THE UNITED REPUBLIC OF TANZANIA

NATIONAL AUDIT OFFICE

PERFORMANCE AUDIT REPORT ON THE MANAGEMENT OF PROVISION OF NATIONAL HEALTH INSURANCE SERVICES

THE MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN AND THE NATIONAL HEALTH INSURANCE FUND

A REPORT OF THE CONTROLLER AND AUDITOR GENERAL OF THE UNITED REPUBLIC OF TANZANIA
MARCH, 2019

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PREFACE

The Public Audit Act No. 11 of 2008, Section 28 authorizes the Controller and Auditor General to carry out Performance Audit (Value-for-Money Audit) for the purposes of establishing the economy, efficiency and effectiveness of any expenditure or use of resources in the MDAs, LGAs and Public Authorities and other Bodies which involves enquiring, examining, investigating and reporting, as deemed necessary under the circumstances.

I have the honour to submit to His Excellency, the President of the United Republic of Tanzania, Dr. John Pombe Magufuli and through him to Parliament the Performance Audit Report on the Management of Provision of National Health Insurance Services as conducted by the Ministry of Health, Community Development, Gender, Elderly and Children and National Health Insurance Fund (NHIF).

The report contains conclusions and recommendations that are directly a concern of the Ministry of Health, Community Development, Gender, Elderly and Children and National Health Insurance Fund (NHIF). Conclusions and recommendations made have focused mainly on strategies available for ensuring all Tanzanians are covered with health insurance services; accessibility of quality health services; availability of required resources to facilitate provision of health insurance services; and monitoring on the performance of NHIF as undertaken by the Ministry of Health and the Social Security Regulatory Authority.

The Management of the Ministry of Health, Community Development, Gender, Elderly and Children and National Health Insurance Fund (NHIF) have been given the opportunity to scrutinize the factual contents of the report and give their comments. I wish to acknowledge that the discussions with the audited entities have been very useful and constructive in achieving the objectives of the audit.

My Office intends to carry out a follow-up at an appropriate time regarding actions taken by the Ministry of Health, Community Development, Gender, Elderly and Children and National Health Insurance Fund (NHIF in relation to the recommendations in this report.

In completion of the assignment, the office subjected the report to critical reviews of the following experts namely: Prof. Phares Gamba Mussumi Mujinja and Dr. Eunice Nahyuha Chomi who came up with useful inputs on improving this report.

This report has been prepared by Deogratius Shayo (Team Leader) and Ndimwaga Shitindi (Team Member) under the supervision and guidance of Ms. Mariam Francis Chikwindo – Audit Supervisor, Mr. James Pilly – Assistant Auditor General and Mr. Benjamin Mashauri – Deputy Auditor General.

I would like to thank my staff for their devotion and commitment in the preparation of this report. My thanks should also be extended to the Ministry of Health, Community Development, Gender, Elderly and Children and National Health Insurance Fund (NHIF) for their fruitful interaction and cooperation with my office

Prof. Mussa Juma Assad
Controller and Auditor General
United Republic of Tanzania
March, 2019

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LIST OF ABBREVIATIONS AND ACRONYMS

AMMIS	:	Advanced Membership Management Information System
CMIS	:	Claim Management Information System
ICD	:	International Classification of Diseases
MoHCDGEC	:	Ministry of Health Community Development Gender Elderly and Children
NHIF	:	National Health Insurance Fund
PO-RALG	:	President's Office Regional Administration and Local Government
SSRA	:	Social Security Regulatory Authority

DEFINITION OF KEY TERMS

Health facilities	:	Registered Hospitals, Health Centres, and Dispensaries
Ministry of Health	:	Ministry of Health, Community Development, Gender, Elderly and Children
Overutilization	:	Amount spent by specified members' group is higher than the contributed amount for the given group
Service Providers	:	Accredited/certified Health Facilities
The Authority	:	The Social Security Regulatory Authority
The Fund	:	National Health Insurance Fund

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EXECUTIVE SUMMARY

Health Insurance is defined by the Unified Journal of Sport and Health Science Vol 2 (1) of June, 2016 as a way of paying for some or all of the costs of health care. It protects the insured person from paying high treatment cost in the event of sickness. Health insurance is also argued to be an important funding mechanism in generating sustainable revenue to the health sector and improving access to health care services especially for the most vulnerable population.[1]

In Tanzania, after independence and before 1990, health services were fully funded by the government through taxation, and provided free of charge to all citizens. However, provision of free health care for all became a challenge due to rising health care costs and a struggling economy resulted from implementation of Structural Adjustment Policy (Kumburu, 2015). To cope with economic challenges and rising health care costs, user fees and other cost sharing arrangements, which include introduction of health insurance were adopted in early 1990.

Currently, there are five Health Insurance Schemes in Tanzania, the largest one being the National Health Insurance Fund (NHIF). The other schemes include; Social Health Insurance Benefit (SHIB) under National Social Security Fund (NSSF), Private Insurance Schemes such as AAR and Strategies, Community Health Fund Scheme and Micro schemes.

However, despite the existing efforts, health insurance coverage in Tanzania is still very low. For example, in 2018, records showed that only 33 percent of population was covered by the health insurance services [2] while in Rwanda the coverage stood at 91 percent of the total population. This is because, health services are often not accessible to the very poor people and NHIF beneficiaries are largely found in urban areas. Additionally, enrollment to NHIF is mandatory for public sector employees who account for only 1 percent of the population; and leaving behind private and informal sector employees since enrollment to NHIF is not mandatory to them. In this regard, the National Audit Office decided to undertake the audit on the area of management of national health

[1] http://ihi.eprints.org/829/1/ihi.pdf Tanzania health insurance regulatory framework accessed on 10/5/2018

[2] [2] National Bureau of Statistics, February 2018.

insurance services to ascertain challenges faced and suggest possible measures to address them.

The overall objective of the audit was to determine whether the Ministry of Health and National Health Insurance Fund efficiently manage the provision of Health Insurance Services to ensure accessibility of quality health services in the country.

The audit covered a period of three financial years and eight months from 2015/2016 to February 2019 and was conducted to the National Health Insurance Fund (NHIF) and the Ministry of Health. The overall objective of the audit was to determine whether the Ministry of Health and National Health Insurance Fund efficiently and effectively manage health insurance services to ensure accessibility of quality health services in the country. Specifically the audit aimed at examining the effectiveness of strategies developed by NHIF to ensure that all Tanzanians are covered with health insurance services and determine whether NHIF beneficiaries can access quality health services through health insurance services provided by the Fund.

In addition, the audit aimed to determine whether there was conducive environment to enhance the role of the NHIF in provision of health insurance services and if there was proper monitoring of the Fund to ensure adequate provision of health insurance services in the country. The audit did not cover Community Health Fund (CHF) services.

The audit team reviewed various documents from the Ministry of Health, National Health Insurance Fund and President's Office Regional Administration and Local Government. Review of the documents intended to gain comprehensive and reliable information on the management of provision of health insurance services provision in the country. Three main methods of data collection were used in to obtain sufficient and appropriate audit evidences. These were: interviews, documents reviews and physical observations.

Quantitative data were analysed by organising, summarizing and compiling them using spreadsheets as well as different statistical methods of computations. The analysed data were presented in different ways including tabulations, histograms and graphs, charts and percentage distributions.

Qualitative data were analysed using content analysis technique through categorisation of different concepts and facts that originate from interviews or review of documents based on their assertions. The recurring concepts or facts were quantified depending on the nature of data being portrayed and summed or averaged in spreadsheets to explain or establish the relationships between different variables.

Main findings

Low Coverage of National Health insurance Services

The audit noted that, up to June, 2018, only 32 percent of Tanzanians were covered by Health Insurance that includes 25 percent CHF members and 7 percent NHIF members. With regard to enrolment of NHIF members, the Fund enrolled only 858,446 contributing members and 3,918,999 beneficiaries in total, of which Public Sector members were 68.79 percent, while for Non-Public Sector the Fund has enrolled only 31.2 percent which included 5.65 percent for Private Employees and 25.55 percent for other categories.

Further, it was noted that the enrolment trend for new principal members has remained constantly at 7 percent of the total Tanzania Population for three years consecutively from 2015/16 to 2017/18. However, there was slightly increase of members' enrolment annually, from 23 percent in 2015/2016 to 30.3 percent in 2017/2018 due to establishment of different membership categories such as; Mutual Groups, Private Individual, Toto Afya Kadi, students and clerics.

Insufficient Strategies in place to increase membership coverage

The audit noted that, despite of the requirement to increase enrolment of voluntary members, the Fund has insufficiently increased the enrolment of voluntary members as the percentage remained at 31 of the total recruited NHIF members. It was revealed that 50 percent of the introduced Non Public membership categories were underperforming by not achieving the set target. For example; Toto Afya Kadi underperformed by 65 percent and Mutual group by 68 percent for the period under review.

Insufficient Assessment on Sustainability of Established Health Insurance Categories

The audit noted that, apart from the Public and Private Employees' categories, there were other seven (7) categories[3] established by the Fund up to December, 2018. The study to assess the sustainability of these categories prior to their establishment was conducted to only two categories which was Toto Afya Kadi and students. It was further revealed that the assessment entailed understanding of the rationale for establishing the category which included willingness and demand from the community and the need to extend recruitment coverage.

The audit further analysed the enrolment and service utilization trend of beneficiaries from age 5 to 19 and their utilization trend and cost based on the NHIF database for the same group for the purpose of projecting their utilization extent. It was revealed that, the actual implementation of Toto Afya Kadi included the recruitment of children below 4 years contrary to the targeted age group of 5 to 17 years.

Not all Services Providers Approved for Loan, Received the Requested Loan

The audit noted that, for the period under review NHIF has issued facilities improvement loans of TZS 2.7 billion equivalent to 70 percent of approved loan to 32 out of 51 approved facilities. It was further indicated that, loans for medicines and medical equipment amounted TZS 9.3 billion equivalent to 63 percent of the approved amount were issued to 30 out of 107 approved service providers.

Not all Certified Service Providers Rendered Quality Health Services

The audit noted complaints regarding the quality of service rendered by dispensaries and health centres. NHIF beneficiaries were complaining about spending much time for them to receive the required treatment and failure to get all the required laboratory tests based on the level of health facilities.

[3] These categories include Clerics, Councilors, Members of Parliament, Mutual (KIKOA), Private Individuals, Students and Toto Afya Kadi

Inefficiency of Installed System

The audit noted that, the health facilities that were connected and given right to access NHIF ICT systems did not always work properly. Physical observations in Dar es Salaam, Kilimanjaro, Ruvuma and Mtwara revealed that the Service Portal was sometimes out of order during the authorization process. Further, there were incidents where beneficiaries' cards were rejected by the system due to system down time.

Insufficient Staff at both NHIF Head Office and Regional Offices

The audit noted that, at Head Office, the Fund experienced an overall staff shortage of 35 percent as of December 2018. The most affected Department was the Directorate of Planning and Investment having a shortage 44 percent while the least affected was the Directorate of Finance with a shortage of 21 percent. On the other hand, the shortage at the NHIF Regional offices stood at 42 percent.

Shortage of Human Resource at the visited health facilities

The audit noted, the visited health facilities experienced staff shortage ranging from 13 to 88 percent.

Overutilization of Members' Contribution by Category

The audit noted **an** overutilization by various groups, where amounts spent by specified groups were higher than the contributed amounts. The level of overutilization by various groups was as follows: Mutual members (KIKOA) - 710 percent, Clerics - 401 percent, Toto Afya kadi - 298 percent, Intern Doctors - 174 percent, Students - 171 percent and Private Individuals - 160 percent.

Unsustainable Investment Income

The audit noted that, some investment made were unsustainable and against the Fund investment policy as they didn't yield returns to the Fund. For instance, the Fund provided eight (8) years loan amounting TZS 24.6 billion from 1st August, 2010 to the Ministry of Home Affairs for purchase of 230 Toyota Pickups and 30 Toyota Station Wagon for use by Police Force. The audit further noted that, investment loans and projects to support Government Health Projects were on long- term basis ranging

from 5 to 8 years with no Government guarantee/collateral. This affected commitment in loans repayment.

ICT Skills Gap by Service Providers

The audit noted there was inadequate understanding on the use of the installed systems in 4 out of 16 visited facilities. Inadequate knowledge and skills ultimately affected timely service delivery by increasing waiting time to almost 8 hours.

Absence of functioning monitoring framework for monitoring health Insurance services

The audit noted that, the Ministry of Health has no functioning framework for monitoring and evaluation of its activities including those related to management of NHIF. Further inquiries revealed that, the Ministry of Health used the Health Sector Strategic Plan IV (HSSPIV) for monitoring implementation of NHIF activities, although the same had no detailed description of required M&E activities.

Overall Conclusion

The audit concluded the Ministry of Health and the National Health Insurance Fund have not been inefficient in ensuring adequate provision of National Health Insurance services in the country. This is because proportion of population covered with National Health Insurance stood at 7 percent only out of 33 percent of population covered with health insurance services in the country.

Further, with the exception of the Toto Afya Kadi and Students categories, all other categories were established without conducting a thorough study to assess their feasibility. This situation partly contributes to underperformance of established membership categories.

Audit recommendations

The National Health Insurance Fund should:

1. Strengthen a mechanism that would facilitate increase of members' coverage and accessibility of national health insurance to non-voluntary/informal members;

2. Conduct a thorough study prior to establishment of new members' categories to reduce risks of non-performance.

3. Establish mechanisms that would facilitate enforcement of issued recommendation and taking corrective measures on observed anomalies following inspection of service providers;

4. Establish web based ICT systems with service providers that would enable instant sharing of information in order to increase data accuracy, reduce work load and rooms for data manipulation; and

5. Make investment and issue loans which are in compliant with the Fund Investment Policy to ensure liquidity and sustainability of the Fund income.

The Ministry of Health should:

1. Ensure monitoring and evaluation frameworks and plans are established and include setting of key performance indicators for measuring the performance of NHIF in the provision of health insurance services.

2. Conduct monitoring and evaluation to NHIF and ensure timely submission of reports for the purpose of establishing performance measurement on health insurance activities executed by the Fund.

3. Establish standards of operation of ICT system to health facilities to enhance information harmonization and facilitate integration of data between different users.

4. Strengthen availability of medical equipment to all level of health facilities to facilitate provision of quality health care services.

5. In collaboration with PO-RALG facilitate availability of human resource to health facilities to improve availability of quality health care services.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Audit

Health Insurance is defined by the Unified Journal of Sport and Health Science Vol 2 (1) of June, 2016 as a way of paying for some or all of the costs of health care. It protects the insured person from paying high treatment cost in the event of sickness. Health insurance is also argued to be an important funding mechanism in generating sustainable revenue to the health sector and improving access to health care services especially for the most vulnerable population.[4]

The primary purpose of health insurance is to smooth out expenditure when someone get sick arises unexpectedly. It also aims at ensuring high quality health care services are accessibility to all people. This is very important in order to attain the WHO as well as Ministry of Health (MoH) goal of universal health coverage.

In Tanzania, after independence and before 1990, health services were fully funded by the government through taxation, and provided without user charges for all Tanzanians. However, provision of free health care for all became a challenge due to rising health care costs, and a struggling economy resulted from implementation of Structural Adjustment Policy (Kumburu, 2015). As a result of economic hardships and rising health care services costs user fees and other cost sharing arrangements which included introduction of health insurance were adopted in early 1990.

Currently, there are five health Insurance Schemes in Tanzania, the largest one being National Health Insurance Fund; other schemes include Social Health Insurance Benefit (SHIB) under National Social Security Fund (NSSF); Private Insurance Scheme such as AAR and strategies, Community Health Fund scheme and Micro scheme.

According to Ministry of Health Strategic Plan of 2010 – 2015, the Government of Tanzania intends to gradually cover all Tanzanian with social health insurance. The move started with the civil servants, but thereafter the coverage was extended to include public servants and

[4] http://ihi.eprints.org/829/1/ihi.pdf Tanzania health insurance regulatory framework accessed on 10/5/2018

councillors as well as retirees. Recently, through the power given to the Minister of Health, health insurance services coverage has been extended to include various institutions, organized groups and individuals such as TIKA, Toto Afya Card, CHF, etc.

Despite the gradual increase use of health insurance among the Tanzania population, wealthier groups working in the formal sector are more likely to benefit from this development than poorer groups. This implies that, implementation of health insurance is yet to reach most vulnerable and unsecured populations in the society, taking into consideration that almost 90 percent of the Tanzanians work in the informal economy.

1.2 Motivation for the Audit

The conduct of this audit was influenced by various factors which included: insufficient coverage of national health insurance services, supporting Sustainable Development Goal (SDGs) number three (3), absence of competition policies among health insurance providers and absence of method for determining health insurance charge fees in the country.

i. Insufficient Coverage of National Health Insurance Services

Health insurance coverage in Tanzania is still very low as only 33 percent of 54,199,163 populations were covered[5] as of December, 2018. Despite the fact that, health services are often not accessible to the very poor people[6], it was further reported that, NHIF beneficiaries are largely found in urban areas where most people are working in the formal sector. Additionally, enrolment to NHIF is limited to public sector employees who account for only 1 percent of the population; leaving behind private and informal sector employees, since enrolment to NHIF is not mandatory to them.

Consequently, most of the poor citizens are not accessing quality health care due to wash medical care costs and therefore they are risking their health and lives as well.

[5] National Bureau of Statistics February, 2018

[6] Poor People experiences of health services in Tanzania

ii. Priority area of Sustainable Development Goal (SDGs)

This audit topic is directly supporting SGD number 3 of the 17 goal of the United Nations which advocates "Good Health and Well-being". This goal is geared towards ensuring healthy lives and promotes well-being for all at all ages.

Many more efforts are needed to fully reduce the burden of diseases of a wide range of diseases, and address many different persistent and emerging health issues by focusing on providing more efficient funding of health systems. Health insurance service is one of the efficient funding systems for health care service provision; henceforth proper management of the same will accelerate the nation drive to attain universal health coverage.

iii. Absence of Competitive Policies among Health Insurance Service Providers

Despite having principles of good governance system, in the country, which include clear responsibility definition, transparency and accountability in operations, these principles are not yet fully reflected in the health insurance system. There are no clear policies for competition among health insurance service providers which include National Health Insurance Fund. In the public sector NHIF has the monopoly while in the formal private sector, private health insurers, NSSF, and NHIF compete for members. Additionally, in the informal sector, some micro schemes compete with CHFs[7].

In the absence of such clear policies on health insurance competition, could possibly lead to overlaps in responsibility and duplication of efforts and inefficiencies could lead to provision of low quality health care services as well.

iv. Absence of method for determining Health Insurance Charge Fees

A review of the Health Insurance Regulatory Framework of 2012 revealed that there is no accepted method for determining fee amounts charged to health insurance beneficiaries registered under National Health Insurance

[7] Report on the review of the Health Insurance Regulatory Framework of 2012

Fund as well as those registered by other Health Insurance Schemes. Charges could be as per mandatory social health insurance charges, wages and percentage based. Voluntary private and community insurance schemes are charging different flat fees[8]. As a result, there is no equity in payment into the health insurance system which affects health insurance services offered.

The above factors motivated, the Controller and Auditor General decided to carry-out a performance audit on the Management of Provision of National Health Insurance Services.

1.3 Audit Design

1.3.1 Audit Objective

The audit objective was to determine whether the Ministry of Health and National Health Insurance Fund efficiently manage provision of Health Insurance Services to ensure accessibility of quality health services in the country.

Specific Audit Objectives

Specifically, the audit focused mainly on determining whether:

a) The National Health Insurance Fund has strategies for ensuring all Tanzanians are covered with health insurance services.
b) Health insurance services provided by National Health Insurance Fund facilitate accessibility of quality health services to its beneficiaries.
c) The National Health Insurance Fund has the required resources to facilitate provision of health insurances services in the country.
d) Relevant authorities, i.e the Ministry of Health and Social Security Regulatory Authority adequately supervise and monitor health insurance services provided by the National Health Insurance Fund.

In order to address the set audit objectives, more specific audit questions and sub - questions are provided in ***Appendix 2***

[8] Review of the Health Insurance Regulatory Framework of 2012

1.3.2 Audit Scope

Main audited entities were the National Health Insurance Fund (NHIF) and the Ministry of Health, Community Development, Gender, Elderly and Children. NHIF was audited because of its main responsibilities in provision of health insurance services that facilitate accessibility of quality health services to its beneficiaries. The Ministry of Health through Policy and Planning Division is responsible for monitoring the implementation of health policies, legislations and guidelines of which includes health insurance.

The audit focused on examining strategies developed by NHIF for ensuring all Tanzanians are covered with health insurance services and whether NHIF beneficiaries can access quality health services through health insurance services provided by the Fund. In addition, the audit focused on determining whether the Fund allocated required resources to facilitate provision of health insurance services and if there was proper monitoring of the Fund to ensure adequate provision of health insurance services in the country. The audit did not cover Community Health Fund (CHF) services.

For the purpose of obtaining strong evidence other key players were: included President's Office - Regional Administration and Local Government (PO –RALG); selected Regional Secretariats and Local Government Authorities, selected accredited health facilities as well as NHIF beneficiaries in the visited regions and districts. PO-RALG was included because of its responsibilities for coordinating and implementing health programs, which include health insurance services in local authorities. Regional Secretariat and Local government authorities are responsible for the provision of health services to NHIF beneficiaries through accredited health facilities.

The audit team visited four Regions and four District Councils. The audit covered a period from July 2015 to February, 2019. The selected period enabled auditors to establish trends required by certain audit findings, and be able to develop reliable conclusions relating to the findings. The time frame for conducting this audit was from November, 2018 to March, 2019.

1.3.3 Sampling, Methods for data collection and Analysis

The audit team gathered reliable and sufficient audit evidences to address the audit questions in order to achieve objective of the audit. Data was gathered from various entities in different regions through different methods namely, document review, interviews and physical observations. Below are the detailed explanations for sampling techniques, each method used and method for data analysis:

(a) Sampling Techniques Used

The audit team visited four regions and four District Councils representing four geographical zones. In each selected geographical Zone, one region was randomly selected. District councils were firstly selected through purposive sampling by considering availability of district hospitals; and thereafter randomly sampling was used to select one district in each region.

Regions and District Councils that were visited are Dar es Salaam (Ilala MC), Kilimanjaro (Moshi DC), Mtwara (Masasi TC) and Ruvuma (Namtumbo DC).

(b) Methods Used for Data Collection

Both qualitative and quantitative data were collected to provide evidence regarding Management of Provision of National Health Insurance Services in the country. Three different methods were used to collect required data which are interviews, review of documents and physical observations.

i. Documents Review

The audit team reviewed various documents from the Ministry of Health, National Health Insurance Fund, Social Security Regulatory Authority and President's Office Regional Administration and Local Government. Reviewed documents also were from four NHIF regional offices, four selected referral/regional hospitals and four selected District hospitals.

The documents reviewed were intended to gain comprehensive and reliable information on the management of provision of health insurance services in the country in areas of NHIF coverage strategies; accessibility of quality health services to NHIF beneficiaries; availability of required

resources and monitoring of health insurance services by the Ministry of Health. Also, to identify the risks/impact and possible causes, and thereafter be able to gather evidences and come up with clear findings, conclusion and recommendations.

Reviewed documents were for the financial year 2015/16 to February, 2019 and included Policies, Legislations, Plans, and Performance reports, Actuarial Reports, Guidelines, Researches and Evaluations. Category of documents reviewed and reasons for their reviews are details in the **Appendix 3.**

ii. Interviews

This is another method used for gathering audit evidence. Different Officials responsible for management of provision of insurance services were interviewed from the Ministry of Health, National Health Insurance Fund, Social Security Regulatory Authority, President's Office - Regional Administration and Local Government and selected regional, LGAs, referral and district hospitals.

NHIF beneficiaries were interviewed to assess accessibility to quality health services using their NHIF membership cards.

During the interviews, auditors were guided by the interview guide developed depending on the responsibilities of the interviewed officials. Refer **Appendix 4** for more details on interviewed officials.

iii. Physical observations

The audit team visited four Regional Hospitals, four District Hospitals, four Health Centres and four Dispensaries in the visited Regions and Districts to observe activities regarding provision of health insurance services to NHIF beneficiaries that were taking place during the visit. During the physical observation process, auditors conducted interviews to NHIF beneficiaries on their views concerning National Health Insurance Fund services provided to them. Also, auditors interviewed facility in charges, Doctors, Nurses and NHIF coordinators on how they were providing health care services through insurance services covered by NHIF as well as their views on service provided by NHIF. Only NHIF accredited health service providers were visited.

(c) Methods for Data Analysis

The audit team analyzed the data gathered through documents review, interviews and physical observations by separating and grouping them into qualitative and quantitative data; so that they could be easily analysed using different approaches.

Quantitative data were analysed by organising, summarizing and compiling them using spreadsheets as well as different statistical methods of data computations. The analysed data were presented through different ways including tabulations, histograms and graphs with quantitative labels on indicators, charts and percentage distribution. The presented data were then explained in order to answer the 'what' and 'how many' questions.

Content analysis technique was used to analyse *qualitative data* by identifying different concepts and facts that originate from interviews or document reviews and were categorized based on their assertions. The extracted concepts or facts were either tabulated or presented as they were to explain or establish relationship between different variables originating from the audit questions.

The recurring concepts or facts were quantified depending on the nature of data being portrayed. The quantified information (concept/facts) were summed or averaged in spreadsheets to explain or establish the relationship between different variables.

1.3.4 Assessment Criteria

The following assessment criteria, extracted from various sources, such as legislations, policies, guidelines and best practices were used during the audit to assess the performance of NHIF in management of the provision of insurance services in the country:

Coverage strategies for Provision of Health Insurance Services

i. NHIF is expected to increase membership coverage from 26 percent to 50 percent by June, 2020 (NHIF strategic plan 2015-2020).
ii. NHIF as a government entity is expected to examine the targeted population needs by looking at the population's epidemiological profile, major barriers to access, unsatisfied demand and major

financial sources to determine the need for health insurance (WB, UNICO Studies Series 25, The Impact of Universal Coverage Schemes in the Developing World, 2013).

iii. NHIF is expected to conduct advocacy awareness to stakeholders and community to enhance understanding of the scheme (Health Sector Strategic Plan, IV, 2015 – 2020; and NHIF compliance manual 2017).

Accessibility of quality health care services through health insurance services provided by NHIF

i. NHIF is supposed to accredit/certify Service Providers to ensure their capacity to provide health insurance services. Accredited service providers should be in operation for at least three years and have required human resources; equipment and physical structures; medicines and medical supplies that are in conformity with established standard (NHIF Act of 1999).

ii. NHIF is supposed to periodically inspect accredited health care service providers as a mechanism for monitoring health insurance services provided by them (Section 39 (a) of NHIF Regulations, 2002).

iii. NHIF is supposed to provide loans to accredited health care service providers to ensure availability of required medicines and medical equipment's; and use the quality of service provided by these accredited HFs as basis for their payment to enhance compliance with required Standards both SOPs and health care standards (Section 26(a) of NHIF Act; and NHIF strategic plan(2015-2020).

iv. Accredited service providers are expected to plan for adequate and skilled human resources; equipment and physical structures; medicines and medical equipment that will facilitate provision of quality health services to NHIF beneficiaries (Section 20 and 21, NHIF Act of 1999).

Availability of required resources to facilitate provision of health insurance services in the country

i. NHIF is expected to enhance human capital capabilities and staff welfare to ensure quality provision of health insurance services to beneficiaries (NHIF Strategic plan of 2015-2020).

ii. NHIF is expected to ensure resources of the Fund consist of contributions from employees and employer, investments, donations and grants, fines and penalties and government budget as approved by the government. MoH have a duty to identify the pattern of health expenditures which include National Health Insurance Services and undertake periodic studies on allocative efficiency to determine a full picture of allocation, disbursements and expenditures NHIF Act, section (32) of 1999; and Health Sector Strategic Plan, IV,2015 – 2020).

iii. NHIF is supposed to prioritize availability of modern offices and sufficient working tools to facilitate provision of health insurance services (NHIF strategic Plan, 2015 -2020).

Monitoring of Health Insurance Services provided by National Health Insurance Fund

i. The Ministry of Health is supposed to have a functioning monitoring framework to monitor on the implementation of Health Sector Strategic Plan which includes health insurance issues (Health Sector Strategic Plan, IV of 2015 – 2020).

ii. The Ministry of Health through its Policy and Planning Division is expected to monitor the Implementation of Health Sector activities which include health insurance services provided by NHIF. On the other hand, the SSRA is required to monitor and review regularly the performance of social security sector, which include health insurance services provided by the NHIF (National Health Policy (2007); Social security Act Cap 135, section 5(h).

1.4 Data Validation Process

The Ministry Health, Community Development, Gender, Elderly and Children and National Health Insurance Fund (NHIF) were given an opportunity to go through the draft audit report.

Both, the Ministry of Health and National Health Insurance Fund confirmed the accuracy of the information presented in this report. The comments and responses of the Ministry of Health and National Health Insurance Fund are shown in ***Appendix One***.

1.5 Standards Used for the Audit

The audit was conducted in accordance with International Organization of Supreme Audit Institution's (INTOSAI) performance auditing standards. The standards require the audit team to plan and perform the audit so as to obtain sufficient and appropriate evidence as well as, provide a reasonable basis for findings and conclusions based on audit objective(s). The audit team believes the evidences obtained provide a reasonable basis for the findings and conclusions based on the audit objectives.

1.6 Structure of the Report

This audit report consists of five chapters as follows:

- *Chapter One:* Background information;
- *Chapter Two* presents the description of the system for managing the National Health Insurance Services in the country. The description included Legal framework, processes, key players and stakeholders together with their responsibilities;
- *Chapter Three* presents the findings of the audit covering all four sub-objectives of the audit;
- *Chapter four* provides overall conclusion and specific conclusions for the audit; and
- *Chapter Seven* outlines the audit recommendations that can be implemented by the Ministry of Health and National Health Insurance Fund so as to improve the system for the management of National Health Insurance Services in the country.

CHAPTER TWO

SYSTEM FOR MANAGING THE NATIONAL HEALTH INSURANCE SERVICES

2.1 Introduction

This chapter describes the system for managing national health insurance services in the country. It covers legal and administrative framework, key stakeholders involved and their main responsibilities and processes for health insurance management in the country.

2.2 Policies, Laws and Regulations for Management of Provision of National Health Insurance Services

2.2.1 National Health Policy of 2007

The policy calls for the more access to quality health services. Its vision is to have a healthy community that contributes effectively to individual as well as Nation's development towards becoming a middle income country. Meanwhile, its mission is to facilitate the provision of basic health services that are of good quality, equitable, accessible, affordable, and sustainable and gender sensitive. Therefore, by having more individuals who are members to health insurance services the policy vision and mission will be attained.

2.2.2 Governing Legislations

National Health Insurance Fund Act, Cap 395

The management of health insurance services are regulated by the National Health Insurance Fund Act Cap 395. The Act and subsequent amendments govern the operations of NHIF.

The Fund was established to cover for medical services rendered to its members and their dependents. Membership to the Fund is stipulated in section 2 of the Act and subsequent amendments open to all public servants, councillors and retirees who were previous members. Participating employers contribute to the Fund at a rate of 3 percent of each employee's salary. In addition, each employee who is a member of the Fund also contributes 3 percent of salary, giving a total contribution of 6 percent.

Section 16 (I) of the Act provides benefits to the contributing member, the spouse and up to four children or dependents. Health services provided by the Fund to its members include inpatient cover including medications and prescription drugs that are specifically included in the Essential Drug List which is prepared by the Ministry of Health. Additionally; the Act prescribes a Fee-for-Service payment mechanism for paying health care providers for services rendered to Fund members. The Act also states that the mechanism for payment may be changed to Capitation or any other mechanism as the Board may determine.

Social Security (Regulatory Authority) Act, Cap 135

Following the need to improve operations of social security schemes, the government enacted the Social Security Act Cap 135which established the Social Security Regulatory Authority (SSRA).

SSRA regulates and supervises Tanzania's social security sector including schemes, custodians and fund managers NHIF inclusive. The legislations provides for roles, responsibilities and procedural requirement in management of social security schemes. NHIF being one of the social security funds is regulated by this Act.

2.3 Role of Key Stakeholders on Management for Provision of National Health Insurance Services

The system for managing health insurance activities involves various stakeholders such as the Ministry of Health (MOH), National Health Insurance Fund, President's Office - Regional Administration and Local Government (PO–RALG), Social Security Regulatory Authority (SSRA) accredited health service providers, Employers and beneficiaries.

Below are detailed responsibilities of each of the above-mentioned stakeholders:

2.3.1 Ministry of Health, Community Development, Gender, Elderly and Children (Ministry of Health)

The Ministry of Health is the custodian of the health activities. The Ministry under Policy and Planning Division is mandated to:

a) Formulate, coordinate, review and monitor implementation of health policies, legislations and rules which include national health insurance service issues; and
b) Develop health strategies and programmes which include Single National Health Insurance.

2.3.2 President's Office - Regional Administration and Local Government

According to the organization structure of PO-RALG, February 2015, PO-RALG under Health, Social Welfare and Nutrition Services is responsible for coordinating and providing administrative support and allocation of resources for delivery of primary health care services. It monitors Regional Secretariat in providing health support to Local Government Authorities where NHIF accredited health facilities are allocated.

PO-RALG through Regional Health Management Team and Council Health Management Team is responsible for managing the performance of health facilities, which include NHIF accredited health facilities.

Regional Administrative Secretariat

Through Regional Health Management Team (RHMT), it provides technical support to LGAs for the implementation of the health program which includes implementation of National Health Insurance services through NHIF accredited health facilities.

Local Government Authorities

Within LGAs, Council Health Management Team manages and supervises the provision of District Health Care services which include health insurance services through accredited health facilities (dispensaries, health centres and hospitals) at district level.

2.3.3 National Health Insurance Fund – NHIF

The National Health Insurance Fund (NHIF) is a statutory Health Insurance Scheme established by the NHIF Act, Cap 395 so as to undertake the responsibility of insuring medical care services to its members. NHIF is a Government agency under the Ministry of Health, Community Development, Gender, Elderly and Children, which considers health insurance as a societal affair rather than an individual need the NHIF

operates under the principle of risk sharing and solidarity among members. The National Health Insurance Fund as per Section 4 (3) of the National Health Insurance Fund Act has the objectives of administering the National Health Insurance Scheme by ensuring accessibility of health care services to all Tanzanians; formulating and disseminating policies for sound administration of the Scheme.

The Fund is dedicated to providing support to its beneficiaries to access health services through a wide network of accredited quality health facilities throughout Tanzania. The NHIF envisages to becoming the leading Health Insurance Scheme of Choice in the Sub-Saharan region in terms of sustainability and quality of services.

Despite the compulsory arrangement to Public servants, the Fund has managed to expand its coverage to include councillors, private companies, religious and education institutions, private individuals, children under 18 (TOTO Afya) as well as mutual groups; whereby all members equally access health services in all accredited health facilities. The Fund is also administering the Bunge Health Insurance Scheme, on behalf of the National Assembly. NHIF established offices in all regions in Tanzania Mainland and an Office in Unguja Island to serve members who are under the Union Government.

Management of the Fund

The management of the Fund is vested to the Board of Directors. However, day to day operations of the Fund are overseen by the Director General, who is also the secretary to the Board.

Core functions of the Fund

As it is specified by the NHIF Act, core functions of the Fund are to:-

i. Register members and issue identity cards;

ii. Accredit and inspect health service providers; undertake quality assurance processes; inspect employers to check compliance; and Process providers' claims

iii. Collect monthly and periodic contributions; Invest the funds so collected in order to earn income; and Account for the fund so collected and invested;

iv. Carry out Actuarial Assessment and Valuation; and

v. Provide health insurance education to the public with the aim of marketing it and enhance public relations.

2.3.4 Social Securities Regulatory Authority (SSRA)

This is a regulatory authority that is responsible to regulate the social security funds. SSRA was established in 2010 by Act Cap 135 as amended to regulate and supervise Tanzania's social security sector including schemes, custodians and fund managers.

The role of SSRA is indicated in section 5 of the Act include:

i. Register all Managers, custodians and Schemes;
ii. Regulate and supervise the performance of all managers, custodians and social security schemes;
iii. Issue guidelines for the efficient and effective operations of the social security sector; Protect and safeguard the interests of members;
iv. Monitor and review regularly the performance of the social security sector;
v. Facilitate extension of social security coverage on non-covered areas including informal groups; and
vi. Conduct awareness, sensitization and tracing on social security.

2.3.5 Health Service Providers (NHIF Certified Health Facilities)

NHIF beneficiaries can access health services through a wide network of accredited health facilities in Tanzania. The Fund's accredited health facilities among others include Public health facilities, Private health facilities and Faith Based Organization (FBO's), which are geographically scattered all over the country. The Fund accredits all levels of health facilities which include:

i. National Referral and equivalent hospitals;
ii. Zonal referral and equivalent hospitals;
iii. Regional referral Hospitals;
iv. District/Designated/ Designated Hospitals;
v. Health Centers;
vi. Dispensaries;

vii. Specialized Clinics;
viii. Diagnostics Centres (Imaging and Laboratories); and
ix. Pharmacies and Accredited Drugs Dispensing Outlets (ADDOs).

2.3.6 Beneficiaries

Beneficiaries are the key users of health insurance services, they are responsible for ensuring that they made contributions to the funds and being vigilant to insure that the funds sustainability is maintained by insuring their NHIF membership ID cards and that of their dependents are not misused.

NHIF beneficiaries include the contributing member, spouse and up to four legal dependants. Under NHIF context, legal dependents include biological children or legally adopted children, parents and in laws.

The Fund has expanded its range of categories of membership that enable other members of the society to join. This is part of the effort to ensure that more members join the Fund. These categories include Public employee, Forces under Ministry of Home Affairs, Students, Retired NHIF members, Private individuals (with no employers/self-employed), Private Companies, Associations and NGOs. Also, it includes religious leaders such as Clergies, members of registered Economical Groups SACCOS and TOTO Afya kadi.

The roles of these key players are as described in the **Figure 2.1**.

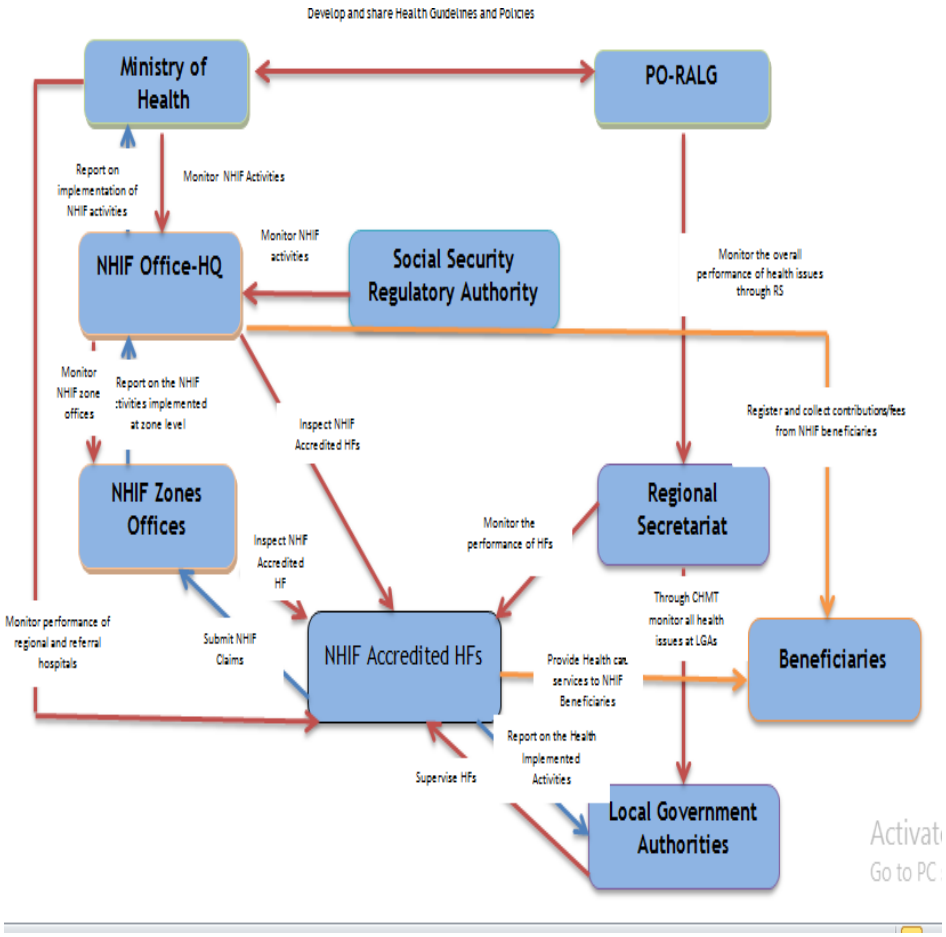


Figure 2.1: System Descriptions for Key Actors for Managing Provision of National Health Insurance Services

2.4 Allocated Resources for Managing Provision of National Health Insurance Services

5.4.1 Sources of Income for the Fund

In managing provision of National Health Insurance Services, NHIF as the main provider of National Health Insurance Services has various types of fund sources which include revenue from statutory contributions, income from investment and other sources. **Table 2.1** provides details of various sources of Income to facilitate provision of National Health Insurance Services at NHIF.

Table 2.1: Sources of Incomes for the NHIF

Source of Income	Amount (TZS Million)		
	2015/2016	2016/2017	2017/2018
Member contribution	354,446,73	363,349.50	395,266.29
Investment income	91,257.62	106,944,63	118,234.58
Other income	1,622.96	761,842	1,096.98
Total	**447,327.31**	**1,232,136.13**	**514,597.85**

Source: NHIF Strategic Plan 2015 - 2020

2.4.2 Allocated Human Resources at NHIF to facilitate Provision of National Health Insurance Services

Human resources at NHIF are organized through seven major directorates in order to facilitate provision of health insurance services in Tanzania. These directorates report directly to the Director General. The operations are further divided into zonal offices. The total number of staff at NHIF was 378 as at January 2018 whereby 157 of them are based at Headquarters and 221 are serving at Regional /Zonal offices. The distribution of staff in terms of numbers is presented in **Table 2.2**

Table 2.2: Allocated Human Resources at both NHIF Head Office and Regional Offices

Unit	Required	Available	Gap	Percentage of Gap
Head Quarters Offices	242	157	85	35.1
Regional Offices	496	378	118	23.8
Total	**738**	**535**	**203**	**27.5**

Source: NHIF staff establishment plan as of January, 2018

2.5 Processes for Managing National Health Insurance Services in Tanzania

The sound management for provision of National health insurance services includes registration of members, collection of contributions, processing and payment of claims and inspection to certified health service providers which include supportive supervision and verification inspections. The process also includes monitoring of the Funds activities to ensure daily operations and planned activities of the Fund are conducted according to established standards. Below is the detailed information for each stage:

i. Registration of Members

Membership to NHIF is according to NHIF Act CAP 392 of 2015 and its regulations of 2002. Those who can be registered are contributing members i.e. the principal members and their spouses, children, parents and in-laws. In order to be registered there must be proof of a legal relationship that exists between the principal members and their dependents.

ii. Collection of Contributions

NHIF collects fees from its members who contribute on a monthly basis through deduction from their salaries. Government employers are required by the laws to remit the 6 percent deduction to NHIF, for those who are employed in private sector are also required to remit 6 percent contributions to the fund.

iii. Processing of Claims

Through the directorate of Medical and Technical Services, claims are received and processed. The process involves reviews of received claims, verification of claims which has indications of fraud and payment.

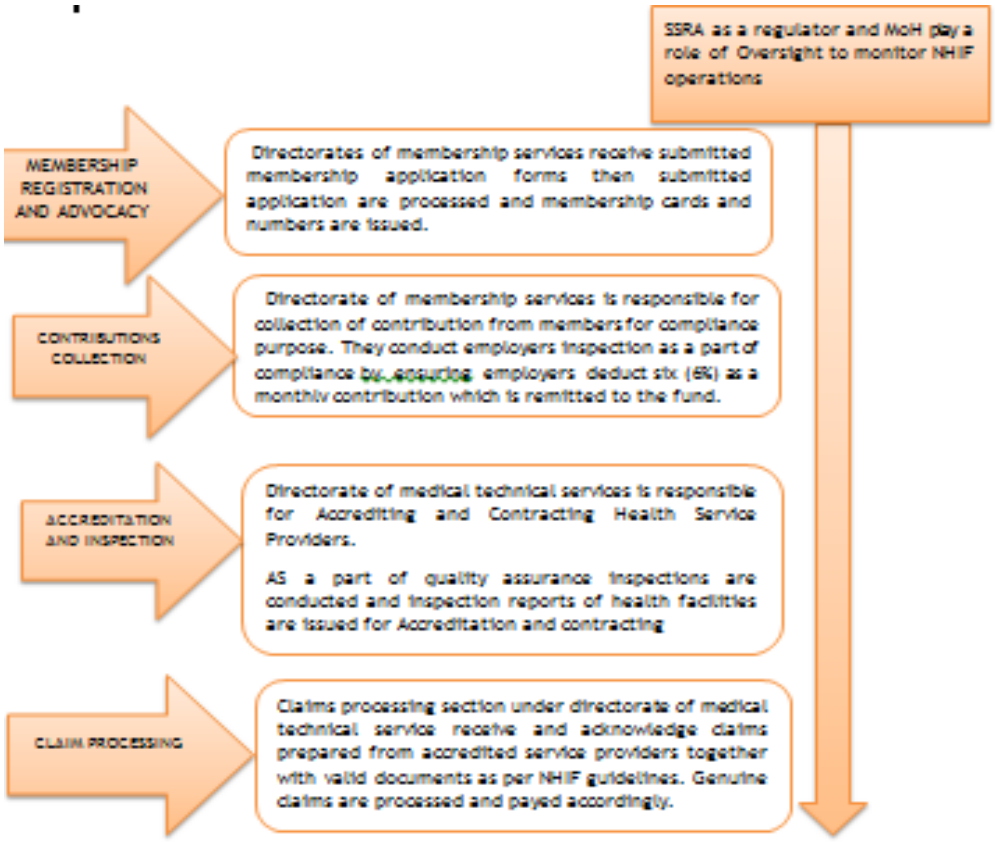
iv. Inspection

NHIF also conducts periodical inspections to health facilities that are certified to offer health services to NHIF beneficiaries; so as to check compliance with the NHIF regulations and procedures. Through this inspections, frauds are being tackled also the health providers are being closely monitored to ensure they do provide the quality health services that are required as per the established standards.

v. Monitoring of Services Provided by NHIF

All insurance activities under NHIF are monitored by the Ministry of Health and Social Security Regulatory Authority to ensure planned activities are implemented as per established standards and guidelines.

Figure 2.2: Key processes involved in the Management for provision of National Health Insurance Services in the Country.



CHAPTER THREE

AUDIT FINDINGS

3.1 Introduction

This chapter presents audit findings on the performance of the National Health Insurance Fund and the Ministry of Health on management of provision of National Health Insurance Services.

The findings address four (4) specific audit objectives described in section 1.3.1 of this report encompassing:

i) Coverage of National Health Insurance Services in Tanzania;

ii) Accessibility of quality health services through health insurance services provided by NHIF;

iii) Availability of required resources to facilitate provision of health insurance; services; and

iv) Monitoring the performance of health insurance services provided by NHIF as undertaken by the Ministry of Health and the Social Security Regulatory Authority in the Country.

3.2 Coverage of the National Health Insurance Services in Tanzania

This section describes the extent of coverage of National Health Insurance services in the country; strategies in place to increase coverage; and assessment conducted to determine sustainability of different health insurance categories introduced by NHIF before their establishment to ensure all Tanzanians are covered with Health Insurance.

3.2.1 Inadequate number of Tanzanians were covered with National Health Insurance Services

NHIF strategic plan 2015-2020, required the Fund to increase membership coverage for Tanzanians from 26 to 50 percent (both NHIF and CHF) by June 2020. The Fund was required to expand the membership base in both formal and informal sectors. Similarly, the Ministry of Health and NHIF are called upon to establish strategies to expand enrolment of Tanzanians into health insurance system (Health Sector Strategic Plan, IV, 2015 – 2020).

Review of NHIF budget for the financial year, 2018/2019 showed that the Fund was determined to extend its coverage through registering members in both formal and informal sectors. The audit noted there was low coverage in terms of population covered by NHIF, which stood at 7 percent and the enrolment of new principal members was not satisfactory as detailed hereunder:

(a) Low Coverage in Terms of Proportion of Population Enrolled

Reviews of Annual Performance Reports for the financial years 2015/16 to 2017/18 showed that up to June 2018, about 32 percent of Tanzanians were covered by Health Insurance, where by 25 percent were CHF members and only 7 percent were NHIF members.

Reviews of NHIF Fact Sheet for the financial year 2017/2018 indicated that, up to June 2018, the Fund enrolled 858,446 contributing members and 3,918,999 beneficiaries in total; of which Public Sector members were 68.79 percent, while for Non Public Sector the Fund had enrolled only 31.2 percent which included 5.65 percent for Private Employees and 25.55 percent, for other categories[9]. **Table 3.1** shows enrolment of both Public and Non Public members by Category as at June 2018.

[9] Other categories include Clerics, Councilors, Members of Parliament, Mutual (KIKOA), Private Individuals, Students and Toto Afya Kadi.

Table 3.1: Enrolment Status per Category of NHIF Members as at 30th June, 2018

S/No	Name of Category	Number of enrolled members	Percentage of the total enrolment (%)
1	Public Employees	590,487	68.79
2	Private Employees	48,544	5.65
3	Clerics	6,280	0.73
4	Councillors	3,458	0.40
5	Members of Parliament	394	0.05
6	Mutual Groups (KIKOA)	33,057	3.85
7	Private Individuals	2,494	0.29
8	Students	114,942	13.39
9	Toto Afya Kadi	58,790	6.85
Total enrolment		**858,446**	**100.00**

***Source**: NHIF Fact Sheet, 2017/2018*

It was further noted that NHIF had no sufficient information on the total number of government employees that would assist in setting a target to ensure all public sector employees were enrolled by the Fund. This is because; despite of request made by the audit team, there was no information availed to auditors on actual number of government employees which would assist auditors to assess the proportion of the potential members that NHIF has been able to enrol. This was also true for other categories.

(b) Trend in Enrolment of the Principal Members was not Satisfactory

Based on the review of NHIF Fact Sheet, 2017/2018 and Performance Reports of 2015/16 to 2017/18, it was indicated that the enrolment trend for principal members has remained constantly low at 7 percent of the total Tanzania Population for three financial years consecutively. The population of Tanzania for the year 2018 was 54,199,163 people[10]. **Table 3.2** provides details on the trend for the enrolled principle members with their beneficiaries in relation to the total population.

[10] National Bureau of Statistics, National Population Projections, 2018.

Table 3.2: Enrolment Trend of NHIF Principal Members versus Proportion to Total Population from 2015/2016 to December 2018

Financial years	Total number of Principle members	Total number of Beneficiaries	Percentage to total population
2015/2016	702,598	3,377,023	7
2016/2017	753,832	3,491,400	7
2017/2018	858,446	3,918,899	7
July – Dec. 2018	836,661	3,636,617	7

Source: NHIF fact sheet for the financial year 2017/2018

Further analysis was made to identify number of new principal members enrolled by NHIF per annum in order to assess its enrolment capacity as stipulated in **Table 3**.3.

Table 3.3: Enrolment Trend of New Principal Members from 2015/2016 to December 2018

Years	Number of Members at the End of the Year	New Members Enrolled during the Year	Proportion enrolled (%)
2014/2015	640,341	120,818	NA
2015/2016	702,598	147,345	23.0
2016/2017	753,832	194,074	27.6
2017/2018	858,446	228,269	30.3

NB: In computing the percentage increment for the year, closing figures of the previous year were used as bases.

Source: Membership and Compliance Reports, 2015/16 to December, 2018

Table 3.3 indicates a slight increase in annual enrolment of members from 23 percent in 2015/2016 to 30.3 percent in 2017/2018. Despite of the increase in the enrolment of new members, NHIF has not significantly increased the percentage of enrolled members as compared to the total population for the three years consecutively as it remained at 7 percent as shown in **Table 3.2**.

On the other hand it was noted that, the contributing factors for the inadequate trend for enrolment of principal members were mainly inefficiencies of available strategies to expand the enrolment of voluntary members since public employees are compulsory and their increase depends on new employment. Other factors were insufficient assessment conducted prior establishment of new categories as detailed below:

3.2.2 Insufficient Strategies in Place to Increase Membership Coverage

Interviews with senior NHIF officials at both NHIF Headquarter and visited Regional Offices showed that, there were various strategies in place for ensuring all Tanzanians are covered with Health Insurance. These include:

i. Extension to voluntary members (Directives from MOH);

ii. Introducing various membership categories such as Toto Afya Kadi, Mutual Group, Private Individuals, Students, Cleric, Councillors, etc; and

iii. Advocacy to increase recruitment of new members.

Review of NHIF Strategies and Annual Action Plans for the period under review revealed that, these strategies were included in NHIF plans and budget; and their performances were reported in the Performance and Fact Sheets Reports.

The audit assessed the implementation of established Strategies by NHIF in order to determine its capacity in achieving the set enrolment target and their sustainability, and the following were observations made:

(a) Unsatisfactory Implementation of Extension to Voluntary Members - Directives by the MOH

Interview with the officials from Directorate of Membership Services revealed that, despite of the Fund having strategies in place to go for the formal sector through various categories such Mutual, Students, private, etc; the Ministry of Health also had issued directives to NHIF through the statement made by the Deputy Minister of Health. The directives required the Fund to introduce different membership packages that would be affordable and encourage individual members to join the package.

To ensure that all Tanzanians are covered with health insurance services, the fund was required to extend recruitment of voluntary members rather than depending solely on compulsory members as required by NHIF Act, 1999.

Review of the Implementation Report on the issued directives showed that, the Fund has already prepared the new packages and were approved

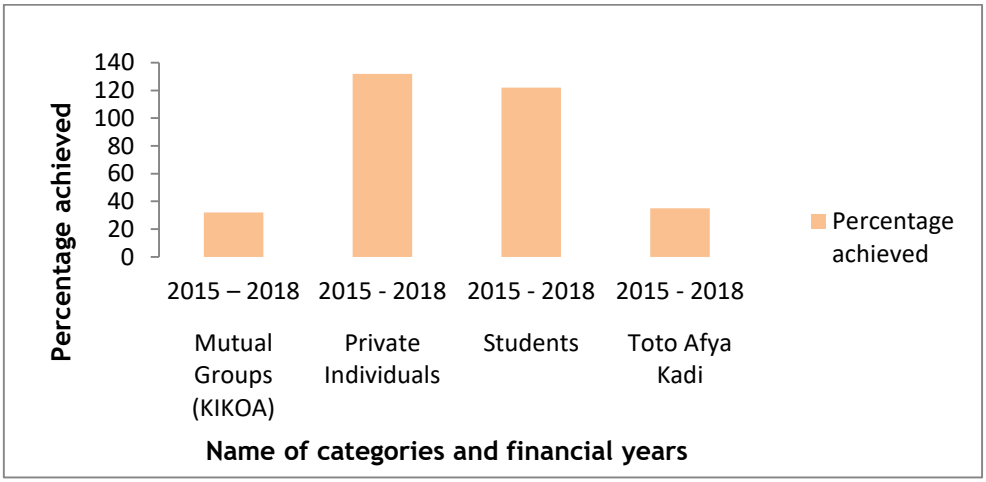
by the Board in October, 2018. It was noted that, at the time of this audit, almost nine (9) months had elapsed since the Fund started to implement the issued directives; however, new packages were not yet operational. It was further noted that the Fund, since October 2018, was waiting for approval of newly proposed voluntary categories from the Ministry of Health prior to its implementation.

Review of the NHIF Fact Sheet, 2017/18 showed that, despite of the requirement to increase enrolment of voluntary members, the Fund has insufficiently increased the enrolment of voluntary members as the percentage remained at 31 of the total recruited NHIF members as shown in **Table 3.1**.

(b) Various Introduced Membership Categories were Underperforming

Review of Compliance and Membership Reports revealed that two out of four introduced Non Public membership categories were underperforming because the set enrolment targets were not achieved as summarized in **Figure 3.1.**

Figure 3.1 Performance of Membership Categories National wide for the Financial Years 2015/2016 to December 2018



Source: NHIF Annual Performance Reports for the financial years 2015/16-Dec.2018

Figure 3.1 indicates that Toto Afya Kadi underperformance by 65 percent, Mutual group was 68 percent, while the Private Individual and Students

Group over performed by 32 and 22 percent. Performance of each category per financial year is as detailed in **Appendix 5.**

Interviews with Senior NHIF Officials revealed that underperformance of established categories were mainly caused by inadequate ability of members in terms of enrolment fees and terms and conditions to join into various categories established. For instance Private Individual's enrolment fee was TZS 1.5 million per annum per private individual, which was found to be very expensive for a normal Tanzanian to afford.

Another category, Mutual Group, requires the members to be in groups, as a result it minimizes the chances of many potential members to be enrolled by NHIF. It was further reported that underperformance was also contributed by inadequate assessment conducted to study the category before introduction of those categories.

The audit performed further analysis to assess performance of various membership categories in the visited Regions with the aim of assessing extent of achievement for set target per category at regional levels. **Table 3.4** illustrates performance of various categories in the visited Regions.

Table 3.4: Overall Performance of Various Categories in the Visited Regions[11] from the financial year 2015/2016 to 2017/2018

Name of Categories	Financial Years	Set Target (No. of members)[12]	Actual Performance (Number of members)[13]	Percentage achieved
Mutual Groups (KIKOA)	2015/2016 – 2017/2018	57,400	7,550	13
Private Individuals	2015/2016 – 2017/2018	151	63	42
Students	2015/2016 – 2017/2018	25,180	30,578	121
Toto Afya Kadi	2015/2016 – 2017/2018	12,986	3,401	26

Source: Compliance and Membership Reports and Auditors' Analysis

[11] Visited Regions were Kilimanjaro, Mtwara, Ruvuma

[12] Set targets represent cumulative target for each category in the visited Regions

[13] Represent cumulative achievement of set target in the visited Regions

Table 3.4 indicates that, for the period under review, the performance of 3[14] out 4 categories was below 50 percent. Total Afya Kadi performance was 26 percent, Mutual Group was 13 percent and Private Individual's was 42 percent. On the other hand, the performance of Students was 121 percent. Performance of each category per financial year is as detailed in **Appendix 6.**

An analysis was conducted to assess whether the set targets were representative of the potential population for the given category. Based on the analysis conducted, it was found that, most of the set targets and performance achieved were unrealistic.

For instance; according to TCU database a total registered university and colleges' students in the country for the year 2015/2016 were 65,064[15] while NHIF set the target of recruiting only 9,759 students in 2016/2017 and the actual recruitment was 10,843 students out of 69,539 registered students for the year 2016/2017.

These set target and achieved performance were unrealistic because they didn't consider factors such as; past year's students' university enrolment as published by Tanzania Commission for University and expected current year enrolment. Another factor was because some of higher learning institutions were not ready to enrol their students to NHIF student category due to already established internal mechanisms to cover health care services to their students.

(c) Conducted Advocacies did not Achieve the Intended Goal of Increasing Recruitment Coverage

Interviews with officials from Directorate of Membership revealed that, NHIF conducted advocacy programmes which were categorized as Advocacy to Stakeholders and Going to Rural. They reported that, advocacy was mainly provided through public meetings and media such as radio, aimed at providing awareness on NHIF operations with the goal of increasing recruitment coverage.

[14] Mutual Groups, Private and Toto Afya Kadi

[15] TCU database of undergraduate students registration status 2015/2016 and 20167/2017

It was further reported that the implementation of both going to rural and stakeholder's advocacies were successfully conducted above 100 percent as indicated in **Appendix 7**.

The performance was due to modality used to set targets whereby the current year target was based on the previous year achievement. For instance, as detailed in the Appendix 7, for instance, at Kilimanjaro NHIF Regional Office, set target for financial year 2016/17 was 48, (the set target of 48 was the performance of financial 2015/16); and for the financial year 2017/2018 the plan was to conduct 66 advocacy meetings which was the performance of 2016/2017.

Despite of achieving set target on stakeholders' advocacy and Going to Rural program, a review of Performance Reports for the period under review showed there were no assessments conducted by NHIF to establish the extent of which the achieved targets have contributed to recruitment of new members.

These reports only indicated number of conducted advocacy against set target, participants covered and medical services provided during advocacies. There was no information on number of enrolled members during the advocacies.

3.2.3 Insufficient Assessment Conducted on Sustainability of Established Health Insurance Categories

Best practice[16] requires NHIF to determine the need for health insurance by examining the targeted population needs that involve looking at the population's epidemiological profile, major barriers to access, unsatisfied demand and major financial sources.

Interviews with senior NHIF officials showed that, out of the Public, Private Employees', members of parliament and councillors categories, there were other seven (5) categories[17] established by the Fund up to December, 2018. They further reported that, assessment to study the sustainability of these categories prior to their establishment was

[16] WB, UNICO Studies Series 25, The Impact of Universal Coverage Schemes in the Developing World, 2013

[17] These categories include Clerics, Mutual (KIKOA), Private Individuals, Students and Toto Afya Kadi

conducted to two categories namely Total Afya Kadi and Student group out of 5 categories[18].

Review of Toto Afya Kadi assessment report of November, 2015, revealed that the assessment detailed the rationale for establishing the category which included willingness and need from the community and the extension of recruitment coverage. The report further analysed the trend of beneficiaries from age 5 to 18, their utilization trend and costs. This is indicated by the NHIF database for the same group for the purpose of projecting their utilization extent.

However, it was revealed that the actual implementation of Toto Afya Kadi included the recruitment of children below 4 years contrary to the targeted age group of 5 to 18 years[19]. On the other hand the assessment conducted for students exclude the age group above 18 years who are the potential members mainly found in the colleges and universities.

Failure to conduct sufficient assessment to the established categories was due to non-inclusion of this activity during preparation of annual action plans and budgets of the Fund. This has partly resulted into failure to meet the set recruitment targets as shown in **Figure 3.1** as well as overutilization[20] of these categories.

For instance, the review of Solvency and Sustainability Report as of June 30th 2018 evidenced overutilization of KIKOA and Clerics members by seven (7) and four (4) percent of the contribution made respectively.

Consequently, inadequate enrolment resulted into increase in cost sharing risks whereby the Fund had to use the available resources of the few enrolled members to reimburse their treatment costs that would result into overutilization of members' contribution.

[18] Mutual (KIKOA), Private Individuals, Students, Toto Afya Kadi and Clerics
[19] Toto afya kadi assessment report 2016
[20] Amount spent is higher than the contributed amount

3.3 Accessibility to Quality Health Care Services through Health Insurance Services Provided by NHIF

A Certified Services Providers are required by NHIF to ensure that the Fund beneficiaries are rendered with quality health care services, Section 20 and 21 of NHIF Act Cap 395.

Interviews with Officials from visited Service Providers showed that the quality of health care services was quite low. This situation was reported to be common among Government health centres and dispensaries.

This was verified through the review of Customer Satisfactory Reports for the period under review, which showed there were complaints regarding quality of services rendered by government dispensaries and health centres. NHIF beneficiaries were complaining about spending much time to receive the required services, failure to get all required diagnostic test based on the level of health facilities and in sufficient capacity of available buildings. These are further detailed in the subsection below:

(a) Long service hours

Physical observation of the NHIF service provision process from registration to dispensing found that patients were spending between 6 and 8 hours to receive services as shown in the **Photo 3.1.**

Photo 3.1: Long queue of Patients' waiting for health service, observed by Auditors at Namtumbo Health centre on 30th January 2019. Picture taken by NAOT auditor

The reviewed Services Providers' Reports, NHIF Performance Reports and Satisfaction Reports for the period under review noted various reasons for the above situation which included:

i. ***Shortage of staff***: at health facilities compared to the requirement. For instance national wide the reported gap of staff in health facilities was reported to be 52 percent.

ii. ***Service Portal System downtime:*** There was frequent downtime of services portal system used for verification of patients' membership prior to treatment.

iii. ***Improper storage of patients' files***: It was observed during visit to sampled services providers that, files were kept in shelf without proper coding while other information were not stored proper files.

iv. ***Inadequate awareness on the use of ICD 10*** *(newly introduced treatment codes)*: This was evidenced in all 12 visited Service Providers where Clinicians complained that they faced challenges in using the new ICD 10. The worse situation was observed at Namtumbo District Hospital where 81 percent of sampled forms had no treatment codes; while at Namtumbo Health Centre 59 percent of sampled forms did not have treatment codes. This was

due to lack of training to most of Doctors/Clinicians. Wrong use of treatment code led to cancellation of the particular folio (file) by NHIF. As a result the total claimed amount submitted would be reduced and the facility would be reimbursed less than what submitted.

b) Insufficient Capacity of available Buildings

Observation made on the available buildings in the visited service providers revealed that the building space was small to accommodate patients as well as required partition for proper provision of services especially for government health centres and dispensaries. For instance, at Namtumbo Health Centre, auditors observed a very small single room that was used as a medical store and medical dispensing room. It was further noted that in this room there was no enough spaces for shelves which could be used for the proper storage of medicines and medical supplies.

c) Failure to get all Required Diagnostic Test Based on the Level of Health Facilities

Based on the observation made to all 16 visited service providers, it was noted that, some diagnostics test were not sufficiently conducted due to failure or absence of medical equipment to facilitate the diagnosis. For instance in 3 out of 4 visited regional hospitals there were challenges in conducting of CT- Scan as the equipment was not available. It was further noted that patient visited these hospitals were issued with a referral to other facilities or had to opt for private hospital with these services.

Similarly, in 2 out of 4 visited dispensaries, MRDT and BP diagnosis test were not performed despite being recommended to their level. Interviewed patients were complaining as they had to travel to other villages to get the service which was an additional cost to them due to transport charges involved.

Apart from the quality of services, the audit assessed the mechanisms in place to facilitate the accessibility of quality health care services among NHIF beneficiaries. These mechanisms were: accreditation and certification of services providers; inspection to service providers; and

provision of loans to service providers. Conducted assessment revealed weaknesses' in all three mechanisms as detailed in subsequent sections:-

3.3.1 Not all Registered Health Services Providers were Certified by NHIF

Section 20(a) and 21(1) of the National Health Insurance Act, of 1999, requires NHIF to accredit service providers based on the sufficiency of the number of allocated human resource; and availability of equipment and physical structure to ensure the quality of provided Services.

Interviews with NHIF officials revealed that the Fund was certifying various service providers upon receipt of their request; by using various criteria as per requirement. This was verified through the review of Certification Reports, which showed that, certification was conducted based on the adherence to the Treatment Guideline, Standards; protocols and SOPs of medical care; and availability of required number of staff and infrastructures to facilitate provision of services.

The review of NHIF Annual Performance Report for the financial year 2017/2018 revealed that not all health service providers who were registered by the MoH were certified by NHIF. **Table 3.5** illustrates the certification status of health service providers up to December 2018 as being conducted by NHIF.

Table 3.5: Certification Status of Service Providers as of December, 2018

S/N	Facility Level	Government	FBO	Private	Total
1	National Referral Hospital	13	5	3	21
2	Zonal Referral Hospital	2	6	5	13
3	Regional Referral Hospital	26	14	14	54
4	District Hospital	92	95	21	208
5	Health Centre	480	164	93	737
6	Dispensary	4,891	399	308	5,598
7	Pharmacy	12	8	378	398
8	ADDO	-	-	207	207

S/N	Facility Level	Government	FBO	Private	Total
9	Specialized Clinics	-	10	98	108
10	Diagnostic Centres	-	1	6	7
Total certified health facilities		**5,516**	**702**	**1,133**	**7,351**
Total registered health facilities		**5,733**	**923**	**1,163**	**7,819**
Total uncertified		**217**	**221**	**30**	**468**

Source: NHIF Annual Performance Report for the financial year 2017/2018

Table 3.5 indicates that 7,351 out of 7,819 service providers in the country were certified by NHIF while 468 service providers were not certified as of December, 2018.

Review of NHIF performance reports and Certification Reports from the financial years 2015/2016 to 2017/2018 indicated that, non-certification of all service providers was caused by non-fulfillment of all required certification criteria. Based on the reviews of Minutes of the Certification Committee from NHIF headquarters, it was noted that, there were common criteria that made most of the services providers fail to qualify for the certification. These common criteria were under-staffing and poor working infrastructures.

Other factor for non-certification of all service providers was insufficient marketing strategy established by NHIF to attract service providers since certification was done only based on the submitted requests from service providers.

On the other hand, based on the review of Inspection Reports, it was noted that, certification to Government Service Providers was mainly performed by considering the factor of increasing the availability of health services close to the community. Other key factors were ignored despite of being reported during inspection; these included understaffing, unavailability of permanent qualified specialist (Oncologist), failure to show medicine stock status, low scored total marks and absence of standard treatment guidelines and SOPs in each department.

As a result some of the accredited Service Providers faced challenges in achieving the objective of providing quality health care services to NHIF beneficiaries as required by the Standard Treatment Guideline (STG). For instance, review of service provider's Inspection Reports showed various

weaknesses during provision of health care services by service providers, which included; poor record keeping especially for patient with multiple investigation, failure to indicate the categories of patient attended in dispensing register and treating patients with no summary of patient's notes. Other noted anomalies were prescribing ciprofloxacin to children under the age 5 and absence of patients' files for Out Patients which could create a risk for corridor prescriptions contrary to STGs requirements.

It was also noted that some of certified service providers failed to comply with NHIF service provision standards; such as proper filling of NHIF forms and proper records keeping of patient information that resulted into poor service delivery and deductions on submitted claims. This situation was observed by the audit team to all 16 visited services providers including Regional and Referral Hospitals, District Hospitals, Health Centres and Dispensaries.

3.3.2 Inspection conducted to Services Providers Recommended Weak actions

The Fund is required to periodically inspect accredited health service providers as a means of monitoring provision of quality health care services through health insurance services (Section 39 (a) of NHIF Regulations, 202).

Interviews with NHIF Quality Assurance Officials showed that the Fund has three types of inspections; Onsite Verification, Supportive Supervision and Fraud Inspections. These inspections were conducted in order to ensure service providers provide quality health care services as per Treatment Guideline Standard and NHIF standards.

Reviews of NHIF Performance Reports from financial years 2015/2016 to 2017/2018 indicated that the Fund has sufficiently inspected health facilities categories[21] as planned. This was because the inspections were successful implemented as detailed in **Table 3.6.**

[21] These categories include; Health Centres, Dispensaries, Pharmacy, ADDO, Specialized Clinics, Diagnostics Centres and Evacuating Facilities

Table 3.6: Status of Inspection to Service Providers for the Period of 2015/2016 – 2017/2018

Financial year	Total planned (number)	Total conducted (number)	Percentage of conducted inspection
2015/2016	6,512	6,822	105
2016/2017	7,505	6,844	92
2017/2018	3,856	6,403	166

Source: NHIF Annual Performance Reports from 2015/2016 – 2017/2018

Table 3.6 indicates good performance on conducted inspection as per set targets. For the financial year 2015/2016 the Fund over performed by 5 percent and for the 2016/2017 has underperformed by only 8 percent of the set target. Reasons for over-performance were due to frequent and ad-hoc fraud investigations and onsite verification caused by increased fraud risks.

However, based on the reviewed 36 sampled inspection reports conducted to service providers, the audit revealed that various anomalies were reported in all sampled inspection reports. However, in most cases, the only actions that were taken to defaulters were to recommend for further improvement, deduction on the submitted claims and, in a few instances, warning letters and blacklisting the service provider. This was regardless of the magnitude and the nature of anomalies observed during inspections.

The audit expected strong actions to be taken to defaulters especially those that were associated with fraud or cheating on the submitted claims to avoid repetition of similar observed anomalies as it was in all 36 inspection reviewed inspection reports.

Interviews with NHIF Quality Assurance Officers also showed that the Fund did not conducted follow-up inspection on the implementation status of the issued recommendations. Review of quality assurance reports 2017/2018, in the visited NHIF Regional Offices also indicated that no follow-up inspections were conducted due to limited resources, especially human resources.

3.3.3 Not all Services Providers Approved for Loan, Received the Requested Loan

NHIF is expected to provide loans to accredited health service providers to ensure availability of required medicines and medical equipment; use the quality of service provided by them as basis for their payment to enhance compliance with required Standards both SOPs and health care standards (NHIF strategic plan(2015-2020).

Interviews with senior NHIF officials revealed that the Fund provided loans to certified health service providers for medicines and medical supplies and for facilities improvement in order to improve the ability of providing quality health service. It was further reported that these loans were provided based on request and repayment capacity of the health facility; and repayments were directly deducted in the approved health facility's monthly claims.

Reviews of NHIF Fact Sheet for the financial year 2017/2018 reported that the Fund had issued a cumulative loan of TZS. 15.3 billion, to 183 out of 330 approved facilities for medical equipment, medicine and medical consumables. For the Facility improvement loan, a cumulative amount of TZS 6.9 billion was issued to 51 out of 140 approved facilities national wide.

Further analysis was conducted to assess extent of loan provision by NHIF to health service providers for the period of three years as indicated in **Table 3.7** to assess capacity of health providers to meet loan requirements.

Table 3.7: Status of loans issued to Service Providers National wide from the financial years 2015/2016 to 2017/2018

Financial Year	Type of loan issued	Targeted Number of service providers	Actual Number of services providers received loans	Percentage achieved	Approved amount (TZS Millions)	Issued amount (TZS Millions)	Percentage achieved
2015/2016	Facility improvement	14	20	143	710.00	1,917.38	270
	Medical equipment	28	25	89	5,757.49	2,261.80	39
2016/2017	Facility improvement	24	10	42	1,542.00	671.72	44
	Medical equipment	52	3	6	3,638.85	6,796.26	187
2017/2018	Facility improvement	13	2	15.4	1,612.61	122.52	8
	Medical equipment	27	2	7.4	5,318.08	265.54	5
Total	**Facility improvement**	**51**	**32**	**62.7**	**3,864.61**	**2,711.62**	**70**
	Medical equipment	**107**	**30**	**28**	**14,714.42**	**9,323.6**	**63**

Source: FMIS/ Performance Reports

Table 3.7 indicates that, for the period under review NHIF had issued facilities improvement loans of TZS 2.7 billion equivalents to 70 percent of approved loan to 32 out of 51 approved facilities. It is further indicates that, loans for medicines and medical equipment amounted TZS 9.3 billion equivalent to 63 percent of approved amount were issued to 30 out of 107 approved services providers.

Based on the reviews of the Loan Files from NHIF headquarters and visited Regions, it was noted that after receipt of loan application from the health facilities, the Fund conducted thorough assessment to establish repayment capacity of each facility subject to claims reimbursement trend. Following such an assessment, most of the health facilities were not able to meet their repayment obligations based on submitted claims for reimbursement. It was noted that, the annual interest rate was ranging from 10 to 13 percent[22] depending on the years of repay of the loan.

[22] Reviewed sampled NHIF contracts with service providers 2018

It was further established that other contributing factors for inadequate provision of loan to services providers was due to the fact that services providers, especially health centers and dispensaries have insufficiently fulfilled the required procurement procedures as one the condition to receive the approved loan. Also, presence of bureaucracy in the procurement procedures especially for government health facilities has contributed to non-issuing of the approved loans to health facilities. This was verified through the review of Accredited Service Providers Satisfaction Reports for the period under review.

Failure to secure the loans affected the capacity of the health facilities especially health centres and dispensaries to make significant improvement on health service provision.

3.4 Availability of Required Resources to Facilitate Provision of Health Insurance Services

This section provides findings related to efforts in mobilizing human resources, funds and working tools for delivery of health insurance services as detailed in the subsection below:

3.4.1 Shortage of Human Resources to Facilitate Provision of Quality Health Services

According to NHIF Strategic plan of 2015-2020, the Fund was expected to enhance human capital, their capabilities and welfare to ensure quality provision of health insurance services to beneficiaries. The Fund also is required to accredit/certify services providers by taking into consideration the availability of human resources (Section 20 and 21 of NHIF Act, of 1999).

Review of staff establishment report dated January, 2019 noted the Fund has insufficient human resources at both Headquarter and at the Regional Offices. The shortage was also noted to accredited services providers as explained in the sub-sections below:

(a) Human Resource Shortage at NHIF

Reviews of NHIF Staffing Level Report and Annual Performance Reports for the period under review revealed that the Fund experienced a staff

shortage of 27.5 percent National wide. The extent of shortage at both Head Office and Regional Offices is as described hereunder:

Insufficient Staff at NHIF Head Office

Review of staffing level report dated January 2019, indicated that there was shortage of staff at NHIF Head Office as detailed in **Table 3.8**.

Table 3.8: NHIF Staffing level Status at Head Office as of December 2018

Name of Department	Required number	Available number	Percentage Gap
Director General Office	70	56	20
Directorate of Membership Services	57	43	25
Directorate of Medical and Technical Services	19	18	10
Directorate of Human Resources and Administration	37	37	0
Directorate of Finance	19	16	16
Directorate of Planning and Investments	16	11	31
Directorate of Information and Communication Technology	24	16	33
Total	**242**	**197**	**19**

Source: NHIF Staff Establishment Document January, 2019**.**

Table 3.8 shows that at Head Office the Fund experienced an overall staff shortage of 19 percent as of December 2018. The most affected Department was the Directorate of Information and Communication Technology and Planning and Investments having a shortage 33 and 31 percent respectively. The shortage also affected the Directorate of Membership Services despite being the key Department in the service delivery to beneficiaries.

Insufficient Staff at NHIF Regional Offices

Further review of NHIF staffing level and performance reports as of December 2018 also showed that there was shortage of staff at the Regional Offices level as illustrated in **Table 3.9**.

Table 3.9: NHIF staffing level status at the Regional Offices Level

Name of Section	Required number	Available number	Percentage Gap(shortage)
Membership and Compliance	107	106	1
Quality Assurance and Claims Processing	211	179	15
Accounts	64	63	2
Administration	114	71	38
Total	496	419	**16**

Source: NHIF staffing level Report dated January, 2019.

As indicated in **Table 3.9**, staff shortage at NHIF Regional offices was 16 percent. The highest staff shortage was experienced in Administration Section by 38 percent, while the rest of sections[23] experienced a lower shortage ranging from 1 to 15 percent.

Staff shortage especially at NHIF Headquarters resulted into increased workload to the available staff as sometimes they had to work extra hours or to be involved in multitask, this situation affected performance of some activities as explained hereunder.

Shortage of staff resulted into:

i. Delays in Processing Submitted Claims in some Regions

Review of NHIF Annual Performance Reports for the financial years 2015/2016 to 2017/2018 showed that there were improvements in meeting the target of claim processing aging period/duration which is supposed to be below 60 days. For the period of the financial years 2015/2016 to 2017/2018 the average aging/duration was 33, 53 and 47 days respectively. However, there were delays in 4 Regions of Mwanza, Lindi, Mtwara and Kagera as their performance exceeded 60 days.

ii. Some of Planned Inspections were not Conducted

NHIF Regulations Require the Fund to inspect accredited services providers frequently. Reviews of Quality Assurance Reports in the visited Regions for the period under review indicated there were Regions which did not achieve the set target of number of inspections expected to be conducted. **Table 3.10** summarized the overall achievement of inspections target in the visited NHIF Regional Offices.

[23] Quality assurance and claims; and Accounts and Administration

Table 3.10: Extent of achievement of Inspection[24] Target in the Visited Regions

Name of the Region	Financial Year	Number of Planned Inspection	Number of Conducted inspection	Percentage achieved
Ruvuma	2015/16	300	296	99
	2016/17	320	362	113
	2017/18	433	377	87
	July2018 –Dec.2018	183	113	62
Mtwara	2015/16	251	198	79
	2016/17	252	230	91
	2017/18	240	180	75
	July2018 –Dec.2018	77	50	65
Kilimanjaro	2015/16	309	283	92
	2016/17	309	157	51
	2017/18	318	353	111
	July2018 –Dec.2018	203	80	39
Total		**3195**	**2679**	**84**

Source: Quality Assurance Reports for the financial years 2015/2016 – 2017/2018

Table 3.10 indicated that the total achievement in service providers' inspection for the period under review in the visited Regions was 84 percent. If the staffing level could have been established as per the required staffing level, the achievement for inspection activities could have been at 100 percent.

(b) Human Resource Shortage at visited health facilities

Interviews with NHIF coordinators and Officers in charge in the visited service providers certified by NHIF stated that the available number of staff was less compared to the required number as per IKAMA. Review of staffing level establishment revealed the stated situation as presented in **Table 3.11.**

[24] inspections include; supportive supervision, pre-accreditation and verification/adhoc inspections

Table 3.11: Staffing Level Status in the Visited Health Service Providers as of December 2018

Region	Name of health facility	Required number	Available number	Percentage gap
Dar es Salaam	Amana RRH	674	392	42
	Mnazi Mmoja DH	278	206	26
	Buguruni HC	142	88	38
	Mongo la Ndege Disp.	36	22	39
Kilimanjaro	Mawenzi RRH	610	471	23
	Kibosho DDH	312	171	45
	Himo HC	35	26	26
	Mandaka Disp.	7	7	0
Mtwara	Ligula RRH	717	256	64
	Mkomaindo DH	582	230	60
	Mkuti Disp.	12	7	5
	Makulani Disp.	14	6	8
Ruvuma	Songea RRH	681	592	13
	Namtumbo DH	155	19	88
	Namtumbo HC	27	55	-104
	Suluti Disp.	7	4	43
Total		**4,289**	**2,552**	**60**

Source: IKAMA of the visited Service Providers as of December, 2018

Table 3.11 shows the visited health facilities experienced staff shortage ranging from 13 to 88 percent. The worse scenario was at Namtumbo District Hospital which has a shortage of 88 percent. However, it was reported that the hospital was new and the buildings were yet to be completed.

It was further reported that the shortage at Mawenzi, Amana and Ligula RRHs stood at 23, 42 and 64 percent respectively. Consequently, the shortage of staff to health facilities affected the quality of service in terms of time spent on beneficiaries and adherence to all required treatment guidelines.

3.4.2 Unsustainability of NHIF Major Sources of Income

Reviews of NHIF Performance Reports, Budget and Solvency and Sustainability Report as of June 2018 revealed that the Fund's major sources of income which include members' contribution and Investments were facing a challenge of being un sustainable as detailed below:

(a) Overutilization of Members' Contribution by Category

NHIF expected that reimbursement of expenses for each membership category would be less than or equal to total contributions per each category. However, Interviews with NHIF Officials from Directorate of Finance showed that there was overutilization by various members' categories. That means total amount utilized by some members' category as treatment costs was much higher than the total contributed amount by the respective category.

Reviews of NHIF Solvency and Sustainability Report as of December, 2018 indicated overutilization (by percentage) was on Mutual members (KIKOA) 710, Clerics 401, Toto Afya kadi 298, Intern Doctors 174, Student 171 and Private Individual 160 percent as presented in **Table 3.12**

Table 3.12: Extent of utilization of various members' categories as of June 2018 (amount in Millions TZS)

Name of category	Actual contribution	Actual utilization	Percentage utilized
Mutual members (KIKOA)	1,921.66	13,649.23	710
Clerics	673.28	2,702.61	401
Toto Afya Kadi	2,769.07	8,246.71	298
Intern Doctors	59.4	103.54	174
Student	5,922.77	10,140.81	171
Private Individual	3,403.63	5,445.03	160

Source: NHIF Solvency and Sustainability Report December, 2018

Overutilization was mainly caused by insufficient assessment made prior to establishment of these categories. It was noted that assessment was only conducted to Total Afya kadi and Student out of these 5 categories.

Other reasons for overutilization showed that, some medical treatment costs were higher; these included treatment of such as Hemodialysis, hospitalized and Caesarean section.

It was further noted that, adverse selection[25] was another factor because principal members for some categories such as Mutual Groups (KIKOA) and Individuals joined the Fund when they were serious sick. It was further

[25] Adverse selection arises when exactly the high-risk individuals, with a relatively high probability of illness choose to buy insurance.

explained that, despite of the criteria set for new members joining the Fund through these categories, still there was overutilization.

As a result the Fund net income has decreased from TZS 87,616.75 million to TZS 32,135.37 million from 2016/2017 to 2017/2018.

(b)Unsustainability of Investment Income

According to NHIF Investment Policy 2017, the Fund is required to ensure any investment made is for the purpose of meeting the obligations for benefit payments and lot of resources were held in short-term investments; that are easily convertible into cash.

Further reviews of Performance Reports showed that the Fund had invested in treasury bills, treasury bonds and corporate bonds, fixed and call deposits, shares, loans and projects. Review of various investment status revealed some investment made were unsustainable.

For instance, the Fund provided eight (8) years loan amounting TZS 24.6 billion from 1st August, 2010 to the Ministry of Home Affairs for purchase of 230 Toyota Pickups and 30 Toyota Station Wagon for use by Police Force.

It was further noted that, investment loans and projects to support Government Health Building was on long- term basis ranging from 5 to 8 years with no Government guarantee/collateral. As a result no return on investment earned by the Fund up to the time of this audit as summarized in **Table 3.13.**

Table 3.13: Status of Direct loan (in million) to the Government as at 30th June, 2018

Loan/project financed	Disbursed amount	Disbursement date	Repayment period	Interest rate (percentage	Amount paid	Outstanding amount (As of June 2018)	Percentage of arrears
Ministry of Home Affairs	24,665.45	1st August 2010	8 years (including 1 year grace period)	13.5	0	45,445.48	184
Benjamin Mkapa Hospital	114,101.22	-	-	-	0	114,101.23	100
Muhimbili Orthopaedic Institute	17,990.06	1st September 2012	10years (including 3 years grace period)	14.5	0	21,912.24	122
National Identification Authority	10,000.00	1st January 2013	7 years (including 2 years grace period)	13.34	0	16,856.144	169
Muhimbili National Hospital	6,886.30	1st September 2016	5 years	10	1,314.13	5,572.17	0
Total	**173,643.03**	-	-	-	**1,314.13**	**203,887.29**	**117**

Source: NHIF Investment Report as of June 2018

Table 3.13 shows that all loans issued to Government health projects were not repaid to the level of 117 percent with huge accrued interest rate of at-least 50 percent of issued amount up to June 2018. The fund also issued a loan amounting to TZS. 114.1 billion to Benjamini Mkapa Hospital without any agreed terms and conditions including absence of interest rate and repayment period since 2012, that resulted into a total loss of return on investment. It was further noted the issued loan to the Benjamini Mkapa Hospital had neither signed contracts nor written statement between those Government Institutions and the Fund to show the detailed terms and conditions between parties involved.

The outstanding amount of TZS 203.8 billion, account for 55 percent of actual members' contribution of TZS. 370.7 billion[26] **of** the Fund for the financial year 2017/2018; If this amount could have been paid it could have a substantial impact to the liquidity and solvency of the Fund in the near future. Consequently, the net income dropped by TZS 55,481.38 billion in 2017/2018 that increased solvency risks of the Fund. Further detailed information's are presented in **Appendix 8.**

3.4.3 Insufficient ICT Systems and Skills

Review of NHIF Performance Reports under the period of review revealed that the Fund established different ICT systems for both internal and for service providers' use. These systems include: Advanced Membership Management Information System (AMMIS), Claim Management Information System (CMIS), Financial Management Information System (FMIS) and Online Member Verification System.

The audit assessed the systems that link NHIF with Service Providers in order to determine their operational efficiencies with regard to service provision to beneficiaries and noted existence of some weaknesses including: frequent system failure; presence of non-networked System; inadequate installation of ICT system to service providers and ICT skills gap by service providers as detailed hereunder:

(a) Frequent System Downtime

Interviews with officials from visited service providers at Regional Referral Hospital, District Hospital and Health Centre level, revealed that the Fund facilitated access to the Service Portal and installed E-claim System. However, it was reported they faced challenges while using the service portal system such as frequent system downtime. They reported the system downtime can sometimes happen twice in a week.

Physical observations on functioning of the service portal revealed that in all 16 visited service providers in Dar es Salaam, Kilimanjaro, Mtwara and Ruvuma, they reported problem of system downtime.

[26] NHIF Performance Report for the financial 2017/2018

(b) Non web based System

Further observations on E-claim system found that the system was not web based that would enable instant sharing of data between NHIF and the service providers. As a result the claims were transferred to a flash disc and submitted to NHIF for processing. This affected the Quality Assurance functions such as tallying of provided services with Standard Treatment Guidelines to manual and labour intensive.

However, it was noted that up to the time of this audit there were 4 facilities connected with web-based e-claim system on pilot basis and are successfully submitting their claims online. These facilities were, TMJ, Temeke, Kinondoni, Benjamin Mkapa and Galapo Hospitals

(c) Inadequate Installation of ICT System to Services Providers

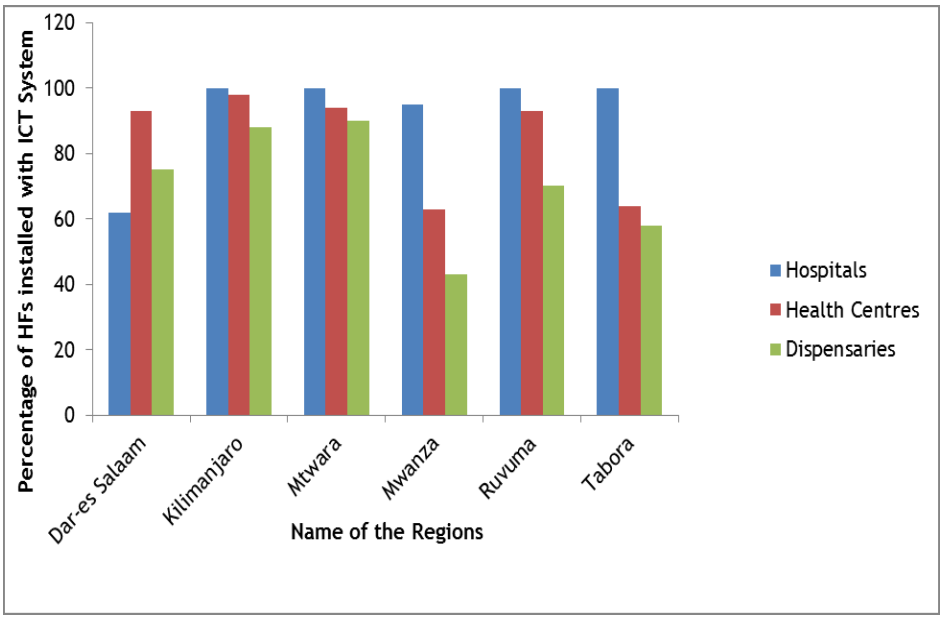
According to NHIF strategic Plan, 2015 -2020, the Fund is expected to prioritize availability of sufficient working tools to facilitate provision of health insurance services.

Interviews with NHIF officials at both headquarters and Regional Offices showed that the Fund installed E-Claim and Service Portal system to service providers in order to enhance control and smooth provision of health insurance services. It was further reported that installation were mainly done in Hospitals and Health Centres.

Reviews of NHIF Performance Report under the period of review showed that installed ICT systems to facilitate quick verification of NHIF beneficiaries prior to treatment as well as claims processing were not sufficient. This was because, not all services providers were installed with NHIF ICT systems as not all certified service providers in the Country were installed with NHIF ICT.

Further reviews of NHIF ICT Reports in the visited Regions exposed that not all certified Hospitals, Health Centres and Dispensaries were installed with Service Portal and E-claim System in especially the dispensaries as detailed in **Figure 3.2.**

Figure 3.2: Instalment Status of ICT System to All Service Providers in the visited Regions as of January, 2019



Source: ICT Reports, 2019

Figure 3.2 indicates that the average instalment of ICT system to hospitals and health centres was 83 percent while to the dispensaries was 69 percent. This implies that, not all services providers in Kilimanjaro, Mtwara, Ruvuma and Dar es Salaam were installed with NHIF ICT Systems. Further detailed information are as presented in **Appendix 9.**

According to NHIF Strategic Plan, the Fund is supposed to use SMS based verification and notification system (SMS Gateway) as an alternative for member's verification to unconnected facilities especially in rural areas.

Physical observation conducted at the visited facilities noted that 100 percent of visited Dispensaries were not utilizing the SMS based system. Because of this, the claims submitted to NHIF from the unconnected dispensaries some folio (file) were considered invalid for payment and eventually deducted from required reimbursement payment. As a result it affected the revenues of the respective dispensary.

This was verified through the review of submitted claims that showed deducted amount from un-connected services providers as their folders were considered to be invalid.

Despite the fact that not all service providers were installed with ICT System, the audit observation showed that even for the remote health centres and dispensaries were not utilizing the SMS based verification and notification system (SMS Gateway) as an alternative for members' verification to unconnected facilities especially in rural areas. Reasons for failure to install ICT Systems to all certified service providers were most of Government facilities lack of ICT tools, lack of reliable power in most facilities located in remote areas and poor ICT knowledge to some officials. As a result it ends up producing invalid claims that finally led into unnecessary deductions by NHIF during claims processing that affected collection of Revenues.

(C) ICT Skills Gap by Service Providers

Accredited service providers are is expected to plan for adequate equipment that will facilitate provision of quality health services to NHIF beneficiaries (NHIF Act of 1999).

However, interviews with officials dealing with installed ICT Systems in the visited service providers showed that there was insufficient understanding of the use of the installed systems. This scenario was further observed in 4 out 16 visited facilities. Consequently, the users were not in a position to utilize the installed systems. This situation ultimately led to long waiting time for patients of almost 8 hours.

Reviews of NHIF Action Plans in the visited Regions showed that the Fund planned training on ICT system to service providers. The planned activities include: training on E-claim and Pharmacy Management System.

3.5 Inadequate Monitoring of National Health Insurance Services

The Ministry of health through Policy and Planning Division is expected to monitor the performance of NHIF in provision of health insurance services. SSRA is also required to monitor and review regularly the performance of social security sector which include health insurance services provided by the NHIF (National Health Policy (2007); Social security Act of 2008, section 5(h).

The audit noted that the Ministry of health has not adequately monitored the performance of NHIF as explained below:

3.5.1 Absence of functioning monitoring framework for monitoring health Insurance services

Ministry of Health is expected to have a functioning monitoring framework to monitor the implementation of Health Sector Strategic Plan which including health insurance issues[27].

Interviews conducted with NHIF focal person at the Ministry of Health reported that the Ministry of Health had no functioning monitoring and evaluation framework for monitoring and evaluating all activities of the Ministry including NHIF issues. It was further added that there was no separate guideline prepared by the MOH to monitor NHIF activities. The reason given for not having monitoring framework was not enough because they reported that the Fund is semi-autonomous; the Director General of the Fund reports directly to the Permanent Secretary of the Ministry of Health.

However further inquiry revealed that, the Ministry of Health used the Health Sector Strategic Plan IV (HSSPIV) for monitoring implementation of NHIF. Based on review of HSSP IV, the audit noted that the document didn't detailed description of required M&E activities since it had to be used as a base for preparation of M&E framework of the Ministry of Health.

This situation was caused by laxity of the M&E Directorate in collaboration with the Directorate of Policy and Planning to initiate the need for preparation of M&E framework for monitoring health sector issues. As a result the Ministry of health has inadequately reported performance of NHIF insurance services.

On the other hand, review of HSSP IV showed that, the Ministry of Health has set M&E indicator relating to assessing the coverage of health insurance to Tanzanians. It was noted that, the Ministry of Health did not go further in evaluating the resources established by the Fund. Similarly

[27] Health Sector Strategic Plan, IV of 2015 – 2020

the Ministry of Health did not set indicator for monitoring accessibility of quality health insurance services to the beneficiaries.

3.5.2 Insufficient execution of monitoring activities

Through M&E department the Ministry of health is expected to monitor the Implementation of Health Sector activities which include health insurance services provided by NHIF (National Health Policy (2007).

Interview with NHIF focal person at the Ministry of Health stated that, the Fund submitted implementation reports on quarterly basis to the Ministry of Health. It was also reported that, the Ministry used the submitted report to prepare the overall Ministry implementation report on quarterly and semi-annual basis which is normally submitted to the Minister of Health for briefing the implementation status of various Ministry activities during key stakeholders meetings.

It was noted that, there was laxity of NHIF in submitting the implementation reports to the Ministry of Health. This is because in most cases the Fund submitted the report to the Ministry of Health upon request on quarterly basis.

Review of the semi-annual and health sector implementation reports for the period under review revealed that, the Ministry of Health assessed the performance of NHIF on members' enrolment status. There was no reporting on other key performance indicators including those related with quality assurance and investment issues which were also crucial for the sustainability of the Fund.

As a result the Ministry lack potential information relating overall performance of the Fund in providing health insurance services in the country.

3.5.3 Inadequate supervision and Regulation of NHIF Performance by SSRA

The Social Security Regulatory Authority is expected to regulate and supervise performance of NHIF as a social security scheme responsible for provision of health insurance services (Section 5(1) (b) of SSRA Act CAP.135).

Interviews with SSRA Officials showed that, the Authority performed onsite supervision as per annual inspection plans and risk-based supervision. The Authority also conducted offsite supervision on quarterly basis based on the quarterly submitted financial returns from NHIF.

Review of Supervision Reports under the period of review, revealed that the Authority has conducted only one (1) out of 3 required supervision as per SSRA Act CAP 135. This situation was partly attributed by inadequate efforts exerted by the Authority in regulating the performance of NHIF. As a result the Authority insufficiently addresses various operational challenges faced by the Fund.

Further review of offsite supervision reports from 2015/2016 to 2017/2018 indicated that the Authority has insufficiently conducted off-site supervision which involve reviews of submitted financial returns from NHIF as detailed in **Table 3.14.**

Table 3.14: Extent of conducted off-site supervision on NHIF activities

Financial year	Required no. of reports	Produced no. of reports	Gap
2015/2016	4	0	100
2016/2017	4	0	100
2017/2018	4	1	75
July 2018 – Dec.2018	4	0	100
Total	**16**	**1**	**99**

Source: Offsite supervision reports from 2015/2016 – 2017/2018

Table 3.14 indicated that the Authority has conducted 1 out of 16, required off-site supervision. This is equivalent to only 1 percent. This implies that, the Authority inadequately execute its regulative functions.

SSRA inadequately received quarterly returns from NHIF

The Authority is expected to receive quarterly returns from NHIF which include components of financial statements with detailed notes and use them to conduct off-site supervision of the Fund.

Interviews with SSRA officials noted the Fund has received the quarterly reports at every end of the quarter and the final returns at the end of each year.

However, review of submitted returns indicated the authority has received 10 out of 16 returns which is equivalent to 63 percent of required returns from NHIF for the period under review as indicated in **Table 3.15**.

Table3.15: Extent of submission of Quarterly NHIF reports/returns

Year	Required number of submission	Number of submission	Percentage submitted
2015	4	0	0
2016	4	4	100
2017	4	4	100
2018	4	2	50
Total	**16**	**10**	**63**

Source: NHIF quarterly returns submitted to SSRA from 2015/2016 – 2017/2018

CHAPTER FOUR

CONCLUSION

4.1 Introduction

This chapter provides conclusions of the findings presented in chapter three. The basis for drawing the conclusion is the overall and specific objectives of the audit as presented in chapter one of this report.

4.2 Overall Conclusion

Despite the fact that the Ministry of Health and the National Health Insurance Fund have jointly undertaken effort to improve provision of National Health Insurance Services, further efforts are still needed to improve the services especially to increase the coverage of the health insurance services to voluntary groups so as to reach many Tanzanians who are out of formal sector. The provision of national health insurance services is not adequately managed to ensure quality health insurance services is accessible to all Tanzanians; for the purpose of increasing the wellbeing and decreasing the burden of diseases to the population to make it contribute effectively to economic development.

Based on the facts presented in the findings chapter, the audit concluded that the Ministry of Health and the National health insurance Fund has inefficiently ensured adequate provision of National Health Insurance services in the country. This is because proportion of population covered with National Health Insurance stood at 7 percent only out of 32 percent of population covered with health insurance services in the country. This is partly because, NHIF has insufficiently established strategies that would enhance increase of coverage and accessibility of health insurance services to many Tanzanians. The enrolment of informal sector that include private individuals, mutual group and Toto Afya Kadi is still low at 0.3, 4 and 7 percent out of total enrolled NHIF contributing members.

Also Toto Afya Kadi and Students members' categories were established after conducting a thorough study, while other categories were established without conducting any study to assess their practicability. As a result, enrolment targets were not reached ending up wasting the Fund financial resources and time. For example the Fund failed to achieve the targets for mutual group (KIKOA) at both national and regions levels. This

is because the Fund has managed to enrol only 33 percent of set target of mutual group members national wide.

4.3 Specific Conclusions

The following are the specific conclusions:

4.3.1 Strategies for ensuring all Tanzanians are Covered by National Health Insurance are not Sufficiently Implemented

The National Health Insurance Fund did not fully perform its duty to ensure that it establish strategies that would ensure all Tanzanians are covered with health insurance services to help them access health care services regardless of their different purchasing power. The strategies available enabled the Fund to increase recruitment on the public sector members group by almost 69 percent out of total contributing members unlike 31 percent for non-public members.

Furthermore, the Fund did not manage to enrol sufficient number of new members per annum as enrolment proportion was below 30 percent per annum. Despite the fact that, the Fund has managed to conduct its planned advocacy including meetings with different employers and going to rural areas programs; there was no significant impact on increased number of new members. The advocacy especially those done in rural areas were mainly focused on health testing and blood donation with little effort to enrol the targeted groups.

Moreover, existence of expensive package such as individual group which cost at least 1.5 million for a contributing member to join the Fund, contributed to non-achievement of recruitment target per annum. On the other hand, members joined through this category are serious sick and require a short-term and huge reimbursement of contributed amount that finally affect the Fund revenues.

4.3.2 Health Insurance Services Provided by NHIF Inadequately Facilitate Accessibility of Quality Health Services to Beneficiaries

The Fund has managed to certify service providers by 94 percent up to December 2018. However, not all certified services providers rendered the

required health services as per the required standard treatment guidelines.

Despite the fact that, the inspections to service providers were successfully conducted including onsite verifications and fraudulent inspections to service providers, the Fund does not sufficiently enforce the recommendations issued to rectify the anomalies. Only exit meetings were conducted to discuss observed anomalies without agreeing on follow-up strategies. This led to repetition of observed anomalies especially those connected with proper filling of NHIF forms, resulting into unnecessary deductions on expected reimbursed amount. For example, at Songea Regional Referral Hospital deductions went up to 32 percent of total claimed amount for the period of January 2018 to December, 2018 due to improper filling of NHIF forms. As a result, the service providers' revenues which could be used for purchasing medical supplies were affected.

On the other hand, the Fund has insufficiently provided loans to service providers. This is because it has managed to provide facility improvement and medical equipment loans by 70 and 63 percent to 62 out of 158 targeted health facilities to be given the loans.

4.3.3 The National Health Insurance Fund has Insufficient Resources to Facilitate Provision of Health Insurances Services in the Country

It is concluded that the Fund had insufficient human resources at both headquarter and Regional Offices. The human resources gap is ranging from 35 to 42 percent at the Head offices and regional level respectively. The Directorates of Membership Services and Medical and Technical Services were also affected. As a result it increased work load in quality assurance, membership and compliance sections especially to the Regional Offices staff while providing required services to beneficiaries and service providers respectively.

The visited health facilities also were not able to provide the needed health services to the beneficiaries on time and of required quality due to staff shortage of at least 37 percent.

The Fund has insufficiently ensured all certified service providers are installed with E-claim system and connected with customers' service portal system. All visited dispensaries were not connected with the service

portal and also not supplied with SMS gateway members' verification system. This implies that the unconnected service providers failed to conduct members' verification prior to service delivery as required.

Furthermore, over utilization of members' contribution for non-public group was at 273 percent on average. As a result the Fund used funds from other sources to reimburse the submitted claims by health facilities based on services delivered to the beneficiaries. This led to decrease of the Fund net income by almost 63 percent from 2016/2017 to 2017/2018.

In total the Fund issued TZS. 203.8 billion to finance government projects including those not related to provision of health services. There was no guarantee issued by the government that provided assurance on repayment of received loans, as a result neither repayment of part of received loans nor repayment of interest were done by the Government institutions received the loans. Up to December, 2018 the amount in arrears was 99 percent out issued loans that risks the liquidity of the fund in the near future.

4.3.4 Inadequate Monitoring of Health Insurance Services by the Ministry of Health

The existing monitoring done by the Ministry of Health did not take onboard broad issues related to the provision of health insurance services undertaken by NHIF due to absence of monitoring frame work. In this regard, the reported issues did not address the key challenges of inadequate coverage of national health insurance services especially for non-compulsory members.

The Ministry of Health lacks broad performance indicators linked to the activities relating to the provision of health insurance services. The only available key performance indicator concentrated on the issues related to coverage of health insurance services while excluding issues related accessibility of quality health care and resources required by NHIF to facilitate implementation of insurance services.

In addition, the Ministry of Health lacks a well-defined effective and functional reporting mechanism with NHIF regarding provision of health insurance services. As a result the NHIF did not officially submitted implementation reports to the Ministry of Health for the period under review.

CHAPTER FIVE

AUDIT RECOMMENDATIONS

5.1 Introduction

The audit findings and conclusion pointed-out weaknesses on the management of provision of national health insurance services.

Areas for further improvement include: increasing coverage, accessibility of quality health insurance services and adequate resources mobilization in order to provide the expected quality of health insurance services to the beneficiaries. Other areas for further improvement are monitoring and evaluation of performance of National Health Insurance Fund in the provision of health insurance services.

The National Audit Office believes the recommendations that have been given in this report need to be fully implemented so as to improve the provision of national health insurance services in the country. The recommendations will also ensure the presence of the 3Es of Economy, Efficiency and Effectiveness in the use of the public resources.

5.2 Specific Recommendations

5.2.1 Recommendation on Improving coverage of National Health insurance Services

The National Health Insurance Fund should:

1. Strengthen mechanism that would facilitate increase of members' coverage of national health insurance to voluntary/informal members;

2. Conduct thorough study prior to establishment of new members' categories to reduce risks of non-performance.

5.2.2 Recommendation on Improving Accessibility of Quality Health Insurance Services

The National Health Insurance Fund should:

1. Establish a mechanisms that would facilitate enforcement of issued recommendation and taking corrective measures on observed anomalies following inspection of service providers;

2. Strengthen advocacy activities to service providers to improve compliance with NHIF requirements and Standard Treatment Guidelines

The Ministry of Health should:

1. Strengthen availability of medical equipment to all level of health facilities to facilitate provision of quality health care services.

5.2.3 Recommendation on Strengthening Availability of Required Resources for Provision of Health Insurance Services

The National Health Insurance Fund should:

1. Establish web based ICT system with service providers that would enable instant sharing of information in order to increase data accuracy, reduce work load and rooms for data manipulation;

2. Make investment and issue loans that would ensure liquidity and sustainability of the Fund income is maintained over time; and

3. Establish strategies that would ensure effective recovery of already issued loans.

The Ministry of Health in Collaboration with PO-RALG should:

1. Facilitate availability of human resource to health facilities to improve availability of quality health care services.

2. Establish standards of operation of ICT system to health facilities to enhance information harmonization and facilitate integration of data between different users.

5.2.4 Recommendations on Strengthening Monitoring and Evaluation Activities

The Ministry of Health should:

1. Ensure monitoring and evaluation frameworks and plans are established and include setting of key performance indicators for measuring the performance of NHIF in the provision of health insurance services.

2. Conduct monitoring and evaluation to NHIF and ensure timely submission of reports for the purpose of establishing performance measurement on health insurance activities executed by the Fund.

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APPENDICES

Appendix 1: Responses from the Audited Entities

This part covers the responses from the two audited entities namely, the Ministry of Health and National Health Insurance Fund. The responses are divided into two i.e. general comments and specific comments in each of the issued audit recommendations. This is detailed in appendices 1(a) and 1(b) below:

Appendix 1(a): Responses from the Ministry of Health

General Comment

The Ministry has observed the findings of the report and shall prepare mitigation measures to ensure that Health insurance scheme in Tanzania is well improved and the beneficiaries are enjoying the services. Also, The Ministry in collaboration with PO RALG will continue to improve the quality of health service by improving the infrastructures of health facilities and the availability and medicine.

Specific Comments

No	Recommendation	Comments of the Ministry	Planned actions	Implementation Timelines
1	Ensure monitoring and evaluation frameworks and plans are established and include setting of key performance indicators for measuring the performance of NHIF in the provision of health insurance services	Agreed	The Ministry will develop the M&E framework to monitor the day to day implementation of NHIF activities	July 2019
2	Conduct monitoring and evaluation to NHIF and ensure timely submission of reports for the purpose of establishing performance measurement on health insurance activities executed by the Fund	Agreed	The Ministry will introduce the subject file to keep records of all periodic reports generated by NHIF for reference.	April 2019
3	Establish standards of operation of ICT system to health facilities to enhance	Agreed	The Ministry will disseminate the Guidelines and standard for	May 2019

No	Recommendation	Comments of the Ministry	Planned actions	Implementation Timelines
	information harmonization and facilitate integration of data between different users		integrated health facility electronic management system	
4	Strengthen availability of medical equipment to all level of health facilities to facilitate provision of quality health care services	Agreed	The Ministry will continue solicit funds for strengthening availability of medical equipment at all level of service provision.	Annually
5	In collaboration with PO-RALG facilitate availability of human resource to health facilities to improve availability of quality health care services	Agreed	The ministry will continue work with PO RALG to facilitate the availability of health human resources during planning period	Annually

Appendix 1(b): Responses from National Health Insurance Fund

General Comment

Areas for further improvement include:

Increasing coverage, accessibility of quality health insurance services and adequate resources mobilization in order to provide the expected quality of health insurance services to the beneficiaries. Other areas for further improvement are monitoring and evaluation of performance of National Health Insurance Fund in the provision of health insurance services.

Responses:
The Fund continue to execute different strategies to ensure increase in membership coverage, accessibility of quality health insurance services and adequate resources mobilization in order to provide the expected quality of health insurance services to the beneficiaries. Among others, the Fund has introduced new health insurance products with different premiums according to ability to pay. In addition, the Fund continues to certify healthcare providers operating in both urban and rural settings to facilitate access to healthcare services. Also, the Fund through provision of soft loans to facilities, beneficiaries are assured of access to quality services. With regard to resources mobilization, the Fund continues to implement the requirement as per staff establishment to achieve optimal use of available resources for economy, efficiency and effectiveness.

Specific Comments

S/No	Recommendation	Comments by NHIF	Planned actions	Implementation Timelines
1	Strengthening mechanism that would facilitate increase of members' coverage to voluntary/informal members.	Agreed	The Fund has designed new health insurance products with different premiums based on ability to pay as strategy to increase enrolment of members in the informal sector. These products are expected to be operational after approval from the Government	April 2019
2	Conduct thorough study prior to	Agreed	The Fund will continue to	Ongoing

S/No	Recommendation	Comments by NHIF	Planned actions	Implementation Timelines
	establishment of new members' categories to reduce risks of non-performance.		conduct actuarial assessment prior establishment of various new products to deter associate risks. In addition, the recently proposed new products have been subjected to actuarial assessment to ensure its sustainability and performance in the market.	
3	Establish mechanisms that would facilitate enforcement of issued recommendations and taking corrective measures on observed anomalies following inspection of service providers.	Agreed	The Fund will continue to strengthen its quality assurance and anti-fraud functions to ensure recommendations put forward during inspections are implemented including establishment of reporting and follow up mechanism on corrective measures on observed anomalies following inspection of service providers. Among others, the Fund is finalizing discussion with other Government machineries to partner in prevention and combatting	Ongoing April 2019

S/No	Recommendation	Comments by NHIF	Planned actions	Implementation Timelines
			fraudulent acts.	
4	Strengthening advocacy activities to service providers to improve compliance with NHIF requirements and Standard Treatment Guidelines	Agreed	The Fund in collaboration with the Ministry Responsible for health matters will continue to provide awareness creation to healthcare provides to comply with set guidelines including Standard Treatment Guidelines and other guidelines issued by the Fund from time to time.	Ongoing
5	Establish web-based ICT system with service providers that would enable instant sharing of information in order to increase data accuracy, reduce work load and rooms for data manipulation.	Agreed	The Fund has put in place a web-based ICT system with service providers that enable instant sharing of information in order to increase data accuracy, reduce workload and rooms for data manipulation. However, the Fund will continue to provide ICT support to healthcare providers whenever need arises. In addition, the Fund is piloting online claims processing system that will enable	Ongoing June 2019

S/No	Recommendation	Comments by NHIF	Planned actions	Implementation Timelines
			claims to be submitted instant and hence reducing claims aging. However, the system works in the facilities that have fully implemented Electronic Hospital Management Information System.	
6	Make investment and issue loans that would ensure liquidity and sustainability of the Fund income is maintained over time	Agreed	The Fund will continue to adhere to investment guideline set by the Government, Bank of Tanzania and SSRA to ensure solvency and sustainability of the Fund	Ongoing
7	Establish strategies that would ensure effective recovery of already issued loans	Agreed	The Fund will continue to establish strategies including making close follow up on loans issued to various institutions so as to recover all issued loans.	Ongoing

Appendix 2: Detailed Main audit questions with sub-questions

This part provides the list of four main audit questions and their respective sub-questions detailed:

Audit Question 1	**To what extent has the National Health Insurance Fund set coverage strategies for provision of health insurance services in the country?**
Sub-Audit Question 1.1	To what extent are Tanzanians covered with health insurance services provided by NHIF?
Sub-Audit Question 1.2	Does NHIF conduct assessment before establishment of new NHIF categories to insure sustainability of the Fund?
Sub-Audit Question 1.3	Are there strategies in place developed by NHIF to ensure all Tanzanian are covered with health insurance services?
Audit Question 2	**Do health insurance services provided by NHIF facilitate accessibility of quality health services to its beneficiaries?**
Sub-Audit Question 2.1	To what extent does NHIF accredit and contract qualified health service providers?
Sub-Audit Question 2.2	Does NHIF inspect accredited health service providers to ensure quality of services provided
Sub-Audit Question 2.3	To what Extent does the Loan provided by NHIF to Service Providers facilitate provision of quality health services?
Sub-Audit Question 2.4	Are accredited health service providers rendering quality services?
Audit Question 3	**Does the National Health Insurance Fund have the required resources to facilitate provision of health insurance services in the country?**
Sub-Audit Question 3.1	Does NHIF have sufficient and skilled human resources to facilitate provision of health insurance services in the country?
Sub-Audit Question 3.2	Does the NHIF sufficiently funds for provision of health insurance services in the country?
Sub-Audit Question 3.3	Does the NHIF establish modernized tools to fasten and facilitate provision of health insurance services to its members?
Audit Question 4	**Do the Ministry of Health and Social Security Regulatory Authority conduct monitoring of Health Insurance Services provided by National Health Insurance Fund?**
Sub-Audit Question 4.1	Does the Ministry of Health and Social Security Regulatory Authority have functioning monitoring framework for monitoring health insurance services provided by NHIF?
Sub-Audit Question 4.2	Does the Ministry of Health and Social Security Regulatory Authority set monitoring indicators, target, goals and modalities on health insurance services provided by NHIF?
Sub-Audit Question 4.3	Does the Ministry of Health and Social Security Regulatory Authority execute its monitoring roles as expected?
Sub-Audit Question 4.4	Are the monitoring reports timely issued and covered relevant performance issues?

Appendix 3: Different Documents reviewed and Reasons for Review

This part provides the list of documents reviewed by the audit team in order to obtain appropriate and sufficient information to enable the audit team to come up with clear findings which are supported by collaborative evidences.

Entity	Name of Document	Reason
Ministry of Health	Strategic Plans,2014 -2018	To examine set strategies at Ministerial level and assess how they include NHIF issues
	Activity Plans from 2014 to December 2018	Assess to what extent the Ministry have include NHIF issues in their plans
	Approved Medium Term Expenditure Framework from 2014 to December 2018	To assess the set budget to facilitate oversight roles on National Health Insurance Issues
	Implementation and Performance Reports from 2015 to December 2018	To examine to what extent the Ministry have implemented NHIF issues
	Monitoring and Evaluation Reports of ASDP, 2011/2012 – 2015/2016	To examine level of monitoring implemented by the Ministry
National Health Insurance Fund	Strategic Plans,2014 -2018	To assess to what extent NHIF have strategies to achieve the target of registering all Tanzanian with National health insurance services as well as achieving Single National Health Insurance
	Registration files and reports from 2014 to December 2018	To assess registered members against population. Requirement and capacity of NHIF to registered new members
	Activity Plans from 2014 to December 2018	Examine overall planning of NHIF activities
	Budget document from 2014 to December 2018	Examine financial capacity for NHIF to register more members and provide quality health care services
	Implementation and Performance Reports from 2015 to December 2018	Assess overall implementation of NHIF activities

Entity	Name of Document	Reason
	Inspection Reports	Access how often inspection is conducted, issues covered during inspection and action taken for observed gaps
PO-RALG	Plans from 2014 to December, 2018	Examine inclusion of NHIF issues in their plans
	Performance reports	Examine level of performance monitoring of Accredited service providers under their mandate
NHIF Zones Offices	Plans from 2014 to December 2018	Assess the to what extent are Zones offices plans for National Health coverage and health care services to be provided through accredited health facilities
	Succession plan and Staff establishment plan	Assess the manpower to facilitate implementation of various NHIF activities
	Performance Reports 2014 to December 2018	Examine level of implementation of NHIF activities at Zone level, challenges in place and quality of services offered.
	Inspection Reports 2014 to December 2018	Access how often inspection is conducted, issues covered during inspection and action taken for observed gaps
Social Security Regulatory Authority	Strategic Plans 2014 to December 2018	Assess to what extent SSRA have included NHIF issues as their part of regulatory activities
	Performance/Implementation reports	Examine to what extent planned NHIF regulatory activities have been implemented
Accredited Health Facilities (Region and District level	Performance reports	Assess level and quality of services offered at visited health facilities
	NHIF members files/records	Assess services offered, claims and received funds as well as received loans from NHIF offices. Assess inspection conducted to them and implementation of issued recommendations after inspection

Appendix 4: Officials interviewed and Reasons for Interviews

This part provides the list of Officials Interviewed by the audit team to get a broader understanding of the audit area and identify existing challenges, root causes and eventually the consequences to those problems and challenges

Entity	Title of official to be interviewed	Reasons for interviewing
Ministry of Health, Community Development, Gender, Elderly and Children	Director of health quality assurance and officials	To assess how they oversee NHIF activities
	Director of policy and planning	To assess if NHIF matters are addressed in ministerial plans and if there is effective monitoring of the schemes. To get challenges hindering implementation of health insurance plans
Social security regulatory authority(SSRA)	Director and responsible officials	To assess how they regulate health insurance schemes in the country.
National health insurance Fund(NHIF)	Executive director	To get challenges facing the fund and their causes.
	Director of planning and investment	To assess available plans and implementation status.
	Officials responsible for implementing NHIF and CHF plans	To assess level of implementation for NHIF and CHF plans as well as challenges hindering implementation
	Director of medicine and technical services	To assess the extent of accrediting and contracting health facilities To assess inspection and quality assurance conducted to health facilities
	Director of membership services	To assess issues pertaining to membership registration and how they undertake advocacy and awareness programs
	Manager responsible for Actuarial, research, and risk assessment unit	To assess possible risks that might hamper sustainability of the fund and levels of risks are mitigated.
	Director of human resource management and	To assess extent of available human resource capabilities and identifying gaps for the effective

Entity	Title of official to be interviewed	Reasons for interviewing
	administration	provision of health insurance services.
NHIF Regional Offices	Regional managers and responsible officials	To assess the level of implementation of NHIF activities at Zone level and reporting mechanism
Selected accredited NHIF hospitals(public and private hospitals in the selected regions and districts	Regional and District/ Township Medical Officers and selected nurses and Doctor NHIF coordinators at Visited District/Township health facilities	To assess implementation of NHIF through health care services provided in their health facilities. To assess challenges related with NHIF To assess the extent of coverage and implementation of other NHIF issues.

Appendix 5: Performance of Membership Categories National wide for the Financial Years 2015/2016 to December 2018

Name of Categories	Financial Years	Set Target per annum (no. of members)	Actual Performance per annum (number of members)	Percentage achieved
Mutual Groups (KIKOA)	2015/2016	146,394	12,760	9
	2016/2017	13,663	27,274	200
	2017/2018	22,377	18,811	84
	July – Dec. 2018			
Private Individuals	2015/2016	712	1,574	201
	2016/2017	1,689	1,234	73
	2017/2018	1,008	1,677	166
	July – Dec. 2018			
Students	2015/2016	53,547	86,240	161
	2016/2017	67,371	101,176	150
	2017/2018	100,652	82,956	82
	July – Dec. 2018			
Toto Afya Kadi	2015/2016	NIL	NIL	-
	2016/2017	59,665	19,499	33
	2017/2018	147,291	54,344	37
	July – Dec. 2018			

Source: NHIF Annual Performance Reports for the financial years 2015/16 – Dec. 2018

Appendix 6: Performance of various categories in the visited Regions from the financial year 2015/2016 to 2017/2018

Name of the Visited Region	Name of Categories	Financial Years	Set Target per annum (no. of members)	Actual Performance per annum (number of members)	Percentage achieved
Kilimanjaro	Mutual Groups (KIKOA)	2015/2016	10,393	473	5
		2016/2017	900	2,637	293
		2017/2018	2,500	3,696	
		July – Dec. 2018			
	Private Individuals	2015/2016	4	11	275
		2016/2017	20	22	110
		2017/2018	20	26	
		July – Dec. 2018			
	Students	2015/2016	3,600	6,662	185
		2016/2017	7,328	8,822	120
		2017/2018	7,180	8,484	
		July – Dec. 2018			
	Toto Afya Kadi	2015/2016	-	-	
		2016/2017	800	1,374	172
		2017/2018	600	299	50
		July – Dec. 2018			
Mtwara	Mutual Groups (KIKOA)	2015/2016	2133	42	1.97
		2016/2017	375	12	3.20
		2017/2018	35,000	110	0.31
		July – Dec. 2018			
	Private Individuals	2015/2016	5	0	0
		2016/2017	39	1	2.56
		2017/2018	12	0	0
		July – Dec. 2018			
	Students	2015/2016	95	368	387
		2016/2017	450	630	140
		2017/2018	500	595	119
		July – Dec. 2018			
	Toto Afya Kadi	2015/2016	0	300	
		2016/2017	1875	812	43.3
		2017/2018	1500	176	11.73
		July – Dec. 2018			

Name of the Visited Region	Name of Categories	Financial Years	Set Target per annum (no. of members)	Actual Performance per annum (number of members)	Percentage achieved
Ruvuma	Mutual Groups (KIKOA)	2015/2016	4,639	361	1
		2016/2017	900	184	20
		2017/2018	600	35	6
		July – Dec. 2018	-	-	-
	Private Individuals	2015/2016	-	-	-
		2016/2017	50	1	2
		2017/2018	1	1	100
		July – Dec. 2018	-	-	-
	Students	2015/2016	516	1,088	211
		2016/2017	1,981	1,391	70
		2017/2018	3,530	2,538	72
		July – Dec. 2018	-	-	-
	Toto Afya Kadi	2015/2016	-	8	-
		2016/2017	2,720	145	5
		2017/2018	4,100	287	7
		July – Dec. 2018	-	-	-

Appendix 7: Extent of Conducted Advocacy at the visited NHIF Regional Offices from 2015/2016 – 2017/2018

Region	Financial year	Number of planned advocacy	Actual Number of conducted advocacy	Percentage of conducted advocacy
Kilimanjaro	2015/2016		48	
	2016/2017	48	66	138
	2017/2018	66	69	105
Mtwara	2015/2016	34	39	114.7
	2016/2017	38	36	94.7
	2017/2018	17	18	105.9
Ruvuma	2015/2016	12	16	133
	2016/2017	16	31	193
	2017/2018	Not set	44	

Source: Compliance and Membership Reports from 2015/2016 to 2017/2018

Appendix 8: Status of Direct loan to the Government as at 30th June, 2018 (amount in TZS million)

SN	Loan/project financed	Disbursed amount	Disbursement date	Repayment period	Interest rate (percentage	Accrued interest	Amount paid	Outstanding amount (As of June 2018)	Percentage of arrears
1.	Ministry of Home Affairs	24,665,455,986.00	1st August 2010	8 years (including 1 year grace period)	13.5	20,780,023,270.77	0	45,445,479,256.77	184
2.	Benjamini W. Mkapa Hospital	114,101,226,613.29				0	0	114,101,226,613.29	100
3.	Muhimbili Orthopaedic Institute	17,990,056,654.52	1st September 2012	10years (including 3 years grace period)	14.5	3,922,185,625.78	0	21,912,242,280.30	122
4.	National Identification Authority	10,000,000,000.00	1st January 2013	7 years (including 2 years grace period)	13.34	6,856,144,924.47	0	16,856,144,924.47	169
5.	Muhimbili National Hospital	6,886,302,369.72	1st September 2016	5 years	10		1,314,130,575.50	5,572,171,794.22	0
	Total					**31,558,353,821.02**	**1,314,130,575.50**	**203,887,264,869.05**	**99.4**

Source: NHIF Investment Report as of June 2018

Appendix 9: Installment Status of ICT System to All Service Providers in the Visited Regionsas of January, 2019

Name of Region	Number of Registered Service Providers			Number of Service Providers installed with ICT System			Percentage connected		
	Hospitals	Health Centres	Dispensaries	Hospitals	Health Centres	Dispensaries	Hospitals	Health Centres	Dispensaries
Dar-es Salaam	45	44	232	28	41	174	62	93	75
Kilimanjaro	16	45	264	16	44	232	100	98	88
Mtwara	6	18	199	6	17	179	100	94	90
Mwanza	20	54	288	19	34	123	95	63	43
Ruvuma	12	28	248	12	26	174	100	93	70
Tabora	10	22	273	10	14	157	100	64	58
Total	109	211	1,504	91	176	1,039	83	83	69

Source: ICT Reports, 2019