Imperial Journal of Interdisciplinary Research (IJIR)
Vol-2, Issue-10, 2016
ISSN: 2454-1362, http://www.onlinejournal.in

Assessment of the Level of Satisfaction between Beneficiaries of Sokoine University of Agriculture Community Health Fund (SUACHF) and Beneficiaries of National Health Insurance Fund (NHIF) in Morogoro Region.

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Abstract: *Health insurance as an alternative source of health care financing is very important source of health care financing in in the developing countries. It has been implemented as part of health reform programmes and strategies aimed at providing effective and efficient health care for most the poor and vulnerable communities. The beneficiaries of the insurance are expected to be satisfied with the services from the accredited health facilities but operationally they are not satisfied but they had some complains on the operation of the insurance systems. This study examined the level of satisfaction between beneficiaries of employer based insurance scheme (Sokoine University of Agriculture Community Health Fund (SUACHF)) and beneficiaries of National Health Insurance Fund (NHIF) in Morogoro Region. The main objective was to compare the level of satisfaction of the beneficiaries of NHIF and SUACHF in consideration of patient file handling, health staff responsiveness, availability of diagnostic services, availability of medicines and medical supplies, coverage in terms of choice of service providers as well as referral for further treatment and checkup. The study involved 102 respondents from the two insurance schemes and the respondents were selected randomly from the study population. Their responses were categorized into either satisfied or not satisfied groups. The results have revealed that the beneficiaries of SUACHF are satisfied with the selected services than those of NHIF who were satisfied only with the aspect of the coverage in terms of choice of service provider.*

1. Introduction

Health insurance is a way of paying for same or all of the costs of health care before using them. The insured person is protected from paying high treatment cost in the event of sickness. Health insurance is still new phenomenon to majority of Tanzanians, given the fact that more than thirty years Tanzanians were used to free medical services. A need to design and implement the National Health Security scheme was propelled by a number of social-economic factors related to the financial sustainability of the health sector due to decline in amount of resources flowing resulted into a decrease of availability and quality of health services in the health sector.

Health insurance schemes in many low and middle income countries most especially in the African continent are still in their early stages of implementation with the goal of universal coverage of the population. In Tanzania after independence, the government had expanded the health services with a vision to improve the health and wellbeing of all Tanzanians with a focus on those most at risk, and to encourage the health system to become more responsive to the needs of the people.

The government financed and provided medical care free of charge to its citizens despite an inadequate revenue base, which made financing the health sector a major challenge. Statistics indicate that the Tanzanian economy has not performed well since 1970s. Underfunding at all levels in the health sector contributed to shortages of medicines and medical supplies, deterioration of the physical infrastructure and low staff morale [2]. The increasingly poor economic performance, change in disease pattern, and escalating cost of disease management ultimately made it difficult for the government to provide medical services free of charge to all citizens[3]. To redress the situation, the country started undergoing some health care reforms under which the private for profit and cost sharing was also introduced.

2. Statement of the Problem

After independence in 1960's, most of the African countries started to have free care services by eradicating user fee charges in government health facilities [4, 5, 6]. The African governments believed that good health is an important element required for development of any national, poverty alleviation and other health development gains needed by all people in the country. To achieve this, the governments have stressed much on delivery of equitable and quality preventive, promotive, curative and rehabilitative health services at all levels. For the Tanzanian, the Arusha declaration of 1967 heralded the start of a series of health sector reforms by ensuring universal access

to social services to the poor and those living in marginalized rural areas.
This measure followed the realization that the ability of central governments to finance and manage effectively health services to people were becoming limited [7]. The inability was largely due to growing population and shrinking resources resulting from reduced economic performance [8]. Lack of adequate financing and management affected access to health care and health care quality. Since 1980s, many developing countries began to introduce reforms in their health care systems [9]. Improving access and quality of health care services therefore have been among the major goals of the health reforms taking place in many developing countries.

The reforms in health care financing in Tanzania started in 1993 with user fees at health centers and referral hospitals. Primary health care services offered at dispensary level continued to be free of charge [10]. However, cost sharing have been alleged to discourage the poor from using health care services causing biasness in access to health care [11, 10]. To address this problem, to boost its financing capacity, and to supplement the available funding sources (mostly taxes, donor funds, and user fees), the government of Tanzania initiated prepaid insurance like Community Health Funds (CHFs) and National Health Insurance Fund (NHIF).

The existing literature points out that CHF schemes in many developing countries perform poorly because of many limitations [10,4] CHF perform poorly in terms of coverage to the community and service delivery to its members. Gwatkin et al., (2000) [13,12] identified four main problems with the CHFs in Tanzania which are; poor quality of services provided by CHFs, scarcity of drugs and essential medical supplies, inappropriate diagnosis due to limited diagnostic facilities; staff-related problems; limited range of services provided and lack of flexibility in allowing members to use health facilities of their choice, coupled with referral problems. Similarly, an assessment report by Kamuzora and Gilson (2007) [12] showed that the NHIF collect a significant amount in contribution from its members but the actual reimbursement for services rendered to members or their dependents remains relatively low. Poor satisfaction to the beneficiaries, unawareness among beneficiaries of the NHIF about the extent and restrictions of the benefit package. An example is the compensation of optical services. There is no information source readily accessible for beneficiary, for example at the facility level to inform members about their benefit packages is long waiting times by the fund beneficiaries, unavailability of medicines and hospital staff attitudes towards the beneficiaries of the NHIF members do not receive their cards timely. Despite the fact that many scholars have studied about several issues pertaining to the two types of schemes, there is no straightforward study which has looked on the comparison of the beneficiaries' satisfaction between these schemes, hence, the current study address that gap. This paper particularly assesses the level of beneficiaries' satisfaction between SUACHF and NHIF in Morogoro region.

3. Objectives

To compare the level of satisfaction between the beneficiaries of SUACHF and NHIF in consideration of the following:

(i) Patient file handling
(ii) Health staff responsiveness
(iii) Availability of diagnostic services
(iv) Availability of medicines and medical supplies
(v) Coverage in terms of choice of service providers
(vi) Referral for further treatment and checkup.

4. Review of Literature

4.1 Health Insurance in Africa

Health insurance as a complementary or alternative source of health care financing has become important in the developing world. It has been implemented as part of health reform programmes and strategies aimed towards providing effective and efficient health care for citizens, most especially for the poor and vulnerable. Health insurance schemes in many Low and Middle Income Countries (LMICs), most especially in the African continent, are still in their early stages of implementation with the goal of universal coverage of the population [14]. There has been a need to understand the enrollee's satisfaction of health service provision in the health insurance scheme in order to effectively monitor the process, and to improve the scheme's implementation.
Health insurance schemes have been broadly introduced in many African countries, which have strived for improvements in health service delivery and the promotion of health care consumption. Client satisfaction with health service provision during the implementation of health insurance schemes has often been ignored since numerous activities take place simultaneously. The satisfaction of beneficiaries and its influencing factors have been providing evidence which have assisted in policy and decision making. Our objective is to determine the enrollee's satisfaction with health service provision under a health

insurance scheme and the factors which influence the satisfaction.

4.2 Health Insurance in Tanzania

The reforms in health care financing in Tanzania started in 1993 with user fees at health centers and referral hospitals. Primary health care services offered at dispensary level continued to be free of charge [8]. However, user fees have been alleged to deter the poor from using health care services, causing inequity in access to health care [8-9]. To address this problem, to boost its financing capacity, and to supplement the available funding sources (mostly taxes, donor funds, and user fees) the government of Tanzania initiated prepaid insurance like Community Health Funds (CHFs) and National Health Insurance Fund (NHIF).

Community Health Fund (CHF) which was piloted in Igunga District and later on rolled over to other districts to save the informal community in the rural and urban areas and National Health Insurance scheme(compulsory) was formed in 1999 by a Parliamentary Act No. 8 of 1999 and started to operate on 2001. While the CHF is primarily intended to benefit the majority of the informal sector (e.g., the self-employed), the National Health Insurance is targeted to formal employees (e.g. civil servants) and some of their dependents [2] . Under the CHF there was an introduction of the employer based insurance scheme like Sokoine University of Agriculture Community Health Fund (SUACHF). The differences between the two insurance schemes despite the general services which are provided by all of them is that with NHIF the coverage is limited while SUACHF has extended its services to referral services outside the country, also SUACHF is doing the ambulatory services as well as the principal member of the SUACHF is getting the service free of charge one year more after retiring while with NHIF the retirees benefits for the rest of their lives. Additionally NHIF has managed to accredit a big number of health services facilities throughout the country while SUACHF has few health facilities which it has accredited. Also the SUACHF reimburses the costs that the beneficiary has experienced, something that is not done by the NHIF.

5. Methodology

The study on which this paper is based was conducted in three health facilities namely Sabasaba Health Centre, Mzumbe Health Centre and SUA health Centre located in Morogoro Region. The choice of those health facilities was due to their accreditation on providing health services to the beneficiaries of the NHIF and SUACHF. A total of 102 study participants were randomly selected through exit interviews. The study involved the use of cross sectional study design. Data collection methods involved were in depth interviews, observation and documentary review. Data processing involved editing after receiving questionnaire from the respondents. Data were analyzed manually and through computer package (SPSS) and through tables and charts. Study participants were informed about the main objectives of the study and their participation in this study was on voluntary basis. The exclusion criteria were for respondents who didn't want to participate voluntarily and those who were unable to respond because of sickness or any other reason and those who were not members of the two health insurance schemes.

6. Findings

A total of 102 study participants were involves in the study. The categories of these participants were as follows: 35 participants were the beneficiaries of SUACHF while 67 participants were beneficiaries of NHIF. In gender wise 48 participants were male while female were 54 participants. Majority (60%) of the respondents were married, with regard to age, 38% of the respondents their age ranged from 18 to 30 while the smallest group was the age of above 60 years with six participants. This information has been summarized in table 1.

Table 1: Summary of Respondents' Characteristics

Characteristics	Attributes	Frequency	Percent
Membership	SUACHF	35	34
	NHIF	67	66
Sex of respondents	Male	48	47
	Female	54	53
Age group of respondents	18-30	39	38
	31-40	24	24
	41-50	21	21
	51-60	12	12
	60+	6	6
Marital status	Married	61	60
	Single	39	38
	Widow	2	2
Level of education	Primary	12	12
	Secondary	22	22
	Certificate	14	14
	Diploma	24	24
	University	30	29

Source: Field data, (2013)

The study aimed at assessing the level of satisfaction between the beneficiaries of SUACHF and NHIF. It specifically focused on patient file handling, health staff responsiveness,

availability of diagnostic services, availability of medicines and medical supplies, coverage in terms of choice of service providers as well as referral for further treatment and checkup.

6.1 Level of Satisfaction with Patient File Handling

It is still common in many hospitals to have a decentralized recording system. A structured and effective records management programme, covering all departments and all records irrespective of media, should be the aim of every hospital for the continuity on the progress of the patients. Among the indicators which the study had put into consideration was the patient file handling. On this aspect what was considered was the time spent form the arrival at the registry up to the time the client get the file and go for treatment. The result on this aspect has shown that the SUACHF beneficiaries were satisfied with this section by74% while for those of NHIF was 71%. From both insurance schemes, those who were not satisfied they mentioned bureaucratic tendencies during registration, shortage of staff the small size of the room were the reason for dissatisfaction on this aspect as they claimed to take long time before someone attended.

6.2 Level of Satisfaction on the Health Providers' Responsiveness to Patients' Problems

This study deliberately assessed the responsiveness of the health providers to patients' problems. The study found out that the beneficiaries of SUACHF are satisfied with the responsiveness by 91% while those of NHIF are satisfied by 61%. The reason for that level of satisfaction was due to the presence of the nurse (triage nurse) around who is sorting the serious patients and takes them to the ward where the doctor goes and sees him/her there instead of queuing at the outpatient department.

The people at the reception helped the relatives to take the patient from the car to the wheel chair and directs them where to go or what to be done and the doctors were giving the patients information about their diseases. For the patients who were not satisfied said that there are times the service provider don't use a good language and they are not polite to them when they are being attended and there is no any consideration of their health status.

However a study conducted by Muhondwa, et al., (2008) [15] in Dar es Salaam on the extent to which patients at the Muhimbili National Hospital (MNH) were satisfied with the services and care they received at MNH. Responsiveness of the health provider to patients' problems is among of the contributing factor to the satisfaction of clients. On their study, the results showed that a total of 1582 respondents (95.9%) expressed the opinion that they were well attended by the doctors. Only 25 patients (1.5%) said that they were not satisfied with their encounter with the doctors for various reasons. They complained about the doctor not being attentive because of talking on the phone during the consultation, and others complained about lack of auditory privacy, which made it difficult for them to talk about their illnesses. These differences on level of satisfaction of the beneficiaries may be due to difference in location, time, mode of payment of the service as well as to what extend was the biasness ruled out.

6.3 Level of Satisfaction on the Availability of Diagnostic Services

Availability of diagnostic services was among the indicator which was used to assess the level of satisfaction of the beneficiaries of the two insurance schemes. Findings on satisfaction of the beneficiaries on availability of diagnostic services have shown that 74% of the respondents from SUACHF were satisfied while for NHIF beneficiaries 49% were satisfied. The reasons behind their level of satisfaction were due to availability of different diagnostic tests like the test for stool, urine, blood slides.

The respondents went further and explained the reasons for dissatisfaction as the long waiting time on laboratory services due to shortage of staff, Small rooms for service delivery as well as the for the other diagnostic (X- ray and Ultra sound services) the respondents said that these services are only available at a specified days which make the beneficiaries not to get that service at that time and they are owed to go to other health facilities to get such services.

Several respondents said that ''*whenever we come at this facility we are only sure of the malaria test since it doesn't need any extra reagent they only prick you and put the blood on a small machine where after sometime you get the results, but for the test that needs reagents we never get them and the service provider always they say that the reagents are out of*

6.4 Level of Satisfaction on the Availability of Medicines and Medical Supplies

When the respondents were asked about the level of satisfaction on the availability of medicines, majority (91%) of the beneficiaries of the SUACHF said that they are satisfied while 69% of the beneficiaries of NHIF said they are satisfied too. The beneficiaries of SUACHF explained that in order to ensure that the beneficiaries get the

medication, before the introduction of SUACHF. One interviewee was quoted saying "*most medicines would often run out of stock, but now if the medicines needed is not available in the university store, beneficiaries can buy the medication and then they get a refund after ''*.

The respondents of this variable they further explained that incase the medication is not available at the particular health facility the health provider give them a form to fill and then they go at the accredited pharmaceutical shop and get the medication. Therefore to large extend it showed that the insurance beneficiaries are sure of getting the medication but what matters is where they will get them.

6.5 Coverage in Terms of Choice of Service Provider

The study went further to examine whether the insurance beneficiaries have a room to choose the type of provider whenever they need a service despite location and time, the results has shown 60% of the SUACHF members has said that the choice is little since there are few facilities which are accredited by their insurance scheme. Eighty five percent of the NHIF beneficiaries said that there a lot of facilities which are accredited by their insurance scheme. The respondents of the both insurance scheme they further explained that its not only they know the facilities which are accredited but also they know the services which are provided by those facilities. They all mentioned them as medical consultation, basic dental services, x-ray, ultra sound, inpatient services. Additionally for the beneficiaries of SUACHF they mentioned transport for the referral.

The beneficiaries of both insurance schemes they had complains of which those of NHIF they said that some of the private health facilities were not accredited with the HNIF as the result they can't access services there while those of SUACHF they said that there are few accredited health facilities which are available at towns only in which few beneficiaries can access the services leaving behind some of the dependents who are out of the towns to have a very limited number of facilities which they can access easily the services, they also said that in case they use their money from treatment to un accredited health facilities, it takes long time to be reimbursed.

6.6 Referral for Further Treatment and Check up

Another sub-objective of this study was to examine whether the insurance beneficiaries can easily get the referral to other health facilities for further treatment and checkup. Results in this aspect has shown that 35 respondents from SUA 86% said that they can easily get referral while 52% of the NHIF beneficiaries said that they can also get referral for further treatment and checkup. The facilities where NHIF beneficiaries can get referral are like all districts, regional and referral hospitals while for SUACHF beneficiaries mentioned Muhimbili, Tumaini, Hindumandali, and Regency. The beneficiaries of SUACHF further explained that at times they go and get the services outside the country despite of getting services from health facilities which are not accredited and then they get back the money from the university.

7. Discussion

The study has revealed that among the mentioned aspects under consideration, the beneficiaries of SUACHF were more satisfied with all the aspects (patient file handling, health staff responsiveness, availability of diagnostic services, availability of medicines and medical supplies, referral for further treatment and checkup) while the beneficiaries of NHIF were more satisfied only on the aspect of coverage in terms of choice of service provider. Accreditation of the few health facilities for the beneficiaries of the SUACHF and reimbursement of the money spent to get services from the unaccredited health facilities, availability of medicine, medical supplies and diagnostic services for treatment has made the beneficiaries to be more satisfied than those of HNIF where there are a lot of accredited health facilities which are not well equipped despite being able to choose the facility to go and get the treatment. Therefore by working on the stated reasons which caused the beneficiaries not to be satisfied and ensuring the availability of sustainable strategies for improving the services, the beneficiaries of health insurance will find the insurance being worth it.

8. Summary and Conclusion

This study has indicated that respondents were more satisfied with SUACHF than NHIF services. The main factors beyond this higher level of satisfaction were the availability of medication and laboratory services as well as the beneficiaries getting proper information about their health. This implies if patients' satisfaction level has to be maintained and if patients' complaints were to be kept minimal, the example of SUACHF must be followed.

Based on the study results, it can be concluded that SUACHF is doing better on all aspects that were included in the study compared to NHIF and the beneficiaries of SUACHF are more satisfied than those of NHIF. The nature of its members and size has made the control of the scheme to be easy

compared to the NHIF facilities whereby there are many accredited health facilities and its members are many where its control is somehow hard. Other factors such as coverage**,** the ease with which consumers can get referrals has a great influence on the satisfaction of the insurance beneficiary.

9. Recommendation

Policy and decision makers have to understand the potential factors influencing beneficiaries' satisfaction in order to viably implement such health insurance schemes. The following measures and strategies need to be taken into consideration in order to satisfy the beneficiaries of the insurance schemes.

Insurance accredited health facilities are supposed to be well equipped in material (medicine, medical supplies diagnostic equipment's) and human resources for beneficiaries' satisfaction depend on them as on its presence there would be no any delay on delivery of service.
SUACHF should extend the coverage to involve more ordinary and referral hospitals in different regions in the country. In this way, dependents like employees' parents who are all over the country can receive health services using their SUACHF cards and there should be more private health facilities which are accredited to provide a wide range of choice for the NHIF beneficiaries.

10. Acknowledgements

I would like to acknowledge the material and moral support, cooperation and encouragement I got from different people to accomplish this work. First and foremost is Dr A. Kihombo from Mzumbe University who supervised me during this research which was a partial fulfillment of the requirement for the master's degree.

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