheme (Suliman, 2002). Similarly, other literature sources do not show a direct association between improved quality of health services and a health insurance scheme similar to the NHIF. For instance, the experience of European countries with well-developed social health insurance schemes evinces difficulty in establishing whether higher quality of health services can be directly associated with social health insurance (DFID Health Insurance Workshop Report, 2002:8).

Despite all the benefits of introducing health insurance as a health financing option, there are doubts about its feasibility and applicability in developing countries. Some authors argue that, instead of improving access to health services, health insurance creates barriers, especially for the poor and those living in rural areas (Quaye, 2004: 97; Bennett and Gilson, 2001: 9). Disparities such as these relating to access to health services



between urban and rural populations can be created by the misdistribution of both health staff and facilities, as these tend to be located in urban centres where there is greater demand and ability to pay (Quaye, 2004:97; Bennett and Gilson, 2001:9). The same concerns were raised by a number of Sub-Saharan countries at the Department for International Development (DFID) Health Insurance Workshop in 2002 (DFID Health Insurance Workshop Report, 2002:18).

The introduction of health insurance in Latin America occurred long before it was instituted in most developing countries, especially Sub-Saharan countries. However, although access may have improved for all population groups, the insurance schemes have also created inequity in both access to and quality of health services among the different groups, for example between urban and rural communities and formal and informal sector employees. The reforms that have been instituted have not been able to address the problem of inequity adequately (DFID Health Insurance Workshop Report, 2002:10).

Using the National Hospital Insurance Fund of Kenya as an example, Quaye (2004:97) cites limited coverage as one of the drawbacks of health insurance. He argues that health insurance does not address the barriers to access adequately because, firstly, most governments prefer using a flat rate contribution without taking into consideration level of income and, secondly, the service providers belonging to the fund are concentrated in urban centres and this creates or enhances geographical barriers to accessing health care.

Other authors also agree that limited coverage is a drawback to health insurance, but with reference to quality of health services (Bennett and Gilson, 2001:8; DFID, Health

insurance Workshop Report, 2002:18). It is their view that, while quality improvement can be achieved for the few insured, this may be done at the expense of the services for the uninsured. This may result from resources being shifted from funding public health services for the poor and uninsured to subsidising the insurance scheme in order to make it more attractive to the beneficiaries (Bennett and Gilson, 2001:8; DFID Health Insurance Workshop Report, 2002:18). Similarly, a study in Kenya revealed that most people covered by the National Hospital Insurance Fund of Kenya were not satisfied with the services in the public hospitals and therefore did not utilise them (Wang'ombe, Germano, Benjamin and Octavian, 2002 in Quaye, 2004:97).

Health reform, health policies and programmes require the understanding and support of the implementers, which include the providers of health services. Service providers who are dissatisfied and sceptical about changes associated with reform may be a threat to the success of such reforms. This is the view of some authors who contend that the success of health reforms depends on staff commitment and, without the support of the staff, reforms are difficult to introduce and may even fail (Martinez and Martineau, 1998:346; Martineau and Buchan, 2000:174). The same may be true concerning the introduction of a scheme like the NHIF.

Review of the literature found no mention of the views of service providers regarding social health insurance. Perhaps this is because the concept of social health insurance is still relatively new in African countries and more attention is, therefore, being focused on the views of the general population for which the scheme is intended. This reinforces the need for more qualitative research to be done with the service providers' views in mind.

#### **1.4 PROBLEM STATEMENT**

The introduction of social health insurance has been confronted with many challenges, certain of which may be linked directly to the perceptions of the service providers. For instance, reports of patient mistreatment, shortages of drugs, non-adherence to MOH standards and fraudulent tendencies by the service providers point to the fact that they may have dissimilar and undesirable perceptions and attitudes regarding social health insurance.

Studies on social health insurance in Tanzania have been conducted, but the focus has been largely on the users of the service. There is a need to explore the impact of social health insurance from the perspective of all stakeholders, as each has a role to play. Acquiring an insider's perspective of service providers concerning the quality and accessibility of health services under social health insurance will complement what may be known from an outsider's perspective and provide valuable insights and understanding into the issues leading to the challenges being faced.

#### **1.5 RESEARCH QUESTIONS**

This study will, therefore, focus on the 'insider' perspective to find answers to the following questions:

- What is the perception of service providers of the quality of health services under the policy of social health insurance?

- What is the perception of service providers of the health service utilization under the policy of social health insurance?
- What is the perception of service providers of the difference in quality and accessibility of health services between patients with social health insurance cover and those without?
- What recommendations can be made based on the findings of the study?

## **1.6 RESEARCH GOALS**

The goal of this study will be to determine the service providers' perceptions of the quality and accessibility of health services following the introduction of social health insurance.

### **1.6.1 Specific Objectives**

The specific objectives of the study are to:

- Determine the service providers' perceptions of the quality of health services following the introduction of social health insurance.
- Determine the service providers' perceptions of the utilization of health services following the introduction of social health insurance.
- Determine the services providers' perceptions of the difference in quality and accessibility of health services between patients with social health insurance cover and those without.
- Make recommendations based on the findings of the study.

## 1.7 DEFINITION OF TERMS

For the purpose of this study, the following key terms will be defined as follows:

**Accessibility of health services:** The presence or absence of physical or economic barriers that people face in using health services. Physical barriers are those related to the general supply and availability of health care services and the distance or travel time necessary to reach the health facilities. Economic barriers are those related to out-of-pocket costs of seeking and obtaining health care (Knowles, Leighton and Stinson, 1997 in Liu, Hotchkiss, Bose, Bitran and Giedion, 2004:32).

**Financial sustainability:** The availability of enough reliable funding to maintain current health services for a growing population and to cover the costs of raising quality and expanding availability to acceptable levels. Usually, the financial sustainability goal also means achieving these funding levels with a country's own resources (Leighton, 1995:2).

**Health insurance:** A form of health financing that pools risks across patients and across time. The objective is to increase equity and protect against catastrophically expensive illness (Witter, 2005:28).

**Health services:** The collection of health education, drugs and medical care that provide assistance for illness, illness prevention and health promotion (Katzenellenbogen, Joubert and Abdool Karim, 1997:148).

**National Health Insurance Fund:** A compulsory, government mandated social health insurance fund for public sector employees in Tanzania (Humba, 2005a:7).

**Perceptions:** In [humans](#), this is the process whereby sensory [stimulation](#) is translated into organized experience. That experience, or percept, is the joint product of the stimulation and of the process itself (Encyclopaedia Britannica, 2006).

**Quality of services:** The degree to which the resources for health care, or the services included in health care, correspond to specified standards (Roemer and Montoya-Aguilar 1988 [in](#) Mliga, 2004:205). Quality has two broad dimensions: technical quality refers to *how well a medical procedure was performed, diagnostic precision and the effectiveness of an intervention*; perceived quality refers to the personal interaction of the patients with the health care system and service providers and the respect of their preferences (Greenberg and Iezzoni, 1997 [in](#) Sekwat, 2003:71).

**Service provider:** An institution or individual offering health services. In this study the term service provider refers to the individuals who offer health services, such as medical and dental officers, pharmacists, nurses, laboratory technicians and assistant medical and dental officers. It will be used interchangeably with health worker and hospital staff.

**Social health insurance:** A system of health care financing through contributions to an insurance fund that operates within a tight framework of government regulations. Social health insurance usually involves mandatory, earnings-related contributions by employers and employees (Kutzin 1996 [in](#) Beattie *et al*, 1996:63).

**User fees:** Direct payment for services at point of use by the patient, which covers some or all of the costs of the service. These payments are officially sanctioned (Witter, 2005:29).

## 1.8 RESEARCH DESIGN

This study will use a qualitative approach to assess the perceptions of service providers of the quality and accessibility of health services under the NHIF. The study will be approached from an insider's perspective, which provides an understanding of their actions, behaviours and decisions (Babbie and Mouton, 2001:271). Accordingly, the study will be descriptive, exploratory and contextual.

The study will be *descriptive* because the actions of the service providers will be described in detail using normal terminology that is understandable and used by the participants (Babbie and Mouton, 2001:272). The premise is to capture the sense of what happens when the service providers are performing their duties. In so doing, an understanding of the service providers' actions and events that occur in the health facilities in terms of their beliefs, perceptions and context will be gained.

The study will be *exploratory* as the evaluation of the NHIF and social health insurance will be from the perspective of service providers rather than from the perspective of policy makers and planners, which has been common practice in the past. Exploratory studies are used when a researcher examines a new interest or when the subject of the study itself is relatively new (Babbie and Mouton, 2001:79). Obtaining an insider's perspective by describing the experiences of service providers is a relatively untouched subject. The researcher anticipates that, through this study, a deeper understanding will be gained of the impact of social health insurance on the quality and accessibility of health services from the service providers' perspective and that this may lead to more effective intervention and address of challenges in implementation of the NHIF.

The study will be *contextual* because the aim is to describe the experiences of the service providers in the natural setting in which they occur, namely the health facility. As Babbie and Mouton (2001:272) state: *....if one understands events against the background of the whole context and how such a context confers meaning to the events concerned, ...one can truly claim to understand the events.* By interviewing the participants in the health facility the researcher will be able to understand what the service providers experience by relating their actions to the environment and conditions of the facility.

## **1.9 METHODOLOGY**

The research methodology will now be discussed.

### **1.9.1 Study Population**

A study population is an aggregation of elements from which the study sample is selected (Babbie and Mouton, 2001:174). The study population of this study will comprise health workers working in health facilities in Dar-es-Salaam, the economic capital of Tanzania. Dar-es-Salaam is also the largest city in Tanzania, with a population of 2.5 million consisting of native Africans, Arabs and Indians. It is the economic capital of Tanzania, and is home to the country's largest harbour. Situated along the Indian Ocean, the Dar-es-Salaam port handles exports of cotton, sisal, coffee and hides. It is also the starting point of the TAZARA railway line and TAZAMA oil pipeline that go to Zambia. The local language is Swahili, which is also the national language of the country. Dar-es-Salaam has been selected because of logistical convenience as well as cost considerations.



The study will involve three private NHIF accredited health facilities and three public health facilities in Dar-es-Salaam. All public hospitals and only NHIF accredited private hospitals provide services to NHIF patients. The participants in the study will be health care professionals who work in the health facilities. The health care professionals will include medical officers, dental officers, pharmacists, nurses, assistant medical officers (AMOs) and assistant dental officers (ADOs).

### **1.9.2 Sampling Strategy**

Sampling is the method used to select a portion of the study population, which will be used as representative of the population (Kerlinger, 1986 *in* De Vos, Strydom, Fouche and Delpont, 2002:198). The logic behind sampling is that it is not feasible to study the entire population and, therefore, a portion of it is studied in order to make conclusions about the whole population. The process of sampling is a scientific procedure (or strategy) that allows the researcher to determine and control the likelihood of specific individuals being selected for study (Babbie and Mouton, 2001:164).

This study will make use of purposive sampling as its sampling strategy. This type of sampling allows the judgement of the researcher to be used in the selection of the study sample (Singleton, Starits, Straits and McAllister, 1988:153 *in* De Vos *et al*, 2002:207). Both types of health facility will be selected according to their location, with preference given to the facilities that are easiest for the researcher to access.

### **1.9.3 Method of Data Gathering**

Data gathering will be done using individual interviews, observation and field notes. The use of more than one method of data gathering or triangulation of measures will ensure the researcher obtains as much information as possible (De Vos *et al*, 2002:341). Triangulation is also seen as one of the best ways of enhancing credibility (Babbie and Mouton, 2001:275) that will build confidence in the research (Laws, Harper and Marcus, 2003:281).

### **1.9.4 Data Analysis**

Data analysis is the process of bringing order, structure and meaning to the mass of gathered data (De Vos *et al*, 2002:339). This process involves the sorting, categorising and coding of data in order to bring meaning to the vast amount of information obtained. In other words, it is a process by which data gathered is made useful. Data analysis in this study will be analysed using Tesch's method of descriptive data analysis (Tesch, 1990:84-94). Using this method, the researcher will read through all transcriptions carefully; firstly, to sort and discard unnecessary information and, secondly, to identify patterns, themes and categories that will be used to organise the raw data in order to make sense of it. This will be followed by interpretation of the data.

### **1.9.5 Use of Literature in the Study**

Literature is an important part of any research process. In the planning stages it contributes towards a clearer understanding of the nature and meaning of the identified

problem (De Vos *et al*, 2002:127). During interpretation of findings, literature serves as a form of control to which the findings are related (Leedy, 2001 in De Vos *et al*, 2002:268). Literature will be used during the early stages of this study to provide the researcher with an orienting framework and background knowledge about social health insurance and its impact on the quality and accessibility of health services. The study will also use literature review as a form of literature control during the interpretation of the findings in order to provide a body of theory from which to relate the findings. Used in this way, literature will contribute towards understanding the participants' perceptions, perspectives and understanding of the concept of social health insurance and how it is affecting the quality and accessibility of health services.

#### **1.9.6 Pilot Study**

A pilot study is conducted prior to the commencement of the actual study with the purpose of determining whether the information being sought can indeed be obtained from the participants (De Vos *et al*, 2002:337). In conducting the pilot study, the researcher will be testing the planned methodology. The researcher will, therefore, select two participants who meet the inclusion criteria and conduct the interviews in the same manner as for the main study.

The same questions will be posed to them in order to ascertain whether these questions will provide the expected information. The interviews will be taped, transcribed and then sent to the research supervisors for assessment of the researcher's technique as an interviewer. The researcher will also attempt to analyse the transcribed interviews to see if themes / sub-themes can be identified.

### **1.9.7 Ensuring Rigour (trustworthiness) of the Study**

Rigour or trustworthiness refers to the extent to which the researcher can persuade his audience that the findings of his research are worth paying attention to (Lincoln and Guba, 1985:551 in Golafshani, 2003:601). Rolfe (2004:305) contends *a study is trustworthy if and only if the reader of the research report judges it to be so*. It is, therefore, the task of the researcher to apply methods that will convince the readers that the study is trustworthy.

There are several methods to ensure rigour of the study. This study will use the framework proposed by Lincoln and Guba (1985:290 in De Vos *et al*, 2002:351), which consists of four criteria, namely credibility, transferability, dependability and confirmability (Babbie and Mouton, 2001:277-278; De Vos *et al*, 2001:351). These will be discussed in more detail in chapter two of the study.

Credibility refers to how accurately the subject of the study was identified and described (De Vos *et al*, 2001:351) and will be ensured by triangulation and referential adequacy.

Transferability is the applicability of the results to another context, setting or population (Babbie and Mouton, 2001:277; De Vos *et al*, 2002:351). Transferability will be ensured by thick description and purposive sampling.

Dependability refers to whether the study provides evidence that, if it were to be repeated with the same or similar respondents in the same context, its findings would be similar (Babbie and Mouton, 2001:278). Dependability will be ensured by triangulation, thick description and a pilot study.

Confirmability refers to whether the findings of the study can be confirmed by another similar study (De Vos *et al*, 2002:352) and will be ensured by independent coding.

### **1.9.8 Ensuring High Ethical Standards**

Ethical standards include the general agreements about what is proper and improper in conducting scientific research (De Vos *et al*, 2002:62). Ethical issues regarding aspects such as informed consent, anonymity, confidentiality, actions and competence of researchers, release of findings and accountability, as explained and described by De Vos *et al* (2002:64-74), Babbie and Mouton (2001:521-526) and Laws *et al* (2003:239-246) will be adhered to.

Informed consent is obtained when all possible or adequate information on the goal of the study, the procedures that will be followed, the possible advantages and the disadvantages and dangers to which the respondent may be exposed has been explained to the participants (De Vos *et al*, 2002:65). Informed consent will be sought by explaining the purpose of the study, the expected value of the study and the importance of the participants' contribution by taking part in the study to the participants before asking them to fill in a consent form (see Appendix I).

It is worth noting that certain prospective participants may be wary of signing a consent form for fear of implications regarding whatever they choose to disclose in their interview. This could result in either their refusal to do so or in their providing inaccurate responses. It is the task of the researcher and of the gatekeepers to set the participants' minds at rest in this regard by assuring them that anonymity will be strictly maintained. This will entail asking the participants to assume pseudonyms of their choice. The

researcher will also explain to the participants that access to the information on the tapes and how that information will be used will be limited to the researcher, the independent coder and the research study supervisors.

Confidentiality and anonymity ensure protection of the participants' interests and wellbeing, since their identities are protected (Babbie and Mouton, 2001:523; Mouton, 2001:243). Anonymity will be ensured by the use of pseudonyms during the interviews, as well as throughout the process of analysis and reporting. Confidentiality will be ensured by not making the interviews public. The information obtained during data gathering will only be viewed by the researcher, supervisors and the independent coder.

Credibility of the researcher is founded on his or her actions and competence (De Vos *et al*, 2002:69-70). Considering this, the researcher recognises her obligation towards the scientific community to report correctly on the data analysis and results of the study. The researcher must gain adequate knowledge of the community in which the study will be conducted so as to be sensitised regarding its cultural values and norms. By respecting the cultural values, the researcher will gain the necessary cooperation of the participants. Full permission and ethical clearance must be obtained from the Advanced Degree Committee and the Human Ethics Committee (see of the Nelson Mandela Metropolitan University (see Appendix II) and from the Commission of Science and Technology (COSTECH) of Tanzania (see Appendix III), as well as from the office of the District Medical Officer (DMO) in Dar-es-Salaam (see Appendices IV and V). Permission will also be obtained from the heads or directors of private health facilities. This will also ensure the legality of the study.

The findings and recommendations of the study must be released to relevant, interested audiences. The researcher recognises that scientific research should never be clandestine but instead should be conducted to enhance knowledge and to contribute to society (Babbie and Mouton, 2001:527; Mouton, 2001:242). Accordingly, the research findings will be presented to the participants as a feedback as well as to the authorities who granted permission to conduct the study. The report will be in a language, format and style understandable and relevant to the audience for which it is intended.

### **1.9.9 Role of Researcher**

The researcher's role in this study will be purely scientific and not participatory. She will be actively involved in the study by personally collecting data by means of individual interviews, observation and field notes in order to gain an understanding of the experiences of the participants in providing health care. This will entail approaching the interviews with an open mind that is free from prior judgements and prejudices. She will make her actions and presence known to the participants. The researcher will also read, analyse and interpret the data. She will play a pivotal role in the planning and organising of the study, as well as in the research process.

### **1.10 CONCLUSION**

This chapter represents the planned roadmap for the actual study. It contains an introduction and background to the topic, which gives readers an idea of the general

issues surrounding the social health insurance. A literature review has been included to indicate what has been documented concerning the impact of social health insurance so as to highlight the successes and challenges surrounding such implementation and to point out information gaps. Also contained in this chapter is a description of the problem and the methodology the study intends to use to answer questions raised by the problem.



## CHAPTER 2

### METHODOLOGY

#### 2.1 INTRODUCTION

Chapter two provides a detailed description of the methodology used by the study to achieve the objectives. The purpose of this chapter is not merely to repeat the methodology described in chapter one, but to focus on how the planned methodology was implemented. The premise is to give the reader a deep understanding of how qualitative research methodology has been applied to gain answers to the research questions. A rationale has been included to emphasize the relevance of the selected design for this study.

#### 2.2 RATIONALE FOR THE STUDY

Social health insurance is an alternative source of health financing and a means to achieve, *inter alia*, improved quality of health services and greater access to the services. Social health insurance provides hospitals with an additional source of revenue, which can be used to pay for quality improvements. By reducing the financial barriers associated with fee for service payments, social health insurance can also lead to improved access to health care.

So far, available literature on social health insurance in Tanzania has documented experiences from the perspective of the demand side (individuals and communities) alone. This is understandable since the fund was introduced in the interest of people in

the public sector and evaluation should focus on this premise. However, the key role that is played by the service providers (implementers) of the scheme has been ignored and, to some extent, the success or otherwise of the fund may be traced to the role played by them. Accordingly, there is a need to evaluate the NHIF from the supply side.

Furthermore, the focus has been more on quantitative studies. The effect of schemes (such as the NHIF) has been measured largely in terms of statistical analysis and a broad framework of the general population for which they were intended. The emic perspective, described by Babbie and Mouton (2001:271) as viewing the world through the eyes of the actors themselves, has not really been studied, hence the lack of information about the actual experiences of the service providers who also participate in the implementation of NHIF.

Service providers play a major role in the implementation of the NHIF. In the first instance, without services provided by the service providers, any health insurance scheme would not be able to operate. Secondly, service providers are the key implementers of any social health insurance scheme since they spend a significant amount of time with patients (some of whom may be members of an insurance scheme). The perceptions of service providers regarding social health insurance are reflected in their attitudes and can assist in pinpointing the source of some of the problems associated with the implementation of such a scheme. Hence, the importance of exploring the perceptions of the service providers of healthcare provision under social health insurance cannot be understated.

Consequently, this study focused on the service providers' perceptions of service provision in Dar-es-Salaam under the NHIF policy, with the aim of eliciting their views on the quality and accessibility of health services after the introduction of the fund.

### **2.3 GOAL OF THE STUDY**

The goal of this study was to determine the service providers' perceptions of the quality and accessibility of health services following the introduction of social health insurance. In order to achieve the aforementioned goal, specific objectives were formulated for the study. The specific objectives were to:

- Determine the service providers' perceptions of the quality of health services following the introduction of social health insurance.
- Determine the service providers' perceptions of the utilization of health services following the introduction of social health insurance.
- Determine the services providers' perceptions of the difference in quality and accessibility of health services between patients with social health insurance cover and those without.
- Make recommendations based on the findings of the study.

### **2.4 RESEARCH DESIGN**

This study used a qualitative approach to assess the perceptions of service providers concerning the quality and accessibility of health services under the NHIF. The study was

approached from an insider's perspective in order to provide an understanding of their actions, behaviour and decisions (Babbie and Mouton, 2001:271). Accordingly, the study was descriptive, exploratory and contextual as has been explained in detail in chapter one.

## **2.5 RESEARCH METHODOLOGY**

### **2.5.1 Research Population**

A study population is an aggregation of elements from which the study sample is selected (Babbie and Mouton, 2001:174). The study population comprised health workers working in health facilities in Dar-es-Salaam (Dar-es-Salaam was the study location considered to be most logistically convenient and cost-effective for the researcher, as she resides in the city.) The study involved two private NHIF accredited health facilities and two public health facilities in Temeke and Kinondoni districts of Dar-es-Salaam. A total of ten participants were interviewed; these comprised four nurses, two medical officers, a dentist, a laboratory technician, a pharmacist and an assistant medical officer (AMO). The professional qualifications of the respondents ranged between Diploma, Advanced Diploma, Degree and Masters Degree, with the majority holding an Advanced Diploma. There were six female and four male participants with ages ranging from 32 years to 50 years. The number of years in the profession ranged from six to 18 years.

### **2.5.2 Sampling Strategy**

The process of sampling is a scientific procedure (or strategy) that allows the researcher to determine and control the likelihood of specific individuals being selected for study

(Babbie and Mouton, 2001:164). This study made use of purposive sampling (as explained in chapter one). Since the study focused on the perceptions of service providers, the researcher used her own judgement to select participants. This was based on her knowledge of the different professional cadres in health care and the degree to which they could contribute to the findings. Accordingly, participants were selected through consideration of shared common characteristics such as health care background, nature of work and place of work. Different professional cadres were selected in order to introduce some heterogeneity within the group and to gain different perspectives. In order to meet the selection criteria, participants had to be:

- A member of one of the following categories of health care providers: medical officer, dental officer, pharmacist, nurse, laboratory technician, assistant medical officer (AMO) or assistant dental officer (ADO).
- Willing to participate in the study.
- Employed at the facility both before and after the introduction of the NHIF.
- Interacting with NHIF members on a daily basis and, therefore, be familiar with the NHIF.

### **2.5.3 Contact with Research Population**

Permission to conduct research in Dar-es-Salaam was first obtained from the Tanzania Commission for Science and Technology (COSTECH) (see Appendix III). On receipt of this, permission to conduct research in the selected districts had to be obtained. This was achieved by contacting the District Medical Officers (DMO) of Temeke and Kinondoni

to obtain permission from the offices of the respective District Commissioners (DC) (see Appendix IV).

After obtaining permission from the DMOs office, the hospital directors of each selected facility were contacted. The hospital directors were used as gatekeepers, which meant that they were used to identify prospective participants for the study and to introduce them to the researcher. The hospital directors were given information about the purpose of the study and details regarding its implementation. This was done in order to gain access to the right participants and to ensure an appropriate environment in which to conduct the interviews.

Personal contact was made with the participants to obtain informed consent from them. The researcher also used this as an opportunity to build rapport and establish a trust relationship so that the participants would feel comfortable about being interviewed. The researcher explained the purpose of the study and how it was to be conducted, the voluntary nature of the study, issues of confidentiality and anonymity, as well as the use of tape recorders.

#### **2.5.4 Method of Data Gathering**

Data gathering was done using individual interviews, observation and field notes. Before the commencement of data gathering, a pilot study was done to determine whether the information being sought could indeed be obtained from the participants. The pilot study was also done to test the suitability of the selected methods for this study.

### ***Individual Interviews***

De Vos *et al* (2002:300) explain that interviews must be conducted at a venue with a quiet environment that is free of interruptions, provides privacy and is comfortable, non-threatening and easily accessible. The interviews were conducted at the hospital facilities in venues selected by the participants that fitted the aforementioned criteria. Two individuals from each hospital were interviewed. The researcher began by reminding the participant of what was to be discussed, the voluntary nature of participation, the use of pseudonyms and the use of tape recorders. Prior to commencement of the interview, the participant was asked to sign the informed consent form.

During the interviews the researcher applied the following interviewing techniques adapted from De Vos *et al* (2002:293-294):

- Use of a general question to break the ice and put the participant at ease. For example, the interviews commenced with the general question “Do you think there have been any changes in health services in recent years?”
- Ensuring that the participant did most of the talking, in order to allow the participant to tell his or her story. The researcher applied this technique by limiting comments and listening intently to what the participant was saying. The researcher only spoke when asking a question or making comments that encouraged the participant to expand on an idea. Interrupting the participant in mid-sentence with another question was avoided; the question was rather jotted down and asked later.

- Asking one question at a time and ensuring the questions were clear and brief. This ensured that the questions were not confusing and were easy to understand. The questions asked were also open-ended, which allowed the participants to respond with as much detail as possible and in their own terms.
- Allowing the participant to take time to think of what to say or add. Therefore, much care was taken not to break a short silence and interrupt the participant's thinking.
- Use of probing and follow-up questions in order to return to incomplete points made by the participants. This helped the researcher to understand any point made earlier that was unclear or to gain more information about an interesting issue. This was done to ensure that the participant provided full information in as much detail as possible.
- Maintenance of focus on the topic of the interview. This was done by politely reminding the participant of the question that had been asked when he or she began straying onto other subjects.
- Termination of the interview when no further probing and follow up revealed any new information. This was usually the case after 30-45 minutes. The researcher ended the interviews by asking whether the participants had anything further they would like to add, followed by a word of appreciation.

An interview guide (see Appendix VI) was used to ensure that the information supplied by the participants related to the research questions. The questions that were posed related to the quality and utilisation of health services, the role of service providers, the



services offered and the changes in health service provision under the NHIF. The researcher did not follow a set sequence in questioning but rather allowed the participant's responses to guide the process, while constantly seeking to avoid deviation from the topic.

The interviews were conducted in Swahili, which is the national language of Tanzania and the one with which most Tanzanians are comfortable; many locals find it difficult to communicate in English. The researcher's experience of living in Tanzania has shown that most people view a person speaking English as an 'outsider'; hence, had the researcher used English as the medium for conducting the interviews, respondents may not have had the confidence and trust required to participate fully. Conducting the interviews in English would also have limited the amount and clarity of information provided by the participants. Hence, Swahili was used in order to ensure the participants communicated with ease and provided rich and detailed information.

The transcribed interviews were translated into English by the researcher. This was done in order to allow the supervisor and independent coder (both of whom do not understand Swahili) to read and understand the transcriptions. Translation was also done in order to make analysis and report writing easier, since both were done in English. Translation was done at the earliest opportunity after transcribing each interview (either on the same day or the day after the interview). This ensured that the researcher was able to recall the context in which the respondents used certain Swahili words in order to translate the meaning into English. The reason for this was that some Swahili words are not directly translatable into English and word-for-word translation would have resulted in sentences

that did not make sense. Each interview was translated twice to ensure no information was lost in the process of translation.

The interviews were recorded on tape as this allowed a more accurate and detailed record than taking notes during the interview. The use of a tape recorder allows the researcher to concentrate on conducting the interview and observing for non-verbal cues (De Vos *et al*, 2002:304). The tape recorders were used with the full consent of the participants; indeed one of them was very excited and enthusiastic about it. External microphones were used in order to increase clarity of voice and, where possible, the tape recorders were placed out of sight of the participants to avoid engendering nervousness.

De Vos *et al* (2002:304) also recommend that both electrical and battery operated tape recorders be used to ensure continued data capturing. The use of electrical tape recorders was not feasible in this study as not all of the venues used for the interviews had electrical sockets. However, the researcher always carried a spare set of batteries and the batteries were always changed after two interviews to avoid a battery running flat during an interview. The same precautions were taken with the tapes; a new tape was used for each interview and the researcher always carried a spare in case one tape failed to work.

### ***Observation and Field Notes***

Observation was done prior to the individual interviews. The researcher used the occasions on which she was introduced to the participants to make observations of the setting and physical environment of each health facility, the infrastructure, the organization and the general attitudes of the staff members. Field notes are a written account of things the researcher heard, saw, experienced and thought about in the course

of interviewing (De Vos *et al*, 2002:304). Field notes were written during these observations with due discretion on the part of the researcher. Brief points were jotted down and then details included at the earliest opportunity after leaving the health facility.

### **2.5.5 Data Analysis**

The qualitative data gathered during the research were analysed using Tesch's (1990:84-94) method of descriptive data analysis as follows:

- The researcher first read through all transcriptions carefully; firstly, to sort and discard unnecessary information and, secondly, to identify patterns and themes that could be used to organise the raw data and make sense of it.
- Each transcribed interview was read through carefully and notes were made of the themes identified. The transcriptions were read through a number of times to ensure that no theme had been omitted.
- Similar themes from all of the interviews were grouped to form the themes of the study.
- The identified themes were then organized into main themes and sub-themes and these were listed.
- The listed themes and sub-themes were then given colour codes for easy identification and retrieval of the responses related to each theme from the interviews.
- Using the list, each interview was re-read to code the raw data according to the identified themes and sub-themes. This was done by giving the raw data the same colour code as the related theme or sub-theme.

- The themes and sub-themes were named with words that described them best.
- The categories were re-read to see if some could be merged together or separated further.

Analysis of the data was followed by interpretation, which involved making sense of the data and determining the “lessons learned”. It also involved searching for, identifying and describing these alternative explanations and then demonstrating how and why the explanation offered was the most plausible of all, using literature studied as a frame of reference from which to relate the findings.

#### **2.5.6 Use of Literature in the Study**

In the planning stages of a study literature contributes towards a clearer understanding of the nature and meaning of the identified problem (De Vos *et al*, 2002:127). During interpretation of findings, literature serves as a form of control to which the findings are related (Leedy, 2001 *in* De Vos *et al*, 2002:268). Literature was used during the early stages of the study to provide the researcher with an orienting framework and background knowledge about social health insurance and its impact on the quality and accessibility of health services. The study also used literature review from journals, textbooks, discussion papers, technical reports and speeches as a form of literature control during the interpretation of the findings for two purposes; firstly, to understand the participants' perceptions and understanding of the concept of social health insurance and how it was affecting the quality and accessibility of health services and, secondly, to link the findings to similar situations documented in other studies.

### **2.5.7 Pilot Study**

A pilot study is conducted prior to the commencement of the actual study with the purpose of determining whether the information being sought can indeed be obtained from the participants (De Vos *et al*, 2002:337). The pilot study was conducted at a public health facility, after going through the process of obtaining permission as explained previously. After contacting the hospital director, permission was obtained to interview one AMO and one nurse. Each interview commenced with a briefing about the purpose of the study, the voluntary nature of participation, confidentiality and anonymity, and the use of tape recorders, after which the participant was asked to sign the informed consent form. Each participant was asked to choose a pseudonym to be used during the interview and throughout the processes of analysis and report writing.

The researcher initiated the main part of the interview with an ‘icebreaker’ (a general question about the participant’s work), following which the questions from the interview guide were used. The questions were posed according to the participant’s responses rather than according to a set sequence. The interview consisted of semi-structured, open ended questions that allowed the participant to give as detailed responses as possible, without being restricted by the questions. Each interview lasted between 30-45 minutes.

Observation of the hospital environment, infrastructure, organization and general attitudes of the staff was carried out prior to the interviews on the initial visit to the facility. These observations were jotted down and more detailed field notes were written after leaving the facility. The interviews were transcribed at the end of the day and the data were then analysed using Tesch’s (1990:84-94) method of data analysis. Due to the

richness of the information gathered by the pilot study, the data were included in the study database.

### **2.5.8 Ensuring Rigour (trustworthiness) of the Study**

Rigour or trustworthiness refers to the extent to which the researcher can persuade his audience that the findings of his research are worth paying attention to (Lincoln and Guba, 1985:551 in Golafshani, 2003:601). The method used to ensure rigour of this study was based on the framework proposed by Lincoln and Guba (in Babbie and Mouton, 2001:277-278; De Vos *et al*, 2001:351), which consists of four criteria, namely credibility, transferability, dependability and confirmability.

**Credibility:** This refers to how accurately the subject of the study was identified and described (De Vos *et al*, 2001:351). Credibility was ensured by means of triangulation. Triangulation is defined by Denzin (1989:236 in Babbie and Mouton, 2001:275) as the use of multiple methods and investigations to overcome the deficiencies that arise from using a single method. This study used more than one method to gather information about service provision under the NHIF, namely individual interviews (to obtain the perspective of the service providers) and observation and field notes (to understand the context in which health care is delivered). The different methods were used to ensure that the information being sought did, indeed, provide a deep understanding of the effect of the NHIF on the quality and accessibility of health services.

The researcher also posed different questions during the interviews to obtain information about the various aspects and issues related to quality and accessibility of health services. The aim was to approach the quality and accessibility of health services from different

angles in order to ensure the subject was accurately described by the information being gathered.

Credibility was also ensured by referential adequacy, which refers to whether the findings were stored in materials that prevent distortion and allow easy retrieval (Babbie and Mouton, 2001:277). The interviews were recorded on a tape recorder in order to keep good records of the raw information obtained. This allowed accurate documentation of the data gathered during the interviews without distorting or leaving out anything. It also allowed easy retrieval of the information to verify what had been documented in the findings.

The interview technique that was used also allowed data to be obtained that was detailed and described accurately the effects of the NHIF on service provision. This entailed the use of an interview guide to ensure that the questions used during the interviews related to the study subject, the use of open-ended questions and listening attentively to the respondents.

**Transferability:** This refers to the applicability of the results to another context, setting or population (Babbie and Mouton, 2001:277, De Vos *et al*, 2002:351). Transferability was ensured by thick description and purposive sampling. This was achieved by providing as much detail as possible in the field notes and the report on the findings.

Thick description in presentation of the methodology and findings was used in order to enable their application in other studies, since it provides a deep understanding of the context. Purposive sampling, using set criteria based on the researcher's judgement, also ensured transferability. By selecting respondents of different professional cadres, the

researcher was able to maximize the range of information, as they may have had different experiences and contexts within which they performed their duties.

**Dependability:** This refers to whether the study provides evidence that, if it were to be repeated with the same or similar respondents in the same context, its findings would be similar (Babbie and Mouton, 2001:278). Dependability was ensured by triangulation, the strategy used to ensure credibility and the pilot study. Thick description of the methods used to gather data was also a measure used to ensure dependability.

The study also used a pilot study to test the applicability of the planned methodology and whether the latter would indeed provide the information being sought. Hence, the pilot study also contributed towards ensuring dependability.

**Confirmability:** This refers to whether the findings of the study can be confirmed by another similar study (De Vos *et al*, 2002:352). Confirmability was ensured by the use of independent coding, which is a method used to ensure objectivity of the findings of the study (Babbie and Mouton, 2001:278). An independent researcher checks the analysis and interpretation of the data gathered by performing an independent analysis and interpretation. The two researchers then discuss the differences and similarities between their findings in order to reach a consensus. Independent coding encourages thoroughness in analysis as well as in documentation of how the analysis was performed (Barbour, 2001) and ensures confirmability of the study. In this study, the independent researcher (coder) was emailed the transcribed interviews and performed analysis using the same methods used in this study, that is Tesch's (1990:84-94) method of data analysis. After performing an analysis of the transcribed interviews, the report of the independent



researcher was compared with that of the original researcher. The subsequent discussion to reach consensus took place via email.

### **2.5.9 Ensuring High Ethical Standards**

Ethical standards include the general agreements about what is proper and improper in conducting scientific research (De Vos *et al*, 2002:62). All ethical issues relating to informed consent, anonymity, confidentiality, actions and competence of the researcher, release of findings and accountability, as explained and described by De Vos *et al* (2002:64-74), Babbie and Mouton (2001:521-526), Mouton (2001:242-244) and Laws *et al*. (2003:239-246) were adhered to.

## **2.6 CONCLUSION**

Chapter two has provided a detailed description of the methodology used in this study. This included a description of the research population, the sampling strategy and how contact with the population was made. The chapter also described the method of data gathering, namely individual interviews, observation and field notes, the pilot study and data analysis using Tesch's (1990:84-94) method of data analysis. Finally the methods used to ensure rigour of the study were described.

## CHAPTER THREE

### FINDINGS AND INTERPRETATION

#### 3.1 INTRODUCTION

The previous chapter presented the methodology used to obtain answers to the research questions. This chapter presents the findings obtained from analysis of the information obtained and begins with a short description of the health facilities and some of the observations made during data gathering.

For purposes of privacy and anonymity, the health facilities are referred to as ‘private’ or ‘public’ and the participants are referred to by their pseudonyms. The public health facilities were relatively large facilities that received referrals from lower health facilities in their respective districts. They provided out-patient and in-patient services and performed both minor and major operative procedures. These facilities were very busy and provided 24 hour services. Comparatively speaking, the private health facilities were also large and busy. They served mainly corporate clients and those covered by different health insurance schemes, most of which were private schemes.

The field work and data gathering took three weeks as it was necessary to conduct the interviews at the convenience of the respondents, which was not always easy to achieve. For instance, interviews were cancelled on certain occasions because respondents were unavailable due to either work commitments or for serious personal reasons. The researcher had, therefore, to reschedule appointments and plan a flexible schedule for conducting interviews.

Initially, most of the respondents, and especially those from public hospitals, were uncomfortable about the use of tape recorders. This meant that the researcher had to spend more time than anticipated explaining about confidentiality and anonymity. However, once they had been reassured in this regard, the respondents felt sufficiently comfortable to provide a wealth of information. Generally, all of the respondents seemed very interested in being interviewed and were quite enthusiastic about discussing the changes in service delivery, as well as how the introduction of NHIF had affected health services.

All things considered, it was a very informative experience whereby the researcher was able to observe the general attitudes of the health workers, the different hospital settings and the interaction of the health workers with each other and with patients. By and large, the health workers were friendly and approachable.

### **3.2 FINDINGS AND INTERPRETATION**

The perceptions of the service providers regarding the quality and accessibility of health services under social health insurance in Dar-es-Salaam were categorized into three main themes with sub-themes. These themes and sub-themes are set out in table 3.1.

**Table 3.1: Identified Themes Related to Service Providers' Perceptions of the Quality and Accessibility of Health Services under Social Health Insurance in Dar-Es-Salaam**

<b>MAIN THEMES</b>	<b>SUB-THEMES</b>
1. Health workers' understanding of the NHIF.	1.1 Understanding of the objectives of the NHIF. 1.2 Understanding of the benefits of the NHIF.
2. Health workers' perceptions regarding the quality of health services.	2.1 Perceptions regarding the availability of drugs, supplies and equipment. 2.2 Perceptions regarding performance of health workers. 2.3 Perceptions regarding the ability to offer more services. 2.4 Perceptions regarding the hospital environment. 2.5 Perceptions regarding extra duties for health workers. 2.6 Perceptions regarding the difference in services offered to NHIF members and non NHIF members. 2.7 Perceptions regarding the effect of the NHIF on quality of health services.
3. Health workers' perceptions regarding the accessibility of health services.	3.1 Perceptions regarding accessibility for NHIF members. 3.2 Perceptions regarding accessibility for non NHIF members.

Discussion and interpretation of these themes and sub-themes will now be presented in more detail and supported by verbatim quotations from the respondents.

### **3.2.1 THEME 1: HEALTH WORKERS' UNDERSTANDING OF THE NHIF**

For health reforms to be successful it is important for the health workers, as key actors in the implementation process, to be well informed. This can influence positively the workers' attitudes and, consequently, their motivation to achieve the goals of the reforms. Accordingly, in order to understand the health workers' perspectives of the impact of social health insurance on service provision, it was important to find out their understanding of the concept of social health insurance and how it applies to the NHIF.

#### **3.2.1a Sub-theme 1.1: Understanding of the Objectives of the NHIF**

The NHIF was introduced in order to increase financial resources for health care as well as to improve the quality and accessibility of health care. The aim is to improve accessibility to health care by reducing the financial barriers and to improve quality by providing additional financial resources. This is made possible through funding by monthly contributions from NHIF members (government employees); these financial resources are then used to finance health services. The extra revenue generated by the hospitals providing services to NHIF members is to be used for quality improvements. As the fund expands, in keeping with the concept of social health insurance, the extra revenue generated will be used to extend health services to those who cannot afford to pay for them, thereby further increasing accessibility to the services.

When discussing the objectives of the NHIF, the health workers shared their view regarding the aim of introducing this fund. According to them, the objectives were to enable government employees to receive health services without having to pay at point of

delivery and to increase hospital revenue. When discussing the objectives of the NHIF, Miss S, who works at one of the public hospitals, said:

*“I think the NHIF policy was introduced with the aim of helping (government) workers to get treatment easily, so that when a (government) worker gets a (health) problem, he shouldn’t struggle (to get treatment).”\**

Sister A, from a private hospital, said the following about the objectives of the NHIF:

*“The way I understand this policy, is that it has to do with treatment of employees who have been making contributions for the purpose of getting treatment.”*

Sister S, a public hospital nurse, mentioned that the public hospital collects a substantial amount of money from the NHIF. Some of the health workers had their own ideas about how this extra revenue was used. Sister K, a public hospital nurse, said:

*“One of them especially is to pay... we were told is to pay (health) workers overtime in order to cover for the shortage of staff. So there are people who work extra hours and that money is the one that has been allocated for paying people overtime, as we were told.”\**

Health workers from private hospitals also mentioned that the objectives of the NHIF were to reduce financial barriers to accessing health care and to increase hospital revenue. However, unlike public health care workers, they added that the revenue collected was used to finance service delivery. For example, Sister M, a nurse from a private hospital, explained that the revenue collected from health insurance was used to pay staff salaries and purchase drugs and supplies. The same was not true for public sector health care

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\* words in brackets added for clarification

workers; most of them perceived the NHIF as having been introduced for the purpose of reducing financial barriers to accessing health care for its members. Therefore, only services for the insured patients could be improved as a result of increased revenue from the NHIF.

This sub-theme highlights the health workers' inadequate understanding of the objectives of the NHIF. The only objective they appeared to be aware of was that concerning reducing financial barriers to treatment; knowledge deficits of the objectives relating to quality and accessibility improvements were apparent. In addition, they appeared to not understand how the NHIF could bring about such improvements. Health workers in the private hospitals seemed to have a slightly better understanding about how health insurance schemes, including the NHIF, could contribute to quality improvements. This was probably due to the fact that, unlike public hospitals, private hospitals depend solely on the revenue collected from health insurance and user fees to finance service delivery. Consequently, in order for public health workers to understand how the NHIF contributes to improvements in service provision, they need to be provided with information and education.

The lack of adequate understanding of the objectives of the NHIF may be due to a lack of adequate information and education concerning how a social health insurance scheme like the NHIF can improve service delivery. This situation is similar to a case study conducted in Karelia that examined the importance of human resources to the success or failure of health reforms and found that understanding of the reforms was inadequate due to inadequate information (Martineau and Buchan, 2000: 178).

The importance of communication regarding health reform was also emphasized by Martinez and Martineau (1998: 346), who stated that poor communication and consultation resulted in human resources posing a threat to the success of the reforms. The NHIF was introduced as a health financing reform strategy, which in turn is part of the reform in the Tanzanian health sector. According to Bennett and Franco (2004: 4), if health workers are to contribute to the achievement of the objectives of the NHIF they require, first and foremost, a good understanding of the objectives.

### **3.2.1b Sub-theme 1.2: Understanding of the Benefits of the NHIF**

Understanding the benefits of the NHIF is important since this will influence the health workers' attitudes towards, and acceptance of, the scheme. As this approach to paying for health services is a new concept within the public health sector it represents change and, like any other change in the workforce, it could be subject to resistance. It is, therefore, important to determine whether the health workers perceive the NHIF as more beneficial than the previous method of paying for health services at the point of service.

The interviews revealed clearly that the health workers perceived the NHIF as being beneficial to government employees (like themselves) because it enabled them to access health services without incurring the burden of cost at the point of use. This is what Dr Y, who works in a public hospital, disclosed about the benefits of NHIF:

*“(Health) workers knew it was beneficial because they are government workers and because their salaries are low, having money to pay at point of use (cash) was a problem. So they immediately saw that they could expect something, that it (NHIF) will help them. And it really does help them.” \**



Mr J, who works in a public hospital, had similar views about how the NHIF was beneficial to health workers:

*“Well, for me, how do I see it (NHIF)? I honestly think it is good, because my salary is also deducted for NHIF. I think it (NHIF) is good and it helps a lot, because you find that my family and I don’t have to worry about health care. For example, what will I do if my child or my wife falls sick suddenly? I know that I will rush to the nearest hospital, that has the NHIF system, which is a government hospital, and then they will be treated.”\**

In developing countries, health workers are often underpaid (Martinez and Martineau, 1998:346) and Tanzania is no exception (Paul, 2005:4). Due to meagre salaries, and the many demands made upon these, health workers rarely have enough money to last until the end of each month. Many patients, including a significant percentage of government employees, really cannot afford to pay for services at the point of use.

The health workers perceived the NHIF as beneficial to government employees. The fact that they also fell into the latter category may have had a positive influence on their attitudes toward the fund and been a motivating factor for improved performance. The health workers apparently realized that the fund provided ‘health security’ for them and their dependants. This recognition of the benefit of the fund is a key to its success, since the health workers are both implementers and beneficiaries of the fund (policy). A similar point was made in a discussion paper at the International Development Policy Debate on Universal Systems of Social Protection, where the authors mentioned acceptance of

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\* words in brackets added for clarification

social health insurance schemes as a key factor in their success (Schramm, Doetinchem, Holst, Hohmann, Möller and Bender, 2005:25).

### **3.2.2 THEME 2: HEALTH WORKERS' PERCEPTIONS REGARDING THE QUALITY OF HEALTH SERVICES**

Quality can be defined in many ways but, for the purposes of this study, it has been defined with two dimensions: technical and perceived. Technical quality refers to *how well a medical procedure was performed, diagnostic precision and the effectiveness of an intervention and is an important dimension of health workers' performance*; perceived quality is *the personal interaction of the patients with the healthcare system and service providers and the respect of their preferences* (Greenberg and Iezzoni, 1997 in Sekwat, 2003:71). When considering quality of health services, this study included aspects such as: availability of drugs; medical supplies and equipment; maintenance and cleanliness of hospital facilities and environment; and performance of health workers.

Generally, from the perspective of the health workers, there have been improvements in the quality of health services. The health workers mentioned improvements such as improved cleanliness and maintenance of hospital environments, availability of drugs and medical supplies, replacement of unqualified staff with qualified staff and recruitment of more health workers.

### **3.2.2a Sub-theme 2.1: Perceptions Regarding the Availability of Drugs, Supplies and Equipment**

Availability of drugs is perceived by the consumers (patients) as one of the aspects of quality of health services. This study has included drug availability, together with medical supplies and equipment, as an aspect of quality since these are resources required in service provision. The availability (or not) of these resources will influence service delivery. According to the health workers, the availability has improved over the years. They said that, compared to previous years, basic drugs are available at least most of the time. Medical supplies like gauze, cotton and reagents are also available most of the time. However, this improvement has been offset by the increased demand, which has not been matched by the supply. Consequently, there is still a scarcity of drugs and supplies, as Sister K explained:

*“Ah, to tell the truth, now I think it is much better than before. Patients had to go and buy medicine themselves, but now honestly, they (the hospital)\* are trying. When funds are available, drugs are available. But now, because the patients are still too many, the drugs are just not enough.”*

During data gathering the researcher observed a woman with a baby asking whether there were any pharmacies outside the hospital. When asked why she was looking for a pharmacy when she could get drugs at the hospital, she replied: *“The medicine is finished, so I have to buy it myself.”* This observation substantiates the point made by Sister S that, although the availability of drugs has improved, there is still a scarcity. However, it may also be an example of the reality of the situation for non-NHIF members.

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\* words in brackets added for clarification

In order to curb the problem of drug shortages, the NHIF has developed a strategy of accrediting private pharmacies that can provide drugs that are unavailable in the hospitals. The aim is to ensure that NHIF patients have access to drugs from this alternative source. However, this arrangement has its own problems as, for example, sometimes patients are denied certain prescribed drugs by private pharmacists. The health workers are of the opinion that pharmacy owners find the NHIF prices of drugs too low compared with the market price, hence the arrangement is not profitable for them. This was what Dr Y had to say about obtaining drugs from private pharmacies:

*“Hmm, hmm, there is a problem. There are some pharmacies, I think, I don’t know if it was an agreement between them, they reach a point where they think maybe, there are some of the NHIF patients pay less (for the drugs) \* than what other patients pay. You may find some patients are told the drugs have run out but when another person who isn’t a member of NHIF goes the drug is available”.*

Sister K shared the following personal experience:

*“And there are so many inconveniences. I have also come across such (a situation). You are given a prescription, you go to the pharmacy and they (pharmacists) don’t give you the drugs because they want to sell them at a higher price. So now when you go, NHIF pays the pharmacy a certain amount of money but the pharmacy wants to sell the drug at a higher price, so you are sometimes told to top up the difference. Now when they (pharmacists) see that you don’t want to top up then you are told the drug is not available.” \**

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\* words in brackets added for clarification

Another problem is that the accredited private pharmacies are often difficult to locate. Even the health workers are unaware of the location of some of them and, therefore, cannot give patients directions. Dr M, from a public hospital, recounted the following:

*“If you prescribe a drug like, say umm, coartem, the new anti-malarial. Here (at the hospital) we don’t have it, nor is it available outside (the hospital) at F pharmacy. They have to go to S, in Kariakoo! Now imagine someone who lives in Mbagala, in the rural area, who comes here, from here has to go to S. He/she doesn’t even know where S is, which street, S pharmacy! Even I don’t know where it is! So it’s an inconvenience.”*

This sub-theme explains the health workers’ perceptions regarding the availability of drugs, supplies and equipment and how this is linked/not linked to the NHIF. Health workers felt that the availability of such resources had improved but that this improvement was not due to the introduction of the NHIF. The health workers’ perceptions implied that, while the availability of drugs and medical supplies had improved somewhat, the improvement had been due to other government initiatives and not to the NHIF.

The health workers’ perceptions corresponded with what His Excellency, President Benjamin Mkapa of Tanzania, mentioned in a speech addressed to Regional Medical Officers (RMO). His Excellency referred to a reduction in drug shortages in health facilities and attributed this to increased budget allocations for drugs and medical supplies from 10 billion Tanzania Shillings in 2000 to 30 billion in 2004 (Ministry of Health, 2005c:2). Therefore, improved availability of drugs may, indeed, be due to

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government effort. However, the health workers' perceptions were in contrast to a report by Humba (2005b:19), which documented improvements in the availability of drugs to increased revenue generated by the NHIF. It is also possible that both government efforts and the NHIF contributed significantly to improved availability of drugs and supplies.

In addition, this sub-theme also highlights the problems that the health workers attributed to the NHIF. The private pharmacies contracted to provide drugs were situated in locations that were difficult to reach, instead of being near the hospitals. This posed logistical barriers to accessing drugs, as was the case in Burundi's social health insurance scheme (Nzohabonimana, 2005:7), resulting in patients resorting to purchasing drugs from the nearest pharmacies. This could result in dissatisfaction and cause patients to opt to pay for services rather than going through cumbersome procedures to obtain prepaid services. Similar findings were reported in a study on the social health insurance scheme of Kenya, where members of the scheme did not utilize their benefits due to dissatisfaction with services in designated hospitals (Wang'ombe *et al*, 2002 *in* Quaye, 2004:97).

### **3.2.2b Sub-theme 2.2: Perceptions Regarding Performance of Health Workers**

Performance of health workers may also determine the quality of health services provided. Performance depends on the competencies, skills and abilities of the health workers, motivation to apply their skills, as well as the tools with which to perform. This sub-theme discusses performance aspects that apply to the health workers themselves, such as skills, abilities and motivation. The health workers mentioned changes in the workforce at the hospitals, such as reshuffling of health workers, hiring of more trained

personnel and removing unqualified staff, in order to improve performance. The health workers also stated that these changes had, indeed, improved the performance of the hospital staff. Sister K said:

*“Many of the staff have been changed, I mean mixed up, removing those (staff) who have been around for long and bringing new ones. And many have been employed. Now I think there are more trained personnel. There are many trained personnel, and many have gone back to school, so you find there are changes. We are progressing well (in performance).” \**

Dr Y expressed a similar view:

*“I say there are changes. Unlike when at first there were a lot of people (health workers) working in the wards who had been there for years and thought they could work through experience. You could have ordered a drip to be given out in the morning, and he (nurse or nurse assistant) just thinks it isn’t necessary to give the patient that drip at that time. Because he thinks he has more experience, while he is a nurse or even a nurse assistant. So after these changes you find that in the hospital now there are standard procedures to follow, (how to) give patients medicine, like a six hourly drug for instance. I tell you if a patient had a prescription, he would have to buy the drugs and keep them himself.” \**

Performance of health workers determines the quality of health services. Indeed, one of the strategies used by the NHIF to improve the quality of health services was to allow members to choose a hospital in order to create competition among service providers

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\* words in brackets added for clarification

(NHIF, see The National Health Insurance Fund, 2002). This implies a move to improve performance, a strategy that has also been discussed by some authors contributing to a discussion paper on social health insurance (Schramm *et al*, 2005:25). These authors contend that effective insurance schemes can challenge health systems to improve their performance.

The health workers in both public and private hospitals all mentioned improved performance and strategies to improve performance among the changes taking place in their institutions. However, they did not think that the NHIF contributed in any way to such changes. In public hospitals these changes were attributed to the government's efforts to improve the quality of health services, while in private hospitals they were seen as a strategy to attract and retain clients. Improving performance of health workers at all levels by capacity building is one of the strategies to improve the quality of district health services outlined in the Guidelines for Reforming Hospitals at Regional and District level (Ministry of Health2005a:14-16). These changes have generally been seen by the health workers as a move to improve performance, which had deteriorated over the years. While this may be the implementation of government-initiated strategies to improve performance, it may also be part of the NHIF strategy to achieve improved quality of health services. By allowing members to choose where to receive health services the NHIF has introduced competition among services providers that depends, among other things, on the performance of health workers.

For private hospitals performance improvement is a strategy that enables them to attract more patients, hence remain competitive. The private sector is driven by competition among providers, with those providing better quality care attracting more clients.



Therefore, high standard of performance is the core of their existence and the NHIF would only be considered a contributing factor if there was a potential for attracting a significant number of its members to utilise private hospitals.

### **3.2.2c Sub-theme 2.3: Perceptions Regarding the Ability to Offer More Services**

Improved quality of health services also includes the ability to offer certain services. This can include services that could not be offered for reasons such as scarcity of resources. Due to the increased availability of supplies and equipment, plus more qualified staff, the hospitals can now offer services to patients that weren't possible previously. For instance, certain laboratory tests (like kidney function tests and cholera specimen culture) and blood transfusions that could only be provided at the referral hospital are now being offered at most district hospitals in Dar-es-Salaam. This is what Mr J said about the current services provided at the hospital as compared to those provided previously:

*“Eh (umm), we do liver function (tests). Management realized that it's important to offer them (tests), but previously it was not like that. You find that, well, in the years that I have worked, a lot of equipment has gradually been brought, you see? For example, previously when there was an outbreak of cholera, we never even bothered to...culture the specimens we took. We would take specimens and rush them to Muhimbili, they do the culture, get the results and send them back. But now, this year, for example we have started doing the cultures ourselves.”\**

Dr Y disclosed the following about services being offered at the hospital where he worked:

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\* words in brackets added for clarification

*“In the beginning when I came here, the x-ray machine had a problem, but then it was fixed. Blood transfusion was a problem, the HIV issue and others. But all that is over, patients can now get blood transfusion here. There are some investigations like Full Blood Picture (FBP) and others, that can now be done right here. You find that many of the investigations that were not being done here are now being done.”\**

Some of the health workers did not think that more services were being offered as a result of the improved availability of supplies and equipment but rather that the same services were being provided more frequently than previously. Sister K, for instance, said:

*“Hmm.....I think they were available except that now honestly I think, eh, they are available more frequently than previous years.”*

This may be due to the increased number of more qualified health workers to provide the services after the government hired more staff, as was mentioned by Sister K when discussing health worker performance. Dr M also thought that the services had always been available:

*“No, all services have always been available. For example, operations like Caesarian sections were being done, hernioraphy was being done, everything was being done, even before NHIF started. But before NHIF, if a person is a government employee and wanted treatment, he/she had to ask (the surgeon who*

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*performs the procedure). But now, because they have NHIF cards, they can be operated on without any hassle.”\**

Compared to previous years, there are more services being offered at the hospitals, both in terms of type and quantity. The health workers did not relate the revenue collected from the NHIF as being a contributory factor to the ability to offer more services. They merely perceived such improvements as an effort by government to improve the quality of health services. According to one respondent, the hospital management had put resources into areas where there was need.

The perceptions of the health workers may correspond with what is actually happening in the health sector. The policy of decentralisation has given districts more autonomy in planning, budget and service delivery, hence making it possible for health expenditure to target priority health needs. Indeed, decentralisation and improved planning at district level are among the achievements documented in various reports such as the Tanzania Second Health Sector Strategic Plan (HSSP) of 2003-2008 (Ministry of Health, 2003: 8) and the 2006 Technical Review of District Health Service Delivery in Tanzania (Technical Review, 2006:2).

Some of the health workers viewed the ability to offer more services as simply making these services more accessible rather than making them more available. That is, the ability to offer more services is restricted to the NHIF members only, since the financial barrier has been reduced. This perception bears similarity to the issue of inequity raised by various authors (Bennett and Gilson, 2001:8; DFID Health Insurance Workshop

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\* words in brackets added for clarification

Report, 2002:18) when discussing the drawbacks to social health insurance in developing countries.

### **3.2.2d Sub-theme 2.4: Perceptions Regarding the Hospital Environment**

Quality of health services also depends on the state of the hospital environment. This has an effect on patient satisfaction as well as on the motivation of health workers. The hospital environment includes the buildings, surroundings and organization of the facility. The health workers mentioned a great improvement in the hospital environment. Buildings have been renovated, new facilities added and the cleanliness has been improved. Miss S said:

*“The hospital environment these days is good, because like there are a lot of sections that have been extended and many buildings are still being built. Hospital cleanliness, cleanliness is done and is satisfactory, there are special people who clean up the hospital throughout the day.”*

The most significant change appeared to be the cleanliness of the hospital, as this was the first aspect mentioned by all of the health workers when asked about the hospital environment. Sister S related the following about cleanliness:

*“Honestly, I think the environment has changed very much. It has changed in a sense that even the cleanliness is not like it was previously. You see? Now there is a big difference. Like now, for example, there is a company that has been hired, to do the cleanliness, and those people are paid.”*

Indeed, this was the first thing observed during data gathering. The high standard of environmental cleanliness was beyond expectation, with well-maintained gardens,

renovated buildings and new buildings being erected. The researcher also noted that the hospitals appeared to have improved with regard to organisation and arrangement since, despite the large number of patients, the facilities did not have a cramped atmosphere. Consequently, it was noted that much effort has been put into improving the hospital infrastructure and environment.

The perceptions of the health workers corresponded with a report on the achievements of the NHIF in which improvements in hospital facilities assessed by NHIF staff were attributed to payments made to hospitals for treating NHIF members (Humba, 2005b:19). The findings are also similar to the achievements of the Burundi social health insurance scheme which was reported to have contributed significantly to the development of health care facilities (Nzohabonimana, 2005:8).

The health workers did not perceive the improvements in the hospital environments as being associated with the NHIF, but rather attributed these to the government. Funds disbursed from a Joint Rehabilitation Fund to district councils enabled the rehabilitation of some hospital facilities as part of the health sector reform strategy (Ministry of Health, 2005b:11). This viewpoint was endorsed by the President who expressed appreciation of the progress made in rehabilitation of health facilities when addressing a Regional Medical Officers (RMOs) conference; he noted that under the health sector reform strategy 184 hospitals, 298 health centres and 992 dispensaries had been rehabilitated (Ministry of Health, 2005c:2).

### 3.2.2e Sub-theme 2.5: Perceptions Regarding Extra Duties for Health Workers

As with any reform in the workplace, the introduction of the NHIF also brought about some changes in the duties or roles of health workers. Such changes may include changes in workload, remuneration, organization and work procedures. Negative impacts on performance of health workers can be avoided if they are well prepared regarding these changes. All of the health workers interviewed mentioned that, due to the NHIF, their paperwork had increased and they had to spend more time with the patients. This meant that they worked longer hours than previously. For instance, Dr Y said:

*“These forms involve more work than treating the patient himself. You know why..... treating the patient can take 5 minutes, but you find that when you fill in the forms, it takes 15 minutes. Maybe you wanted to prescribe a drug like artesunate, and then you find it is out of stock. When you fill in this form, you also have to fill in this one too, and all the way up to here (he shows how much needs to be written) and all this when you have already filled this one (he show an in-house prescription). So you find that it’s a lot of work and patients continue to wait. So maybe if these forms were made simpler, it would be easier.”\**

Sister S endorsed this viewpoint:

*“Now they (the health workers) have extra work, because there are a lot of documents to fill in there. It’s not the same as this other place (for non-insured patients), you see. So that causes, sometimes people find that they can’t finish work within the normal hours. I mean, they can’t say that by 3.30pm (they will*

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\* words in brackets added for clarification

*have finished), perhaps until 8pm they are still there, eh (yes). Now one patient has like four forms that need to be filled in by the same nurse, eh.”\**

Some, like Sister K, thought that the paperwork was not their job and that instead a clerk should be hired to complete the NHIF forms:

*“They shouldn’t have given me clerk’s duties. We had wanted them to start a special section, and add a place for clerks, a place for nurses to provide services and a place for doctors. Doctors and nurses should just do our duties of treating and prescribing medicines and, what, providing services.”*

Sister S was also of the opinion that all health workers who treat NHIF patients do extra duties that are not within their job description. According to the health workers there was a shortage of staff, especially those who attended to NHIF patients. They mentioned that they should at least be paid for the extra time spent at work filling in the NHIF forms. They felt that were underpaid and that the overtime pay was never on time. Dr M said:

*“You are told to ask for overtime of 5000/-! Just imagine! Now I can work for a whole month, when I finally get paid, for instance, for January or for February I get paid today (June)! Also, remember it was 8 days pay, you get 3 days pay instead (because), the hospital, the Municipality has no money! One month, I got 30,000/-, I worked 12 days of overtime. There were a lot of public holidays that month was it March or April, there were many public holidays. I would come, do a lot of work, I got paid 30,000/-, which means 6 days! But I worked, honestly, I*

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*come in 2pm, leave at 8pm and even on Sundays and public holidays. I know I have 12 days then I get paid only 6.”\**

Despite the health workers complaints about filling in NHIF forms, they seemed to understand the importance of the forms. They knew that the forms were needed for reimbursements to be made to the hospitals by the NHIF and that the health workers had a role to play in ensuring that the claims were genuine. When discussing the issue of completing the forms, Miss S said:

*“Filling in those forms helps to improve the quality of health services, because now if you don’t fill them in people won’t know how many patients you have seen, how much medicine you have used and how much you have to be paid. They can’t know, so you have to fill in the forms, you have to keep record to show how much work you have done, what you have done.”*

The health workers in private hospitals also mentioned filling in forms for the NHIF but had different perceptions about doing so. To them, filling in forms was part of their daily activities and not an extra duty. Private hospitals have been providing services to other health insurance patients for many years, which always involved filling in forms. Sister A said:

*“It is not new because all health insurance (companies) require the same process; it is something normal that we have been dealing with for a long time. We use the same procedure for a lot of companies, even those not under this health insurance. So it is not something new to us.”*

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\* words in brackets added for clarification



The health workers also mentioned that, apart from filling in forms, they also have to perform 'customer service' duties. According to them, NHIF members complain about problems encountered to the health workers. Most of the causes for complaint are beyond the control of the health workers, who try to explain NHIF procedures and the extent to which they as health workers can address the problems. Dr M explained:

*“And then the patients come and complain to us, ‘the services themselves are poor’, they think we are NHIF (employees). We tell them, ‘Please we are just employees, just like you. I also have my salary deducted for NHIF. So, the way you complain to me, I don’t really understand. I don’t know any employee of NHIF, so when you bring your complaint to me, it’s useless, what do I do about it?’”*

Patients' complaints to the health workers were perceived by the latter as stemming from wrong attitudes on the part of the former. The patients thought that the health workers were employees of NHIF and, therefore, expected them to be in a position to address directly any problem associated with NHIF procedures or services.

Health workers also said that NHIF patients have incorrect attitudes about their membership status. They mentioned that the members thought they were entitled to superior services than non-insured patients, simply because subscriptions were being deducted from their salaries. Mr J commented:

*“When an NHIF patient comes to the lab, he thinks he is different from a patient who... pays at the point of use. I mean, the patient who pays cash, you see. Now when the patient gets here, I tell you, he wants to be helped immediately. I mean he wants his test to be done faster than the other patients.”*

Sister S agreed with the aforementioned comment:

*“Here you are providing services to people, especially when you take into consideration that an insurance patient knows that his salary is deducted, you see! So he comes there (hospital) like a private (patient), although he is not a private (patient), but as you know the way we are (she laughs). Eeh (yes) he sees himself as different from that one (non-insured patient), so he wants ‘when I come here I want to get something that perhaps is different’.”\**

This sub-theme highlights some of the negative impacts of NHIF or, rather, what the health workers perceived as being negative impacts. According to them, completing NHIF forms and dealing with patients’ complaints are an additional burden to the already heavy workload of the day. While it is true that these are extra duties, perhaps the health workers would have been more positive about performing them had there been prior communication regarding the additional tasks. Public sector health workers are not accustomed to performing customer services, which form an integral part of work in the private sector. The health workers seemed to be experiencing difficulties in adjusting to these changes in health worker-patient relationships because they were not prepared for them.

Before introducing any changes in the workplace or in any society, it is important to consider the desirability of such changes. The question, “How well will the changes be received?” needs to be asked. According to Normand and Weber (1994:15) and Conn and Walford (1998:13), the same applies to social health insurance. The authors argued

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\* words in brackets added for clarification

that the existing attitudes and traditions in the provision of health services were among issues to be considered when deciding on the desirability of social health insurance.

The health workers also felt that they were inadequately remunerated for their extra work. According to theories of motivation, employees will only feel motivated to put their greatest efforts into performing well if they feel their needs are being met (Hellriegel, Jackson, Slocum, Staude and associates, 2001:264-268; Grobler, Warnich, Carrell, Elbert and Hatfield, 2002:105-107). A good salary is seen to be a lower level need that is superseded by personal achievement and recognition, but this depends on whether or not the lower level needs are met. If lower level needs are not being met, as was the case with the public health workers in this study, then higher level needs will be replaced by the need to receive adequate and timely remuneration, thus affecting overall performance. Health worker performance may be affected when their expectations are not met.

The scenario regarding health workers in the private sector is different, as they perceive completing the NHIF forms and customer service role as an integral part of treating their patients. This is due to their background of many years of dealing with patients with health insurance and, hence, being accustomed to completing forms when performing their duties. Private hospitals are dependent on the revenue collected from service provision for their continued existence and possible expansion. The amount of revenue depends on the flow of patients, which is influenced by patient satisfaction with the services. Consequently, health workers in the private sector play a major role in maintaining excellent customer services on a daily basis.

### **3.2.2f Sub-theme 2.6: Perceptions Regarding the Difference in Services Offered to NHIF Members and non NHIF Members**

The difference in services offered depended on the hospital. At certain hospitals all patients were treated the same, regardless of NHIF membership. The only difference lay in the fact that a cash-paying patient only received treatment after paying (except in emergency cases), whereas the NHIF patients received treatment whenever there was a need. Sister K expressed the following about the types of services offered:

*“The only section that has been separated is that for consultation and registration. Like here, and a section for receiving drugs. Other places like injection rooms, are shared (with other patients) and the laboratory and x-ray.”\**

At other hospitals, for example where Sister S worked, the services were different; a separate section for consultation and a separate dispensing window had been allocated for NHIF patients. Sister S explained:

*“Here (at the hospital), insurance patients are treated at a separate section, you see which does not mix with the others (non-insured patients). So (therefore) on their side they get everything.”\**

During data gathering the researcher noted this difference, namely that NHIF patients were allocated separate consultation rooms, injection and wound dressing rooms, wards and dispensing windows. This was a reflection of public hospitals with private wings for those who could pay more for better services.

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\* words in brackets added for clarification

\* words in brackets added for clarification

On the occasions when there were fewer NHIF patients than non-insured patients, the former enjoyed less waiting times and better quality of services. These situations appeared to validate the concerns raised by some authors concerning the disparity in quality of services to insured and non-insured members of the population (Bennett and Gilson, 2001:8; DFID Health Insurance Workshop Report, 2002:10, Conn and Walford, 1998:12). Some authors have argued that these differences are important in order for the insured members to perceive that they are being offered significant advantages by contributing to the insurance fund (Normand and Weber, 1994:20). While this may be true, it needs to be done in a manner that does not compromise the quality of services for the uninsured patients. By shifting health workers from the already understaffed sections in health facilities to special sections designated for the insured patients, disparity is created between the two groups and, hence, more inequity is perpetuated.

Health workers in private hospitals had different perceptions regarding the services received by NHIF patients. According to these health workers, services to NHIF patients had to be limited to the NHIF benefits package and did not always compare favourably with those provided to cash-paying patients and members of other insurance companies.

Dr R explained:

*“When you are attending those patients coming from these kinds of organizations, you have to treat them but bearing in mind that you are restricted in amount of money so you should be careful, I mean with the kind of investigation you are going to request.”*

Dr C also commented on the differences between NHIF patients and cash-paying patients:

*“There is a bit of (a) difference between NHIF patients, cash paying patients and other insurance patients that we treat because, it (the NHIF package) only covers certain procedures compared to other insurance policies (insurance packages) and those (cash) paying patients. Coz, for example here we only treat, they are only allowed extraction, only extraction procedure and just maybe consultation.”\**

Private hospitals depend on the revenue generated from providing services to cover the associated running and administrative costs. In order for them to survive in the private service industry, it is important to have a good balance between the cost of providing services and the reimbursement they receive. For this reason, NHIF members utilizing private health facilities are restricted in the services they can receive, which to some extent may be demoralizing for the health workers.

### **3.2.2g Sub-theme 2.7: Perceptions Regarding the Effect of the NHIF on Quality of Health Service**

Despite the general perception that there had been quality improvements, the majority of public health workers did not perceive the improvements as being due to the introduction of the NHIF. They mentioned government efforts in progressing with development and patient demand for better services as being the driving forces behind quality improvements. This does not necessarily imply that NHIF is failing in achieving its objectives, but may rather reflect the lack of proper understanding of the NHIF by the health workers. For example, when asked about how these improvements were made possible, Dr Y replied:

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\* words in brackets added for clarification

*“That’s why I said it’s the changes brought by the government. Ah, there, there is some progress, I mean, maybe that has resulted from new leadership. But honestly there are changes. That is, for the hospital in general. We can’t say that NHIF is responsible because it (the improvement) is very big. Honestly, the revenue generated by NHIF, it hasn’t been able to do all this at once. I just think it is progress made by the hospital in general.”\**

Sister K responded similarly:

*“Um, I don’t think there is any connection with NHIF. Maybe it’s (the hospital) progressing well with development. But I don’t think it’s because of NHIF. It’s according to (trends in development) changing times. They say (advancements in) science and technology, and competition (between service providers) also.”\**

The health workers attributed quality improvements to various factors other than the presence of the NHIF. This finding is corroborated by findings reported in the DFID Health Insurance Workshop Report (2002:8) and by a study done in Sudan (Suliman 2002) where there was no direct association between improved quality and health insurance schemes. However, these results present a different picture when compared to the success experienced by Vietnam, Costa Rica and Korea, where social health insurance has been used to equip public hospitals (McIntyre, Doherty and Gilson, 2003:52).

Health workers in private hospitals said that it was difficult for them to attribute quality improvements specifically to the NHIF or to any other insurance company for that matter.

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\* words in brackets added for clarification

Dr C made this point when asked whether he thought the NHIF had contributed to quality improvements to the hospital:

*“Because the problem is that we have so many insurance agencies, some companies that are paying for their employees so I cannot just be specific with NHIF.”*

Others thought that the NHIF could not have made a significant impact due to the small number of patients that actually seek treatment from private hospitals, as explained by Dr R from a private hospital:

*“Well, with the hospital, what I can say is that you see if at all we are getting something it is very little. If we are getting something it is very little. If you can get a good number of patients probably we can benefit. But so long as the number we are getting is very little, I don’t see if at all we are, there is a benefit out of it.”*

Responses from health workers in the private hospitals were similar to findings by Nzohabonimana (2005:6), who argued that limited coverage and, hence, a limited pool of funds to benefit the whole population were among the challenges faced by the Mutual Benefit Society for Formal Employees of Burundi.

### **3.2.3 THEME 3: HEALTH WORKERS’ PERCEPTIONS REGARDING THE ACCESSIBILITY OF HEALTH SERVICES**

Accessibility has been defined as the presence or absence of physical or economic barriers that people face in using health services. Physical barriers are those related to the general supply and availability of health care services and the distance or travel time



necessary to reach the health facilities. Economic barriers are those related to out-of-pocket expenses. For the former, funds come from the contributions to the insurance fund; these funds free government resources, which can then be used to finance the latter costs of seeking and obtaining health care (Knowles, Leighton and Stinson, 1997 in Liu, Hotchkiss, Bose, Bitran and Giedion, 2004:32). Social health insurance can improve access to health services by reducing economic barriers both for those with insurance and those without.

### **3.2.3a Sub-theme 3.1: Perceptions Regarding Accessibility for NHIF Members**

All of the health workers said that the number of NHIF members and their families seeking health care had increased over the years since the introduction of the fund. They perceived this as being due to the removal of the financial barrier to treatment, since the patients were not required to pay up front for services rendered. Dr Y confirmed this:

*“NHIF patients have increased. Also a patient who would not have come to the hospital can come because what is needed is only transport to come here. Absolutely, you see some patients coming who wouldn’t have been brought, if it was previous years. Or if it was just OPD (Out Patient Department where non-insured patients receive services) he wouldn’t have come”.* \*

Whereas previously it was difficult to obtain certain services, it was now just a matter of the patient presenting the NHIF card. Dr M compared the difficulties experienced by government employees in receiving treatment prior to the introduction of the NHIF with the current situation as follows:

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\* words in brackets added for clarification

*“But now because he/she is a member of NHIF, if he/she needs any procedure it is done, I think it has helped (NHIF) employees who are members, it helps them, at least they get medicine, compared with previously (before NHIF).”\**

Sister K said:

*“Especially on the dates, bad dates (when the salary has run out), you find that many patients can’t come to hospital because they don’t have money, from my experience. But when a person has his/her (NHIF) card they come to hospital expecting to get treatment.”\**

Health workers in private hospitals said that not all NHIF members were authorized to seek treatment at private hospitals, with the majority being restricted to government hospitals. Dr R explained:

*“There are two categories... one is the, what is known as the green card and another one is the yellow card. Now yellow card, they usually go to the, I mean to the district hospitals, to the Muhimbili National Hospital and other hospitals. Those with the green card they are the ones who go, usually go to the big private hospitals like eh, Mikocheni, Aga Khan, TMJ and others.”*

Sister A explained in addition that the NHIF members authorized to receive treatment from private hospitals were high level officials such as ministers and directors who could afford to pay for services at the point of need:

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*“You find that most of them are those with high positions where they work, its not that they are people of low status (economically).”\**

The NHIF has been successful in improving access to health care for its members. The remarks of the health workers concurred with the report by the Chief Executive (Humba, 2005b:14), who argued that the vast increase in members improved the accessibility even for poor dependants who would not have sought health care in the absence of the NHIF. The increased number of NHIF patients utilizing the health services has shown that social health insurance is, indeed, a mechanism that can improve access to health services as well as prevent catastrophic health expenditure and that social health insurance can be implemented in a developing country like Tanzania. This corroborates findings from various countries implementing social health insurance such as Sudan, Indonesia and Burundi (Suliman, 2002; World Health Organization, 2003; Hidayat *et al*, 2004:332 and Nzohabonimana, 2005:8).

Despite the increase in membership there are still challenging equity issues, since access to better quality of services from private hospitals is restricted to only a few of the members. One of the principles in establishing the NHIF was to allow free choice of providers to civil servants who were previously restricted to government health facilities (Health Care Financing in Tanzania, 2005b:1). This is true for a small proportion of the civil servants. Problems of inequity of access have been a major challenge in Latin American countries implementing social health insurance, despite various reforms put in place to address the issue (DFID Health Insurance Workshop Report, 2002:8).

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\* words in brackets added for clarification

### 3.2.3b Sub-theme 3.2: Perceptions Regarding Accessibility for non NHIF Members

All of the respondents said that the utilization of health services has increased, including among non NHIF members. However, few of the health workers interviewed attributed this to the NHIF. According to them, accessibility had not improved for non NHIF members, since they still had to pay for services at the point of delivery or be denied access. Dr M elaborated:

*“If the patient is a non-member, he/she has to pay. Even if it is an emergency, he/she has to pay. Because if it's a non-member, if it's an emergency, if the medical supplies and drugs may not be available, for instance no syringes, relatives have to buy this and that...”*

The health workers mentioned various reasons other than improved access for the increased utilization of health services. Sister K remarked:

*“Ah, there are a lot of patients who have increased, especially these ones, hmm, of HIV, there are so many. And expectant mothers have also increased. Patients have increased because services, to be honest, have improved now compared with previous years. And the more patients are educated, and informed about the importance of coming to hospital, so many come to hospital. Like to give birth, bring their sick children, to bring the sick, people have been educated.”*

Mr J commented:

*“Many things have contributed, to the increase in the number of patients. One of them is, because the major diseases, hmm, that people suffer from are... .. malaria, you find cholera, gastro-intestinal diseases, you see. And the one that has just come in, HIV is also a problem. Now this HIV also causes other small*

*infections, you see. Now you find that all these diseases, when you try and trace the source, we go back to the fact that people are careless about their health.”*

While increased utilization would probably imply improved access, the health workers were not of that opinion. The reasons mentioned by the health workers, such as increased burden of disease, increased population and increased awareness of health issues, are factors known to influence the demand for health services. The demand for health services also depends on the health-seeking behaviour of the population, which could also be a contributory factor influencing the increased utilization of health services mentioned by the respondents. The health workers' responses highlighted important factors that need to be considered when linking increased utilization and improved access.

### **3.3 CONCLUSION**

This chapter documented the perceptions of health workers regarding service provision following the introduction of the NHIF. Generally, the health workers had accepted the NHIF as a new form of paying for health services and found it to be beneficial to its members. They also perceived the quality of health services as having improved in comparison to previous years, but they did not think that the NHIF had made a significant impact in this regard. According to them, the NHIF had contributed significantly to the improvements in quality and access to health care for its members, while the overall improvements were the result of implementation of health sector reforms by the government.

## **CHAPTER FOUR**

### **DISCUSSION OF FINDINGS, RECOMMENDATIONS AND CONCLUSION**

#### **4.1 INTRODUCTION**

This chapter contains a discussion of the findings presented in chapter three. The possible explanations for the findings and the implications are presented, along with recommendations for the way forward. The chapter begins with a statement of the objectives and how these were achieved.

##### **4.1.1 Objectives of the Study**

The objectives of the study were to:

- Determine the service providers' perceptions of the quality of health services following the introduction of social health insurance.
- Determine the service providers' perceptions of the utilization of health services following the introduction of social health insurance.
- Determine the services providers' perceptions of the difference in quality and accessibility of health services between patients with social health insurance cover and those without.
- Make recommendations based on the findings of the study.

All of these objectives have been reached. The first two were achieved by focusing on any changes in the quality and accessibility of health services and whether these changes were associated with the introduction of the NHIF. The third objective was achieved by

focusing on information about the differences in the quality and accessibility of health services between NHIF members and non-NHIF members. The fourth objective will be dealt with in this chapter.

## **4.2 DISCUSSION OF FINDINGS**

This treatise reports on the findings from individual interviews with health workers. The aim was to determine the perceptions of the health workers regarding service provision, with a focus on health service quality and accessibility following the introduction of the NHIF. Generally, the findings highlighted three issues: 1) The health workers' understanding of the NHIF; 2) The health workers' perceptions about the quality of health services under the NHIF; 3) The health workers' perceptions about the accessibility of health services under the NHIF.

### **4.2.1 Understanding of the NHIF**

Lack of understanding of the objectives of the NHIF and how the latter can achieve them is important since health workers are the main implementers of the financing mechanism. Therefore, health workers need to understand these objectives, how they are to be achieved and the role they need to play for the fund to be successful. In this way, the health workers would share the mission of the NHIF and, therefore, positively contribute to the achievement of its goals. When discussing the factors affecting health worker motivation, Bennett and Franco (2000:4) contend that a strong sense of the organizational mission not only enables health workers to understand how they can contribute to the

achievement of its goals, but also motivates them to do so. Similar arguments have been made by various authors when discussing health sector reform and human resources for health (Martinez and Martineau, 1998:346; Martineau and Buchan, 2000:174).

A report by Quaye (2004:100) stated that NHIF members complained of abuse by the health workers. One possible explanation for this may be the lack of understanding on the part of the health workers concerning the objectives of the fund and the roles they have to play in order to achieve them. Perhaps if the health workers were adequately informed about the objectives of the NHIF they would be motivated to perform better and have better attitudes towards NHIF patients. Another explanation may be the resistance to change. The introduction of the NHIF represents a change from treating patients who pay for services at the point of delivery to patients being treated without having to pay at the point of use. Such a change is threatening to health workers who may have depended on the old system which provided leeway for them to receive unofficial payments as a means of extra earning.

Hellriegel *et al* (2001:390) explain that it is common for employees to resist changes in the workplace, but that such resistance can be reduced by education, communication and participation. The same may be applicable to the introduction of the NHIF, where providing the right education and allowing health workers to participate in the process could result in better health worker attitudes towards patients enrolled by the Fund.

The concept of social health insurance is still new to the public health workers in Tanzania. Before the introduction of the NHIF, health workers in the public sector had no experience in dealing with health insurance. They were accustomed to operating under a



‘free services system’ and then the ‘user fee system’. This explains the fact that health workers in private hospitals, where private health insurance has been the main source of health financing for many years, have a better understanding of the concept of social health insurance and how it can be used to make improvements in quality and accessibility of health services. Furthermore, it also stresses the need for more information and education about social health insurance and how it can be used to improve service delivery. This may go a long way to eliminating undesirable behaviour and cultivating better performance instead to improve the quality of health services, as well as achieving the other objectives of the Fund.

One of the prerequisites for the introduction of a social health insurance scheme, or any programme for that matter, is its acceptance by the implementers and the beneficiaries. Providing the necessary information to influence positive attitudes within the intended parties should promote acceptance by the latter. Perhaps in the case of the NHIF the information imparted was slanted towards the advantages of membership of the scheme (that is towards the beneficiaries) rather than towards the details relating to implementation. This was probably due to the necessity of persuading the target group members to accept the associated salary deductions. As beneficiaries, the health workers may have accepted the fund, but as implementers they may have been unaware of the importance of their roles in achieving the Fund objectives. They may also have been unaware of how, as implementers, they stood to benefit from the fund by enabling it to achieve its goals (for example, provision of a better working environment.)

#### 4.2.2 Quality of Health Services

It is quite difficult to attribute improvement in the health services specifically to the NHIF, since such improvements have also come about through significant strategies developed during the health sector reforms. These reforms have brought about a number of changes such as increased budgetary allocation for health expenditure, as reported in the Tanzania Joint Annual Health Sector Review (Ministry of Health, 2005b:13) and Public Expenditure Report, 2005 (in Health Care Financing In Tanzania, 2005a), which state that per capita health expenditure has risen to US\$7.42 in 2005 (compared to US\$5.41 in 2003/04).

Some other changes include decentralization of management of health services to district level, rehabilitation of health facilities, human resource capacity building and distribution, restructuring of hospital organization, improvement in the supply of drugs and equipment and health financing reform strategies (Ministry of Health, 2005a:7,13). All these have contributed to the improvements in the quality of health services. Consequently, it is difficult to determine exactly which parts of the quality improvements were due to the NHIF and which were due to the other reforms.

Nevertheless, it does not mean that the Fund has not contributed to the improvement in the quality of health services. On the contrary, the NHIF has provided an additional source of revenue that may be utilized to improve services, especially for government owned hospitals. Humba (2005b:19) reported that more than three billion Shillings (equivalent to USD 30 million) has been paid to health facilities in 2005 as reimbursement for providing services to NHIF members. If this revenue has been used to

improve the quality of health services as per contractual agreement between the health facilities and the NHIF, then a significant part of the quality improvements must be attributed to the NHIF.

Whether this agreement has been honoured or not is beyond the scope of this study but suffice to say that the manner in which the generated revenue is utilized is the responsibility of hospital management. It is also the responsibility of hospital management to make hospital staff aware of how the revenue has been utilized. Indeed, one of the district level strategies of the Health Sector Strategic Plan (HSSP) to improve the quality of health services was to publish annually the health performance data and to discuss this with hospital staff (Ministry of Health, 2003:15). Such a practice would serve as a feedback to the health workers on performance of the health facilities, not only to inform them of the contribution of the NHIF to any improvements, but also to motivate good performance.

The improvements brought about by the NHIF may not be very significant at this stage owing to the relative infancy of the Fund. As one of the health workers pointed out, the quality improvements such as those in the hospital environment required more funding than what could have been generated from NHIF members. Although membership has increased, NHIF coverage is still limited to less than half of the Tanzanian population; hence, revenues generated cannot be expected to bring about visible changes. With increased coverage and a larger pool of funds, more significant improvements that are visible to health workers and patients alike could be made. The same is true for Latin American countries and others like Germany, where it took decades for the social health insurance systems to work. Accordingly, the NHIF is, generally speaking, still in its

infancy with insufficient members to create a pool of funds that could bring about significantly noticeable changes in the availability of drugs and medical supplies.

The introduction of the NHIF has also had drawbacks or undesirable effects that may have impacted negatively on the quality of health services. It has resulted in health workers having to perform duties for which they were not adequately trained. Health workers have to complete NHIF forms and deal with patient complaints and, consequently, spend more time on each patient. The net result is that they end up working longer hours. This situation has not been appreciated by most of the health workers, especially as they believe they are inadequately remunerated. This state of affairs could have been avoided had the health workers been sufficiently prepared for the changes.

Communication, information and education strategies are vital in achieving the objectives of the Fund; that is, how they are to be achieved and the role the health workers need to play. One of the strategies of the HSSP (Ministry of Health, 2003:15) to improve the quality of services is to make services more client-oriented. This entails health workers performing customer service roles; it also requires their commitment and motivation, which can only be ensured if they are adequately prepared through timely provision of information and education strategies.

In addition, patient complaints with which health workers have to deal could be considerably curtailed if the patients had a better understanding of the meaning of social health insurance scheme membership. It is possible that their expectations of superior services stem from the notion that they are paying more for the same services because of the monthly subscription deductions from their salaries. This could be due to advocacy

undertaken prior to the introduction of the Fund in order to encourage acceptance by the intended members. Expectations surrounding aspects such as not having to wait their turn or being able to demand specific types of drugs that are unheard of among non NHIF patients could be attributed to a misunderstanding of the whole purpose of the Fund.

#### **4.2.3 Accessibility of Health Services**

Significant improvements were reported regarding the accessibility of health services to patients. However, according to the health workers, these improvements were restricted to NHIF members. Unlike the quality of health services, improved accessibility due to reduced financial barriers was readily understood by the health workers. The ability to receive services without payment at the point of use must have been part of the advocacy campaigns to encourage acceptance of the NHIF scheme by intended members. Therefore, it is not surprising that, as they are members of the NHIF, health workers from health facilities linked improved accessibility to the Fund.

Inequity of access to health services between insured and non-insured members of the population was a concern of most of the health workers interviewed. According to the health workers, NHIF members were treated in a separate section of the hospital giving rise to the perception that the quality of services was better than for non NHIF members. This practice may have been instituted to make membership of the Fund attractive and reduce resistance to its acceptance. However, it is contrary to the nature of social health insurance whereby access to health services is governed by treatment needs and not the ability to pay. Social health insurance is meant to improve quality for all patients, not only for those who contribute to the fund.

Generally, the health workers thought that increased utilisation of health services has resulted from a high burden of disease and better health awareness of the Tanzanian population, which have served to create a greater demand for health care. According to the Tanzania Second HSSP (Ministry of Health, 2003: vii) and the World Health Organisation (2002:5-6), the burden of diseases such as malaria, pneumonia, diarrhoea, malnutrition and HIV-AIDS has increased, thus also increasing the demand for health services.

### **4.3 LIMITATIONS OF THE STUDY**

Any research process is bound to encounter some shortcomings and this study was no exception. It was not possible to get a good mix of respondents who fitted the selection criteria. For this reason, there were more nurses and medical officers than dental officers, laboratory technicians and pharmacists. It was also difficult to ensure complete privacy during some of the interviews in certain hospitals due to the difficulties in obtaining a venue that was free from distractions. Sometimes the interviews had to be stopped due to distractions such as noises outside the venue.

Private hospitals have a different operation and financing system to the public sector, therefore some of the questions prepared in the interview guide did not relate to their context. This was not detected in the pilot study since the latter was conducted in a public hospital. This was overcome by changing the original guide to relate to the context of private hospitals. This applied to questions regarding the availability of drugs and

medical supplies, maintenance of health facilities and the utilization of health services by different population groups (see Appendix I).

The first two questions were omitted from the guide since private hospitals handle patients from more than two health insurance schemes making it difficult for the health workers to attribute any changes to any one of them. The question about utilization of health services also did not relate to the private hospital setting since there are no exemption policies for special groups of the population. Accordingly, it was changed to utilization of health services by NHIF members.

Another limitation was the distance between the main supervisor and the researcher. The main supervisor was from the Nelson Mandela Metropolitan University of Port Elizabeth, South Africa. Consequently, all correspondence had to take place via email, which at times presented challenges in the discussions relating to the various aspects of the study.

As the main supervisor was from another country and, therefore, unfamiliar with the Tanzanian health system it was difficult for her to advise on issues relating to the latter. This was overcome by using a local co-supervisor to ensure that all aspects relating to the Tanzanian health system were accurately described and used.

Finally, translation of the interviews from Swahili into English presented a challenge. As some of the Swahili words have no direct translation in English, the meaning of sentences could have been changed or lost. This was overcome by the researcher seeking to understand the meaning of the sentences in Swahili first before attempting to translate them into English; hence, rather than translating word for word the researcher sought to convey the meaning of what was said.

## 4.4 RECOMMENDATIONS

In the light of the findings of this study, the researcher wishes to make the following recommendations:

### 4.4.1 Education

More effort should be made to educate health workers about social health insurance and how it can be used to finance the provision of health services as well as improvements in quality and accessibility of existing health services. This can be achieved by:

- **Seminars:** The NHIF can organize seminars where health workers can learn about:
  - NHIF objectives.
  - Methods to achieve these objectives.
  - Their role in achieving these objectives.
- **Training courses:** The government plans to provide regular training for health workers as one of the strategies to improve their performance. Incorporating education about social health insurance and the NHIF into such training courses should result in greater acceptance on the part of health workers of the changes in their roles as service providers.

### 4.4.2 Clinical Practice

Implementation of the fund and treatment of clients can be improved by the following:

- **Site visits:** During site visits NHIF officers should pay more attention to the concerns and suggestions of the health workers, as they are the people who



interact with the patients (who are NHIF members) and can, therefore, provide insight into some of the problems noted.

- **Benchmarking:** The NHIF could make use of benchmarking to improve delivery of services and treatment of clients; this would entail health facilities being encouraged to adopt the best practices from other facilities that are performing better.
- **Routine visits:** NHIF officers could make routine visits to the workplaces of its members in the same way that it does for service providers. This would:
  - Create an opportunity to learn about the problems being faced by members when they attend the health services.
  - Give the members a sense of satisfaction and also ensure that they know where to channel their complaints about the fund.
  - Enable the NHIF to provide proper information about the benefits package and the required procedures to be followed when seeking treatment.
  - Influence bringing the attitudes and expectations of the members more in line with what was intended by NHIF.
- **Information to health workers:** Health workers should be informed about utilization of the revenue collected from the NHIF. This could be done by including the information in staff meetings. It could be used as a feedback mechanism regarding their efforts towards contributing to the success of the NHIF as well as a motivator for better performance.

#### **4.4.3 Research**

This study had limited scope and the findings are, therefore, for explorative purposes. The author recommends studies of a larger scope focusing on expanding insurance coverage, improving equity of access to health care, stimulating competition between service providers in the public sector and making it easier for NHIF members to access drugs from accredited private pharmacies.

#### **4.5 CONCLUSION**

This report can conclude on the following note: health workers generally have accepted the NHIF as a new form of paying for health services, mainly due to the benefit of ‘health security’ for them and their families. Attributing improvements in the quality of health care specifically to the NHIF is somewhat difficult due the multiplicity of strategies that have been implemented in the health sector reforms.

The study also highlights the importance of health workers to the success of the NHIF. As implementers of the Fund, more information needs to be provided in order for the health workers to better understand the objectives of the NHIF and how they fit into the achievement of these objectives. It is the services they provide that will give patients the satisfaction necessary to encourage growth and expansion of the fund. With expansion in coverage, more significant improvements in service delivery will be achieved.

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APPENDIX I- INFORMATION AND INFORMED CONSENT FORM

**TITLE OF THE RESEARCH PROJECT:** THE IMPACT OF SOCIAL HEALTH INSURANCE ON THE PROVISION OF HEALTH SERVICES IN TANZANIA: A SERVICE PROVIDER PERSPECTIVE.

**REFERENCE NUMBER:** .....

**PRINCIPAL INVESTIGATOR:** DR EUNICE. N. CHOMI

**ADDRESS:** P. O. BOX 71397 DAR ES SALAAM TANZANIA

**CONTACT TELEPHONE NO.:** +255 746 926 806


<p>DECLARATION BY OR ON BEHALF PARTICIPANT:</p> <p>I, THE UNDERSIGNED,.....(name)</p> <p>[I.D. No:.....] the participant in my capacity as .....of the participant [I.D.....] of ..... ..... (address).</p> <p>A. HEREBY CONFIRM AS FOLLOWS:</p> <p>1. I/The participant was invited to participate in the abovementioned research project, which is being undertaken by (name) Dr Eunice. N. Chomi of the Department of Health and Welfare Management in the Faculty of Health Sciences, Nelson Mandela Metropolitan University.</p>	<p>Initial</p>
<p>2. The following aspects have been explained to me/participant:</p>	<p>Initial</p>

<p>2.1 Aim: The investigators are studying: The impact of social health insurance on the quality and accessibility of health services in Tanzania from the perspective of service providers.</p> <p>The information will be used for: study purposes as well as adding to the knowledge base of the impact of social health insurance in Tanzania, which be vital in addressing the challenges being faced.</p>	
<p>2.2 Procedures: I understand that the investigator will conduct a discussion, whereby the impact of social health insurance will be discussed among colleagues and myself. During this discussion our conversation will be recorded on tape by an assistant and both the investigator and assistant will also be taking notes of our conversation.</p>	Initial
<p>2.3 Risks:</p> <p>There are no risks, as anonymity will be ensured.</p>	Initial
<p>Possible benefits: As a result of my participation in this study I will be able voice my concerns and views about service provision under social health insurance and its impact on the quality and accessibility of health services.</p>	<u>Initial</u>
<p>Confidentiality: My identity will not be revealed in any discussion, description or scientific publications by the investigators.</p>	<u>Initial</u>
<p>Access to findings: Any new information / or benefit that develop during the course of the study will be shared with me.</p>	<u>Initial</u>
<p>Voluntary participation / refusal / discontinuation: My participation is voluntary. My decision whether or not to participate will in no way affect my present or future medical care/ employment / lifestyle.</p>	<u>Initial</u>





## APPENDIX II-LETTER OF APPROVAL FROM THE ADVANCED DEGREE COMMITTEE



**Nelson Mandela  
Metropolitan  
University**  
*for tomorrow*

• PO Box 77000 • Nelson Mandela Metropolitan University  
• Port Elizabeth • 6031 • South Africa • [www.nmmu.ac.za](http://www.nmmu.ac.za)

Summerstrand South  
Faculty of Health Sciences  
Tel . +27 (0)41 504 2121 Fax. +27 (0)41 504 2854  
[gail.ehbel@nmmu.ac.za](mailto:gail.ehbel@nmmu.ac.za)

---

**Ref:** 204006686

**Contact person:** Ms G Ehbel

**Date:** 30 November 2005

**Address:**

Dr EN Chomi  
C/O Dr Chilandga Asmani  
PO Box 10414  
Save the Children  
DAR-ES-SALAAM  
TANZANIA  
131

Dear Dr Chomi

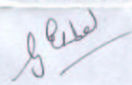
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**FINAL RESEARCH PROPOSAL: MA HEALTH AND WELFARE MANAGEMENT**

Please be advised that your final research proposal was approved by Faculty Management subject to the following suggestions/recommendations being made to the satisfaction of your Supervisor:

- i) That it was suggested that the title be amended as follows:  
A SERVICE PROVIDER PERSPECTIVE ON THE IMPACT OF SOCIAL HEALTH INSURANCE ON HEALTH SERVICE PROVISION IN TANZANIA
- ii) that when saturation point was reached in terms of sampling and in the focus group discussion, needed to be addressed;
- iii) that the proposal needed to be submitted to the Human Ethics Committee;
- iv) that editorial amendments were to be made throughout the document.

Yours sincerely



**OFFICE OF THE DEAN  
FACULTY OF HEALTH SCIENCES**  
SG/rj/H:/rachael/letters/final research proposal/june

APPENDIX VII- LETTER OF APPROVAL FROM THE HUMAN  
ETHICS COMMITTEE



## APPENDIX III- RESEARCH PERMIT FROM COSTECH

**TANZANIA COMMISSION FOR SCIENCE AND TECHNOLOGY  
(COSTECH)**

Telegrams: COSTECH  
Telephones: (255 - 22) 2700745-6  
Director General: (255 - 22) 2700750 &  
Fax: (255 - 22) 2775313  
Telex: 41177 UTAFITI  
E-M: [Rclearance@costech.or.tz](mailto:Rclearance@costech.or.tz)



Ali Hassan Mwinyi Road  
P.O. Box 4302  
Dar es Salaam  
Tanzania

**RESEARCH PERMIT**

No. 2006 -02-NA-2005- 136

Date 2<sup>nd</sup> January 2006

1. Name : Eunice C. Asmani
2. Nationality : Tanzanian
3. Title : The Impact of Social Health Insurance on Service Provision in Tanzania: A Service Provider Perspective
4. Research shall be confined to the following region(s): Dar es Salaam
5. Permit validity 2<sup>nd</sup> January 2006 to 1<sup>st</sup> January 2007.
6. Researcher is required to submit progress report on quarterly basis and submit all Publications made after research.



H.M. Nguli

for: **DIRECTOR GENERAL**

**APPENDIX IV- PERMISSION TO CONDUCT RESEARCH IN  
KINONDONI DISTRICT**

**KINONDONI MUNICIPAL COUNCIL**

ALL CORRESPONDENCES SHOULD BE DIRECTED TO THE MUNICIPAL DIRECTOR

Tel: 2171022



MUNICIPAL MEDICAL OFFICER  
OF HEALTH,  
KINONDONI MUNICIPAL COUNCIL  
P.O. BOX 61665,  
DAR ES SALAAM

In reply please quote:

Ref. No. FB/K/133-V 168

Date: 31/05/2006

**TO  
WHOM IT MAY CONCERN,  
KINONDONI MUNICIPALITY.**

**RE: RESEARCH PERMIT: -**

**Ms. Eunice C. Asmani**

The above-mentioned is a student pursuing a Masters Degree in **Health and Welfare Management at the Nelson Mandela Metropolitan University of Port Elizabeth, South Africa**. She has been given permission to conduct a research on "**THE IMPACT OF SOCIAL HEALTH INSURANCE ON SERVICE PROVISION**" in our Municipal Hospital starting from 31/05/2006 to 30/06/2006.

Kindly provide her with the necessary assistance in order to enable the performance of her activity comfortably.  
Best wishes,

.....  
Dr Hafidh K.H. Ameir

**(Research Coordinator.)**

**Kinondoni Municipal Council**

Copy: To above mentioned Candidate.

# APPENDIX V- PERMISSION TO CONDUCT RESEARCH IN TEMEKE DISTRICT

## TEMEKE MUNICIPAL COUNCIL

ALL COMMUNICATIONS TO BE ADDRESSED TO MUNICIPAL DIRECTOR

P.O.Box. 45232  
Tel: 2850142



TEMEKE MUNICIPAL MEDICAL OFFICE OF HEALTH  
DAR ES SALAAM  
TANZANIA.

Date 05/06/06

*MO/C Temeke Hospital*  
*Temeke Municipal*

### REF; PERMISSION TO CONDUCT HEALTH RESEARCH ACTIVITIES IN TEMEKE MUNICIPALITY.

Please refer to the above heading.

Permission has been granted to ~~Mr./Mrs/Ms/Prof./Dr.~~ EUNICE-C. ASMANI  
From (Institution) NELSON MANDELA UNIV Address P.O. BOX 0787 839 432 71397 DSM  
Tel. No. ~~27415042662~~ 0787 839 432 to collect data for research work at your institution.

The research title is

THE IMPACT OF SOCIAL HEALTH INSURANCE ON SERVICE PROVISION IN TANZANIA: A SERVICE PROVIDER PERSPECTIVE

S/he has submitted a proposal for the mentioned study to the MMOH Office as a pre - condition prior to authorisation.

The researcher has been instructed and agreed to submit the research progress reports and final results to the MMOH prior to any publications.

Data collection will start from 05/06/06 to 30/06/06  
Sample size.....

This research work is part of academic fulfilment for Diploma/Advanced Diploma/Degree/Master/PhD/its part of the ongoing research in your Institution.

I am kindly requesting you to give him/her the necessary assistance so as to accomplish this task timely.

Yours Sincerely

*[Signature]*  
Dr. Mashombo M

For; Temeke Municipal Medical Officer of Health  
Copy MUNICIPAL MEDICAL OFFICE

Copy 1. Eunice Asmani  
2.....

## APPENDIX VI- INTERVIEW GUIDE

**General question:** tell me your views on the quality and accessibility of health service under NHIF.

**Main questions:**

1. **English Version:** What do you think about the availability of drugs and medical supplies?  
**Swahili version:** Je, una mawazo gani kuhusu upatikanaji wa madawa na vifaa vya hospitali?
2. **English version:** What do you think about maintenance of the health facilities?  
**Swahili version:** Je una mawazo gani kuhusu ukarabati na utunzaji wa mazingira ya hospitali?
3. **English version:** What do think about the performance of the health care professionals?  
**Swahili version:** Je, una mawazo gani kuhusu ufanisi wa kazi wa wafanyakazi wa hospitali?
4. **English version:** What do you think of the utilisation of health services by the population?  
**Swahili version:** Je, una mawazo gani kuhusu wananchi wanavotumia huduma za afya?
5. **English version:** Do you think there are any changes in the role of service providers brought about by the introduction of NHIF?  
**Swahili version:** Je unafikiri kuna mabadiliko yoyote katika wajibu wa wafanyakazi wa afya baada ya kuanzishwa kwa NHIF?
6. **English version:** Do you think there is any difference between services provided to NHIF members and non-NHIF members?  
**Swahili version:** Je kuna unafikiri kuna tofauti yoyote kati ya huduma wanazopewa wanachama wa NHIF na wale wasio wanachama?