THE UNITED REPUBLIC OF TANZANIA
NATIONAL AUDIT OFFICE

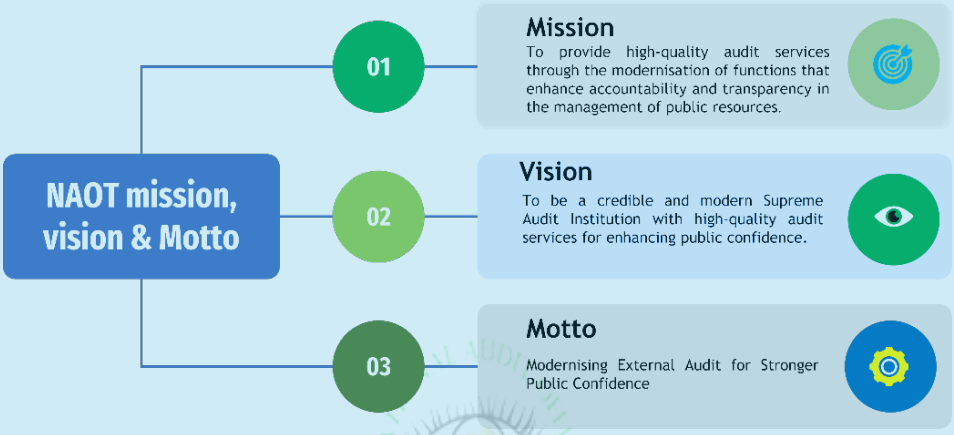
PERFORMANCE AUDIT REPORT ON THE CONTROLS OF PAYMENTS MADE BY NHIF TO ACCREDITED HEALTHCARE FACILITIES

MARCH 2023

CONTROLLER AND AUDITOR GENERAL

About the National Audit Office

The statutory mandate and responsibilities of the Controller and Auditor General are provided for under Article 143 of the Constitution of the United Republic of Tanzania, 1977 and in Section 10 (1) of the Public Audit Act, Cap. 418.



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PREFACE

Section 28 of the Public Audit Act, CAP 418 [R.E. 2021] gives mandate to the Controller and Auditor General to carry out Performance Audit (Value-for-Money Audit) to establish the economy, efficiency and effectiveness of any expenditure or use of resources in the Ministries, Departments and Agencies (MDAs), Local Government Authorities (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 Her Excellency, the President of the United Republic of Tanzania, Hon. Dr. Samia Suluhu Hassan, and through her to the Parliament of the United Republic of Tanzania, the Performance Audit Report on the Controls of Payments Made by NHIF to Accredited Healthcare Facilities.

The report contains findings, conclusions, and recommendations that are directed to the National Health Insurance Fund.

The National Health Insurance Fund had the opportunity to scrutinize the factual contents of the report and comment on it. I wish to acknowledge that discussions with the National Health Insurance Fund have been useful and constructive.

My Office will carry out a follow-up audit at an appropriate time regarding actions taken by the National Health Insurance Fund in implementing the recommendations given in this report.

In completing the audit assignment, I subjected the draft report to a critical review of subject matter experts, namely Dr. Amani Anaeli, Lecturer from Muhimbili University of Health and Allied Sciences and Mr. Kuki Gasper Tarimo, a Health Financing Advisor who came up with useful inputs for the improvement of this report.

The report was prepared by Mr. Bhourat Kombo (Team Leader), Mr. Gerald A. Nduye and Ms. Ndimwaga Shitindi (Team Members) under the supervision and guidance of Ms. Mariam F. Chikwindo (Chief External Auditor), Mr. James G. Pilly (Assistant Auditor General) and Mr. George C. Haule (Deputy Auditor General).

I would like to thank my staff for their commitment in preparing this report. I also acknowledge the audited entities for their cooperation with my Office, which facilitated the timely completion of the audit.

Charles E. Kichere
Controller and Auditor General
United Republic of Tanzania
March, 2023

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LIST OF ABBREVIATIONS AND ACRONYMS

CAG	-	Controller and Auditor General
CEA	-	Chief External Auditor
CMIS	-	Claim Management Information System
e-GA	-	e-Government Authority
eHMIS	-	Electronic Health Management Information Systems
FBOs	-	Faith Based Organisations
FIFO	-	First In First Out
HCF	-	Healthcare Facilities
HDU	-	High Dependency Unit
HSSP	-	Health Sector Strategic Plan
ICT	-	Information Communication Technology
ICU	-	Intensive Care Unit
JKCI	-	Jakaya Kikwete Cardiac Institute
M&E	-	Monitoring and Evaluation
MCT	-	Medical Council of Tanganyika
NAOT	-	National Audit of Tanzania
NHIF	-	National Health Insurance Fund
PA	-	Performance Audit
PCCB	-	Prevention and Combating of Corruption Bureau (PCCB)
PSO	-	Pharmaceutical Services Officer
QSO	-	Quality Assurance Officer
RM	-	Regional Manager
SDGs	-	Sustainable Development Goals
STG	-	Standard Treatment Guideline
TZS	-	Tanzania Shilling
VNR	-	Voluntary National Review

EXECUTIVE SUMMARY

Background of the Audit

The National Health Insurance Fund (NHIF) is a Social Health Insurance Institution established under the National Health Insurance Act, Cap 395 with the main objective of ensuring accessibility of healthcare services to people.

Among other functions, the Fund is responsible for accreditation of healthcare facilities and processing their claims. As of December 2021, the number of accredited healthcare facilities was 8,869. The ownership of the accredited facilities included Faith Based Organizations (9%), Government (71%), and Private (20%)[1]. On the other hand, NHIF's membership coverage stood at 4,734,388, equivalent to 8% of Tanzanian population by December 2021.

As at June 2022, the Fund had 11 benefit packages that were offered to its beneficiaries through accredited healthcare facilities both in Tanzania mainland and Zanzibar. Benefits were offered to beneficiaries as per Standard Treatment Guidelines issued by the Ministry of Health and adhering to the NHIF regulations.

In recent years, NHIF has invested in various interventions to improve its operations including automation of payment systems (e-claim system) and online registration[2].

The main audited entity was the National Health Insurance Fund (NHIF) which is responsible for the provision of health insurance services to facilitate accessibility of quality health services to its beneficiaries. In particular, the Fund is responsible for processing payments of claims from healthcare facilities.

[1] NHIF AFYA NJEMA, March 2022, Edition No. 18

[2] First Quarter Performance Report For the Financial Year 2018-19

The audit aimed at assessing whether the NHIF has set adequate control mechanisms on processing payments of claims from healthcare facilities to ensure that they are authentic, correct and complete. Specifically, the audit focused on the following: processing of claims after the provision of healthcare services to the entitled beneficiaries, control mechanisms at NHIF to ensure authentic claims are approved for payment, remedial actions taken as a result of malpractices conducted by healthcare providers and performance evaluation of NHIF on processing and payment of claims. The study covered a period of three financial years from 2019/20 to 2021/22.

The following is the summary of major audit findings, conclusion and recommendations developed from this performance audit.

Main Audit Findings

a) Existence of Unauthentic Claims and Incorrect Payments

Anti-Fraud Reports for the period from 2019/20 to 2021/22 noted existence of unauthentic and incorrect claims raised from healthcare facilities. Out of a total of TZS 1.71 trillion paid to the healthcare facilities in the last three financial years from 2019/20 to 2021/22, TZS 14.46 billion was paid for unauthentic and incorrect claims. The Audit noted that, for the period under review there was an increase of unauthentic and incorrect claims from TZS 4.32 billion in the financial year 2019/20, TZS 4.55 billion in the financial year 2020/21 and TZS 5.59 billion in the financial year 2021/22.

Existence of unauthentic and incorrect payments of claims were noted at different levels of healthcare facilities. For instance, review of Anti-fraud reports and On-site Verification reports for the period from 2019/20 to 2021/22 showed that Zonal and Regional Referrals, District Hospitals and Specialized Clinics had unauthentic and incorrect payments of more than TZS 2 billion.

Similarly, unauthentic and incorrect payments of claims were noted at various ownership categories of healthcare facilities. The Audit noted that private owned healthcare facilities had high amounts of paid unauthentic claims compared to Government and Faith Based Organizations. This is evidenced by the fact that more than TZS 10.39 billion were paid to the Private healthcare facilities for the period from 2019/20 to 2021/22

compared to TZS 2.49 billion and TZS 1.58 billion paid to the Faith Based Organizations and Government healthcare facilities respectively.

The existence of unauthentic and incorrect claims was noted to be associated with malpractices during identification and registration of patients, consultation services, investigation and diagnostic procedures, dispensing processes and non-adherence to Standard Treatment Guidelines.

b) NHIF Did Not Ensure Healthcare Facilities Adhere to Standard Treatment Guidelines (STG) and Contractual Agreements During the Provision of Services to Entitled Beneficiaries

The Audit noted various efforts which were implemented by NHIF to ensure healthcare facilities adhere to the Standard Treatment Guidelines and Contractual Agreements during the provision of services to entitled beneficiaries. The noted efforts included a review of Quality Assurance and Claims Manuals in the financial year 2020/21. Since June 2021, NHIF took full time medical surveillance in 13 Hospitals. Furthermore, the Fund empowered regional offices to deploy Quality Assurance Officers by adding more Doctors to assist in the medical surveillance.

However, the Audit noted weaknesses which indicated that NHIF did not adequately ensure healthcare facilities adhered to the established Standard Treatment Guidelines and Contractual Agreements during the provision of healthcare services to NHIF beneficiaries as detailed below:

100% of the Visited 131 Healthcare Facilities Did Not Adhere to Standard Treatment Guidelines and Contractual Agreements

The Audit noted that, for the period under review, 100% of 131 visited healthcare facilities in Mwanza, Mbeya and Dodoma regions did not adhere to Standard Treatment Guidelines.

This was caused by inadequate enforcement of contractual agreements and related guidelines issued to the healthcare facilities. For instance, the Audit noted absence of Risk Registers that would have supported conducting of effective verification and supportive supervision as required in section 4.2 of the Quality Assurance Manual, 2021.

Non-adherence to Standard Treatment Guidelines by healthcare facilities may result into financial losses to the Fund. For instance, the Audit noted unrecovered unauthentic claims amounted to TZS 157 million which were identified through onsite verifications conducted during the period under review in Mbeya, Mwanza and Dodoma Regions.

The existence of unauthentic and incorrect claims was noted to be associated with malpractices during identification and registration of patients; consultation services; investigation and diagnostic procedures; dispensing process; and non-adherence to Standard Treatment Guidelines. It was further noted that the main causes were inadequate adherence to standard treatment guidelines and contractual agreement; inadequate existing control mechanisms; failure to adequately take remedial action on unauthentic claims; and inadequate performance evaluation.

Weaknesses on Pricing of the NHIF Packages

Review of the Price Market Research (2021), Standards, and Supplementary Packages showed that, the existing prices were not reviewed for more than six years. That creates variations between the market and actual prices charged by the Fund to healthcare facilities.

It was further noted that, during the year 2021, NHIF conducted market survey which aimed at measuring market prices of the medicines in order to update NHIF prices in line with the prevailing market prices of the selected medicines. However, the survey did not cover other medical services in NHIF benefit packages such as consultation, diagnostics, medical examinations, surgery and other procedures.

The result of the market survey showed that, the 2016 pricelist which was in use was expensive compared to the market prices in the financial year 2018/19. The Audit noted that, the Fund paid TZS 100.79 billion in the financial year 2018/19 instead of TZS 93.9 billion if the prevailing market prices would have been used. This would have cut the cost for those items by TZS 6.84 billion which is equivalent to seven percent.

The Audit noted that, the significant variation between the market price and NHIF pricelist was caused by lack of review of benefit packages in order to reflect current market conditions.

Due to significant variation between the market price and NHIF pricelist of 2016, the Fund lost money, a loss which was caused by overpayments due to using 2016 NHIF pricelist. For the period from 2019/20 to 2021/22, the Fund could have saved TZS 11.06 billion on the paid claims to the healthcare facilities, if market prices were adopted for 20 selected medicines and anticancer medicines.

Healthcare Facilities Did Not Manage and Maintain True and Proper Patients' Records at All Points of Services

For the financial years 2019/20 to 2021/22, the Audit noted inadequate record keeping on provided services at healthcare facilities. This was observed during the fraud investigation which disclosed missing documents, improper handling and record keeping of patient case notes, ghost records for justification of fictitious claims, false stock of medicines and dispensing records. Healthcare facilities with inadequacy of records keeping on provided services ranged from 11% to 28% per annum.

The Audit noted that, the cause for inadequate management and maintenance of proper records was lack of clear contractual consequences on non-compliance with the requirement for keeping medical records by service providers.

Unavailability of records at various points of services led to inconsistency of information between the submitted claims from healthcare facilities and actual services provided, which may create room for payments for services that were not provided.

c) Control Mechanisms at NHIF do not Ensure Claims Processed and Paid to Healthcare Facilities are Authentic and Accurate

In June 2021, NHIF reviewed the benefit package and submitted proposals to the Ministry of Health in its efforts towards ensuring sufficient control mechanisms for processed claims are in place. Furthermore, the Fund in collaboration with law enforcement organs such as Police and PCCB jointly undertook fraud investigations when deemed necessary. In order to address recommendations issued through fraud investigations, NHIF requested professional Boards through letters with Ref. Nos. CAG.143/191/01/259-02 and CAG.143/191/01A/49 to take disciplinary actions to staff who committed malpractices when providing healthcare services to NHIF

beneficiaries. Despite the noted efforts, the following weaknesses were observed during the Audit:

Membership Verification and Authorization at Healthcare Facilities was Not Adequately Conducted

It was noted that, membership verification and authorization at healthcare facilities was inadequately conducted because: most of the features in the NHIF membership cards were insufficient to support identification and verification of beneficiaries during the provision of services; and there were beneficiaries who accessed healthcare services using initials as signatures. Further, the Audit noted that, ineligible patients who were not registered members accessed dialysis services from certified healthcare facilities.

This was caused by the failure of the Claim Management Information System and Health Information Systems used by the facilities to capture important beneficiary's information such as signatures, fingerprints and photos of beneficiaries which may help in the identification of beneficiaries. This shortcoming may provide loopholes to patients or service providers to misuse the cards which could result in NHIF reimbursing money to service providers for services which were not provided to the beneficiaries. This will ultimately lead into financial losses to the Fund.

Unfavourable Claim Processing Aging

Annual Performance Report for the financial year 2021/22 indicated that, the NHIF recorded an average of 62 days claims aging to all 30 regions. Compared to a similar period in the past financial year where the average aging was 57 days. This could be interpreted as an increase of eight percent on the number of days for processing claims. Furthermore, for the sampled regions, claims aging were ranging from 34 days to 73 days, whereas Dodoma and Mwanza recorded claims aging above set targets.

The long claims aging was attributed to a number of factors including: suspension of claims by Quality Assurance Officers in regional offices due to various reasons hence recording high aging in regional offices; claims with fraudulent indicators hence taking longer time to process and verify; and shortage of staff in regional offices while there was an increase in the number of claims including supplementary claims.

Late processing of claims affects the cash flow of healthcare facilities that would have enabled them to run their facilities efficiently and hence deliver quality services to NHIF beneficiaries.

Claim Information Management System Did Not Ensure Claims Processed were Authentic and Correct

The review of Claim Management Information System noted various weaknesses which indicated that the system used did not ensure processed claims were authentic and correct as explained. The system did not assign Quality Assurance Officers the role to establish delays on claims submitted by healthcare facilities, which made Quality Assurance Officers to rely only on notices which were sent by healthcare facilities to NHIF when they failed to submit claim on time. This condition was caused by lack of regular reviews of the Claim Management Information System. As a result, it was difficult for the Quality Assurance Officers to carry out monitoring and enforce compliance to NHIF requirements that require healthcare facilities to submit claims online within 24 hours after the provision of health services to NHIF beneficiaries. It was however noted by the Audit that, the submitted online claims by healthcare facilities did not show results of the medical investigations.

The Audit noted that, claims/folios which were submitted online lacked results of the investigations taken when patients were receiving healthcare services. The submitted claims/folios only attached form 2 (a) and (b) and case notes. This condition led to Quality Assurance Officers adopting a manual mode of operation when processing claims/folios, which resulted into delays in processing claims.

d) Inadequate Remedial Actions Taken by NHIF on Unauthentic Claims Submitted by Healthcare Facilities

The Audit noted various weaknesses regarding remedial actions taken by NHIF on the submitted unauthentic claims by services providers. Despite taking various efforts on recovering unauthentic claims identified through onsite verifications and fraud investigations, the Audit noted that recovery of the unauthentic claims was not adequately done. This is because the Annual Performance Reports, Anti-fraud Reports, Onsite Verification Reports and Loan/Fraud/Verification Recovery Schedule as at December,

2022 noted that fraud cases amounting to TZS 7.72 billion were not recovered.

Furthermore, the Audit noted that, inadequate measures were taken against staff involved in malpractices. It was noted that, 146 staff from both NHIF and healthcare facilities were involved in fraudulent activities. To deal with these staff, Anti-fraud Unit reported 19 NHIF Officials involved in fraudulent activities to the NHIF Disciplinary Committees/Investigation Committee for proceedings. On the other hand, the Unit reported 129 staff from healthcare facilities to the Ministry of Health and their professional boards. Out of the 19 staff from NHIF, it was noted that 12 staff were dismissed from work, two staff were given warning letters, and one staff was temporarily suspended.

However, with regard to the remaining four staff, there was no evidence provided to show the disciplinary measures taken against them. Further, there were no actions taken against the other reported staff from healthcare facilities by their Disciplinary/Investigation Committees, the Ministry of Health and professional boards.

e) Inadequate Performance Evaluation Regarding Processing and Payment of Claims from Healthcare Facilities

In order to guide and enhance monitoring and evaluation of the NHIF activities, during the financial year 2020/21, the Fund planned to develop an M&E framework. The Audit noted that, performance evaluation regarding processing and payment of claims from healthcare facilities were inadequately conducted due to observed anomalies as highlighted below:

Delay in Developing the M&E Framework to Ensure Improvements in Processing Claims for the Period from July 2019 to June 2022

The Audit found that, the Fund did not manage to develop monitoring and evaluation framework for two consecutive financial years (2020/21 and 2021/22) despite the activity being included in the NHIF Annual Action Plans.

The reason for the failure to develop M&E framework was a late issuance of a new project and program guideline by the Ministry of Finance and Planning whose framework finalization was extended to the financial 2022/23. Thus, the postponement of the activity to the next financial year 2022/23 was due to overlapping of activities. This implies that establishment of monitoring and evaluation framework was not given high priority, that is why it has been postponed twice i.e., for the financial years 2020/21 and 2021/22. However, the M&E Framework was finalized in December 2022, which was a delay of more than two years.

Key Performance Indicators for Monitoring Claims Processing Activities were not Adequately Achieved

The Fund set key performance indicators which are used for monitoring the performance of planned activities related to processing of claims. This includes reduction of staff fraud activities, decrease of fraud cases and increasing satisfaction of beneficiaries with NHIF services. However, the Audit noted persistence involvement of staff in fraud cases and fraudulent practices to healthcare facilities.

For instance, the Fund conducted anti - fraud investigations, both preventive and detective, to the healthcare facilities suspected of malpractices and found that a total of 301 facilities defrauded the fund during services provision. Whereas, 117 were found in the financial year 2019/20, 112 were found in the financial year 2020/21 and 72 in the financial year 2021/22.

Audit Conclusion

The Audit recognizes the efforts made by the National Health Insurance Fund (NHIF) towards improving the control of payments made to healthcare facilities for the purpose of ensuring continuity in accessibility of healthcare services to people. These efforts include: verification and authorization of NHIF beneficiaries before they access healthcare services; conducting supportive supervision; onsite claims verifications, clinical audit and advocacy; ensuring healthcare facilities charge agreed price and maintaining true and proper patients' records.

However, more interventions are still needed to further improve the control of payments made by NHIF to accredited healthcare facilities. This is because, based on the findings, the National Health Insurance Fund (NHIF) has not adequately managed the control of payments made to accredited healthcare facilities.

This was evidenced through the payments made for unauthentic and incorrect claims which were raised from all levels of healthcare facilities and ownership categories. The Audit further indicated that, for the period under review, there was an increasing trend of unauthentic and incorrect claims.

All stages of provision of healthcare services were noted to be associated with unauthentic and incorrect claims which include: identification and registration of patients; consultation services; investigation and diagnostic procedures; and dispensing processes.

Generally, the Audit concluded that, inadequate control of payments by NHIF to accredited healthcare facilities is associated with: inadequate adherence to standard treatment guidelines and contractual agreement during the provision of health insurance services to the entitled beneficiaries; failure of existing control mechanisms at NHIF to adequately ensure claims processed and paid were authentic, correct and complete; failure to timely take remedial actions on unauthentic claims in order to reduce financial losses; and inadequate performance evaluation.

Audit Recommendations

Adherence to Standard Treatment Guidelines and Contractual Agreement

In order to ensure healthcare facilities adhere to STG and contractual agreements during the provision of health insurance services to the entitled beneficiaries, NHIF should:

1. Set and implement strong and cost effective controls for beneficiaries verification and authorization at health facilities to ensure genuine NHIF beneficiaries are obtaining health services; and

Control Mechanisms on Claims Processed and Paid

In order to improve the existing control mechanisms on claims processed and paid so as to ensure payments made were authentic and correct, NHIF should:

1. Carry out regular reviews of price schedules for all items to reflect current market situation; and

2. Set control mechanisms which will ensure claims/folios are submitted for processing on real time upon service delivery.

Remedial Actions on Unauthentic Claims in order to Reduce Financial Losses

In order to reduce financial losses based on malpractices conducted by healthcare facilities and staff, NHIF should:

1. Collaborate with the Ministry of health and other key stakeholders (such as Police, PCCB and Professional bodies) to take appropriate actions to staff and healthcare facilities involved in fraudulent activities during provision of health insurance services; and

2. Strengthen recovery mechanisms that will ensure the stated amounts were recovered from the healthcare facilities with malpractices.

Performance Evaluation of NHIF on Processing Payments of Claims

In order to enhance periodic conduct of Performance evaluation on processing payments of claims from healthcare facilities, NHIF should:

1. Ensure upgrade of ICT systems and make sure the systems are used by the healthcare facilities throughout provision of healthcare services; and

2. Collaborate with e-GA to certify ICT systems used by the healthcare facilities.

CHAPTER ONE

INTRODUCTION

1.1 Background

The National Health Insurance Fund (NHIF) is a Social Health Insurance Institution established under the National Health Insurance Act, CAP 395 with the main objective of ensuring accessibility of health care services to people. The Fund considers health insurance as a societal affair rather than an individual need and thus operates under the principles of risk sharing and social solidarity among members[3].

Despite the compulsory enrolment arrangement to public servants, the Fund has expanded its coverage to include other groups like councillors, private companies, education institutions, private individuals, children under the age of 18, farmers in cooperatives as well as organized registered groups like Machinga and Bodaboda groups. The Fund is also administering the Bunge Health Insurance Scheme and covers Members of the Zanzibar House of Representatives[4].

Among other functions, the Fund is responsible for accreditation of healthcare facilities and processing their claims. As at June, 2022 the Fund had 11 benefits package that were being offered to its beneficiaries through accredited healthcare facilities countrywide. Benefits are offered to beneficiaries as per Standard Treatment Guidelines issued by the Ministry of Health alongside the Fund`s regulations. The package includes: - Consultation; Medicines and medical supplies; medical Investigations; Surgical Services; Inpatient Care Services including ICU and HDU; and Physiotherapy and rehabilitation service. It also includes Eye and Optical Services; Spectacles; Dental and Oral health Services; Retirees Health Benefits; and Medical/Orthopaedic Appliances[5].
Further, in recent years the fund has initiated various efforts to improve its operations such as automation of payment systems (e-claim system) and online registration[6].

[3] The Challenges Facing the Operation of the National Health Insurance (NHIF) The Case of Tanzania, 2013

[4] Ibid

[5] Home | National Health Insurance Fund (nhif.or.tz)

[6] First Quarter Performance Report For the Financial Year 2018-19

As of December 2021, number of accredited healthcare facilities was 8,869. The ownership of healthcare facilities includes Faith Based, Government, and Private which represent 9%, 71%, and 20% of all accredited facilities respectively[7]. On the other hand, NHIF's membership coverage stood at 4,734,388, equivalent to 8% of Tanzania population. Further, during financial year 2020/21, a total of TZS 551.51 billion was claimed by healthcare facilities out of which the amount paid was TZS 515 billion. This implied that 6.6% of the claims was rejected[8].

1.2 Motivation for the Audit

The Audit was motivated by indications of performance weaknesses in controls of payments that needed attention in order to improve management of health insurance services. Below are the problem indicators:

a) Significant Rejections of Medical Insurance Claims by NHIF

Through Annual Performance Report and Audited Financial Statement of NHIF for the period 2015/16 to 2017/18 it was noted that, significant amounts were rejected from claims lodged by accredited healthcare facilities in the country. **Table 1.1** shows the extent of claims rejected by NHIF.

Table 1.1: Claims Rejected by NHIF

Financial Year	Amount Claimed (In billion TZS)	Amount Paid (In billion TZS)	Amount Rejected (In billion TZS)	% of Rejected Amount
2015/16	218.6	209.7	8.9	4
2016/17	282.8	263.5	19.3	7
2017/18	414.0	371.0	43.0	10

Source: *Annual Implementation Reports (2015/16-2017/18)*

Further, review of CAG Annual General Report for Public Authorities of March 2022 revealed that, during the financial year 2020/21 Muhimbili National Hospital and Jakaya Kikwete Cardiac Institute (JKCI) lodged claims to NHIF amounting to TZS 55.53 billion. Out of which claims amounting to

[7] NHIF AFYA NJEMA, March 2022, Edition No. 18

[8] Annual Performance Report, 2020/21

TZS 3.87 billion (7%) were rejected by NHIF, while in 2019/20 the rejected amount was TZS 3.13 billion (4%).

The reasons for rejections include: calculation errors, missing details of services claimed to be provided after verification of claims, improper coding of disease, double claiming, proven cases of fraud, no/invalid NHIF approval letter, no/invalid authorization number, no/invalid clinician or patient signature, non-adherence to NHIF pricing, non-adherence to Standard Treatment Guideline (STG), not in NHIF benefit package, over utilization of prescribed item, overprescribing, invalid/no seal of health facility on form 2C/2E and long hospital admission without notification.

b) Deficiencies in Systems and Operational Controls

NHIF AFYA NJEMA, June 2020, Edition No. 14 revealed NHIF targeted to take serious measures to entities and beneficiaries who indulge in forgery so as to access benefits/health services. NHIF targeted to ensure payments to healthcare providers were in line with the health services provided by healthcare facilities. However, it was noted that some healthcare providers charged beneficiaries' extra money for services that were covered by NHIF. On top of that, it was noted that non-members accessed health services to accredited healthcare facilities by using cards of NHIF members.

Further, it was noted that some employers tend to pay for ghost employers who are closely related to employer so as to allow such relatives to access health services. It was further established that some employees tend to forge document related to dependents in order to access services.

Review of the CAG Annual General Report for Public Authorities of March 2020 indicated that a total of 21,042 active NHIF cards received medical services with claims totalling to TZS 1.78 billion but their principal members had not made any contributions. A total of 104,729 over-age dependants (with age above 18 years) received medical services with claims totalling to TZS 15.17 billion. A total of 4,441 revoked memberships also received medical services with claims totalling to TZS 202 million. Further, it was noted that there were 8,672 members registered as retirees who were in reality below the minimum retirement age of 55 years as at the beginning of the financial year 2018/19 with claims totalling to TZS 2.88 billion.

Offering medical services to ineligible members is contrary to the requirements of Compliance Manuals and may result in material financial loss to the Fund leading to its inability to serve its members.

This was attributed by weaknesses on validation process at the health facilities, processes that were specifically designed to ensure inactive cards are identified and members are not provided with service until such time their membership status is in good standing.

c) Priority Area of Sustainable Development Goals (SDGs)

This audit undertaking is directly supporting SGD goal number three of the 17 goals 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.

Specifically, the goal targeted to achieve the following results; reduce the global maternity ratio to less than 70 per 100,000; End preventable deaths of newborns and children under 5 years of age with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live birth; Reduce under 5 mortality to at least as low as 25 per 1,000 live births; End the Epidemics of AIDS, Tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases. The Fund also target to achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.

Therefore, inadequate accreditation and controls of payments to healthcare facilities may result into unsatisfactory provision of health care services which may consequently affect the successful attainment of this goal.

Based on the above problem indicators and challenges, the Controller and Auditor General decided to carry-out a performance audit on the controls of payments made by NHIF to accredited healthcare facilities.

1.3 Design of the Audit

1.3.1 Audit Objective

The main objective of the audit was to assess whether the National Health Insurance Fund (NHIF) has set adequate control mechanisms on processing payments of claims of healthcare facilities to ensure that they are authentic, correct and complete.

Specifically, the audit assessed whether:

1) NHIF ensure healthcare facilities adhered to standard treatment guidelines and contractual agreement during the provision of health insurance services to the entitled beneficiaries;
2) The existing control mechanisms at NHIF ensure claims processed and paid were authentic, correct and complete;
3) Remedial actions were timely taken on unauthentic claims in order to reduce financial losses; and
4) Performance evaluation of NHIF on processing payments on claims from Healthcare Facilities was periodically conducted.

In order to address the audit objective and its specific objectives above, five main audit questions which were supported by sub-questions were developed. **Appendix 2** presents the audit questions and their respective sub-questions.

1.3.2 Scope of the Audit

The main audited entity was the National Health Insurance Fund (NHIF) which is responsible for provision of health insurance services and facilitate accessibility of quality health services to its beneficiaries. In particular, the Fund is responsible for processing payment of claims from healthcare facilities.

Specifically, the audit focused on processing of claims after the provision of health services to the entitled beneficiaries. In this aspect the audit focused on established standards on clinical conditions, diagnostic criteria, non-pharmacological, medicines of choice for the medical condition and important prescribing information. On the other hand the audit covered on adherence of agreed price schedule and maintenance of true and proper

patients' records in all points of service in accordance with the guidelines provided by the Ministry responsible for health.

The audit covered control mechanisms at NHIF to ensure authentic claims are approved for payment. In this aspect, issues such as identification and authorization of beneficiaries, segregation of duties and quality check of claims were assessed.

Further, the audit focused on remedial actions taken due to malpractices conducted by healthcare providers. Whereas, issues such as recovery mechanisms, reconciliation and adjustments of doubtful claims were assessed. Moreover, the audit focused on performance evaluation on processing and payment of claims with a view to assess data sharing, monitoring and evaluation of the claims.

Moreover, the audit focused on performance evaluation of NHIF on processing and payment of claims. In this aspect, key performance indicators were assessed. Also, capturing data at real time during provision of health services was covered.

The audit covered all categories of healthcare facilities namely national, zonal, regional, district, dispensary, health center, accredited pharmacy, and specialized clinic. The audit also covered all stages of provision of healthcare services from registration, consultation, investigation, pharmacy, admission and discharge. Further, the audit covered all categories of claims raised after provision of healthcare services. Moreover, the audit covered both Government, faith based and private healthcare facilities in the selected regions.

The audit covered a period of three financial years 2019/20 to 2021/22. The period has been chosen because it was during this period through which various efforts were implemented by NHIF such as online claim submission, the Fund migration to ERMS system and e-Office.

1.3.3 Audit Criteria

The assessment criteria were drawn from various sources which give NHIF mandate to perform their respective functions. Therefore, the following assessment criteria were used to assess the performance of the NHIF:

(a) Processed Claims are Authentic, Correct and Complete

Section 3 of the Claim Management Manual, 2021 requires the Fund to scrutinise, authenticate and pay claims for services which have been done at healthcare facilities and NHIF offices. Also, clause 11.2 of the Template Contract between NHIF and Service Provider requires the Fund to effect payment of all genuine claims arising from services rendered to members and beneficiaries within 60 days from the date of submission.

(b) Adherence to Standard Treatment Guidelines and Contractual Agreements by Healthcare Facilities

According to Section 2(b) of the Claim Management Manual, 2021 requires certified health service providers to provide quality services to the entitled beneficiaries in accordance with the Standard Treatment Guidelines (STG) and basic standards for health facilities as set by the Ministry responsible for Health matters and Service Agreement.

Section 4.3 of the Quality Assurance Manual, 2021 requires checking whether the treatment given to NHIF beneficiaries adhered to the Standard Treatment Guidelines (STG). Further, Section 16(1) of the National Health Insurance Fund Act, 2015 requires health services benefits granted to a beneficiary shall be the inpatient hospital care fee consisting of a fixed sum determined by board and outpatient care consisting of medicine in generic prescription in accordance with the national essential medicine list unless an explicit exception is granted by the Fund.

Part II of Standard Treatment Guidelines, 2021 requires that, during the provision of health services the practitioners are required to observe clinical conditions, diagnosis criteria, non- pharmacological, medicines of choice (and alternatives) for the medical condition, important prescribing information such as dose, duration, contraindications, side effects, warnings, medicine interactions and the referral criteria.

Moreover, Clause 12.1 of the Template Contract between NHIF and Service Provider requires the Fund to pay the Service Provider for the services rendered in conformity with the acceptable treatment guidelines, terms and conditions of the Agreement and according to the agreed rates/price.

(c) Presence Control Mechanisms to Ensure Claims Processed and Paid to Healthcare Facilities are Authentic and Accurate

According to Section 2.6.2 of the Claims Management Manual 2021 requires service providers to verify membership card presented by a patient prior access to medical service which can be done through online verification system or short message service as directed by the Fund.

Section 3.4.9 of the Claims Management Manual, 2021 requires beneficiaries to physically show their IDs to the providers who will identify and treat the actual beneficiary portrayed on the photograph.

Service Providers have to do the following before submitting claims to the Fund's offices otherwise the claim forms will be rejected forthwith. The key certification practices include:

a) Signatures by the member or beneficiary will have to be put at the completion of obtaining services, and not before;
b) Illiterate beneficiary's thumbprint will be accepted, in case of a child, quadriplegic, mental derangement or, an authentic guardian's signature will be accepted, but it should be clearly spelled out as 'Guardian'; and
c) Initials will not be accepted as signatures.

Further, Section 4.3.3 of the Quality Assurance Manual, 2021 requires claims submitted to be quality checked before making payment. Also, Section 5.7 of the Quality Assurance Manual, 2021 requires the Fund to Station NHIF staff in the selected facilities to carry out medical surveillance and verifying the services offered to NHIF members.

Whereas, Section 2(b) of the Claim Management Manual, 2021 requires the certified health service provider to verify membership status of beneficiary through verification of card and personal presenting to health facility seeking medical services. Section 2.1.2 of the Claim Management Manual, 2021 requires, the Quality Assurance Officers not to verify a claim that they themselves have processed.

Clause 11.46 of the Template Contract between NHIF and Service Provider requires, service provider to submit online claims within twenty-four hours after attending the beneficiary of the Fund.

Moreover, according to the Strategic Plan (2020/21-2024/25), the Fund intends to reduce the average claims aging from 50 days to 30 days by June 2022.

(d) Measures to Improve Payment Process of Benefit Claims

According to Section 4.3.7 of the Quality Assurance Manual, 2021 requires the claims disputes to be subjected to reconciliation processes should not exceed three (3) months from the time when the Fund's decision (for action to be reconciled) was effected. Also, Section 5.7 of the Quality Assurance Manual, 2021 requires the Fund to set measures to address increase in acts of fraud, wastes and misuse of services among unethical service providers and NHIF beneficiaries. Further, Section 4.4.2 of the Quality Assurance Manual, 2021 states that, onsite claim verification acts as one of controls for mitigating submission of fraudulent or unauthentic claims intentions among providers. Similarly, Section 4.4.1 of the Quality Assurance Manual, 2021 requires necessary adjustments should be done and allotted amount shall be either recovered by the Fund or refunded to the healthcare facilities.

Further, Clause 11.14 of the Template Contract between NHIF and Service Provider requires NHIF to notify the service provider in case of delay on claims reimbursement. Clause 23 of the Template Contract between NHIF and Service Provider states that, acts of the fraud stipulated in the contract may result into rejection of claims, termination of contract or lead the Fund to seek legal remedy.

(e) Performance Evaluation on Processing and Payment of Claims from Healthcare Facilities

According to Section 27 of the National Health Insurance Fund Act, CAP 395 [R.E 2015] requires the Fund to enter into contract with healthcare provider to ensure monitoring mechanisms to safeguard against; over-utilization of health care services; under-utilization of healthcare services; unnecessary diagnostic and therapeutic procedures and intervention; irrational medication and prescription and inappropriate referral practices.

Section 14 (a) of the Section 27 of the National Health Insurance Fund Act, CAP 395 [R.E 2015] requires the membership to the fund shall cease where one of the following circumstances occurs: Death, termination of

employment, failure to contribute to the Fund for three consecutive months and any other circumstances which in the opinion of the board shall be considered as factor for cessation of membership.

Clause 11.46 of the Template Contract between NHIF and Service Provider requires, Service Provider to submit a monthly report at the end of the month in not less than seven days of the following month. Further, Clause 12.4 of the same Contract Template requires the service provider to submit dully filled in claim forms 2A or any claim form approved by the Fund within (30) thirty days from the last date of service, with a monthly report (NHIF 6 form) detailing the types of the services rendered including a list of the names of all attended beneficiaries during that period.

Further, Section 3.3.3 of Anti-Fraud Policy, 2018 requires the Fund to develop an ICT system to enable the Management to detect fraud just in time.

1.4 Sampling, Methods for Data Collection and Analysis

Below are the detailed explanations for sampling techniques, methods for data collection and analysis used during the audit:

1.4.1 Sampling Techniques

In assessing the controls of payment of claims, the audit team used both cluster and purposive sampling methods to select Regions and healthcare facilities which were covered during the audit.

The selection process was guided by the following factors:

a) Amount of claims processed and paid;
b) Coverage of all categories of healthcare facilities; and
c) Ownership of healthcare facilities.

a) Amount of Claim Processed and Paid

NHIF Regional Offices were selected based on claims paid which were clustered into three categories based on the amount of claims paid namely; High (3), Medium (2) and Low (1). Low interval ranges from TZS 0 – 49

billion, Medium ranges from TZS 50 to 99 billion and High ranges from TZS 100 to 149 billion as indicated in **Appendix 3A**.

NHIF Regional Offices with highest, medium and lowest claims paid were covered during the audit in order to assess functionality of the established controls on processing and payment of claims raised in the respective regions.

b) Coverage of All Categories of Healthcare Facilities

The audit team selected NHIF Regional Offices with availability of categories of healthcare facilities namely, National, Zonal, Regional, District, Dispensary, Health Center, Pharmacy and Specialized Clinic as indicated in **Appendix 3B**.
In this factor, the selection of NHIF Regional Offices was based on availability of maximum number of categories of healthcare facilities.

c) Ownership of Healthcare Facilities

Further, the audit team considered the ownership of healthcare facilities such as Government owned healthcare facilities, Private owned healthcare facilities and Faith Based owned healthcare facilities in the selection of NHIF regional offices. The audit team selected the offices which covered all type of ownership of healthcare facilities as indicated in **Appendix 3C.**

The selection included Zanzibar due to the fact that, provision of health insurance is a union matter, whereas a region from Zanzibar with highest claims paid was selected.

Table 1.2 presents the selected regions based on consolidated factors namely, amount of claims processed and paid; coverage of all categories of healthcare facilities; and ownership of healthcare facilities.

Table 1.2: Selection of Regions

Region	Claims Ranking	Availability of 8 Categories of HCF	Availability of all Categories of ownership	Total	Selected Region (Highest Amount of Claims)
Ilala	3	8	3	14	Ilala (Dar es Salaam)
Kinondoni	3	8	3	14	
Mwanza	2	7	3	12	Mwanza
Kilimanjaro	1	8	3	12	
Mbeya	1	7	3	11	Mbeya
Arusha	1	7	3	11	
Mtwara	1	7	3	11	
Geita	1	7	3	11	
Temeke	1	7	3	11	
Dodoma	1	6	3	10	Dodoma
Manyara	1	6	3	10	
Tanga	1	6	3	10	
Singida	1	6	3	10	
Tabora	1	6	3	10	
Katavi	1	6	3	10	
Kigoma	1	6	3	10	
Iringa	1	6	3	10	
Ruvuma	1	6	3	10	
Njombe	1	6	3	10	
Songwe	1	6	3	10	
Lindi	1	6	3	10	
Kagera	1	6	3	10	
Mara	1	6	3	10	
Shinyanga	1	6	3	10	
Rukwa	1	6	3	10	
Simiyu	1	6	3	10	
Morogoro	1	6	3	10	
Pwani	1	6	3	10	

Region	Claims Ranking	Availability of 8 Categories of HCF	Availability of all Categories of ownership	Total	Selected Region (Highest Amount of Claims)
Zanzibar (Unguja)	1	8	3	12	Zanzibar (Unguja)
Kaskazini Pemba	1	6	3	10	
Kusini Pemba	1	6	3	10	

Source: *Auditor's analysis from the Claims Processed and Paid, categories of HCF and Ownership of HCF (2022)*

From **Table 1.2,** the selected NHIF Regional Offices included Ilala (Dar es Salaam), Mwanza, Mbeya, Dodoma and Unguja.

1.4.2 Methods for Data Collection

Both qualitative and quantitative data were collected so as to provide a strong and convincing evidence on the controls on payment of claims. The team used two methods to collect data from NHIF and healthcare facilities. These methods include Interviews and documents review as explained below:

a) Documents Review

Various documents regarding processing and payment of claims at NHIF and healthcare facilities were reviewed. Documents related to quality assurance, verification, fraud investigation, payment documents, adjustment and reconciliation, and membership were reviewed with a view of identifying performance problems and respective root causes. The documents reviewed were from NHIF Headquarter, NHIF Regional Offices and healthcare facilities. Moreover, those reviewed documents were the ones generated during the period from 2019/20 to 2021/22. **Appendix 4** shows various documents that were reviewed during the audit.

b) Interviews

Interviews were conducted with officials from NHIF and healthcare facilities for the purposes of obtaining relevant information regarding processing and payment of claims. Moreover, interviews were conducted to verify

information obtained through documents reviews. During interviews different officials from NHIF Headquarter, NHIF Regional Offices and healthcare facilities were interviewed. The main officials that were interviewed include Claim Manager, Quality Assurance Manager, Regional Managers, Anti-fraud Manager, ICT Officers, Medical Officers, Pharmacists, and Laboratory Technicians. These officials were from different levels of management. **Appendix 5** shows list of officials interviewed during the audit.

1.4.3 Data Analysis Methods

Quantitative data collected through interviews and documents review were analyzed using excel spreadsheet.

Quantitative data were analysed by organizing, summarizing and compiling using different statistical methods for data computations. The analysed data were then presented in tables and graphs.

Qualitative data were organized and categorized based on the audit objectives. The analysis included categorization of cases, events, explanations, which were then grouped under the pre-existing themes to form a concrete audit evidence. The existing evidence from the collected data was then used to develop conclusion for this report.

To answer the question of why and how, the collected qualitative data through interviews and documents reviewed were coded in numerical format. This involved entering interview into a spreadsheet format for analysis. Simple pie-charts graphs and tables were used to describe and compare the proportion under each main theme.

1.5 Data Validation Process

The management of National Health Insurance Fund was given the opportunity to go through the draft report and comment on the facts, figures and information presented. This procedure allowed National Health Insurance Fund to confirm on the accuracy of the figures used and information being presented so as to improve on the content of the report and its validity.

The management of the National Health Insurance Fund confirmed on the accuracy of the information presented in this report and their comments and responses are shown in **Appendix 1**.

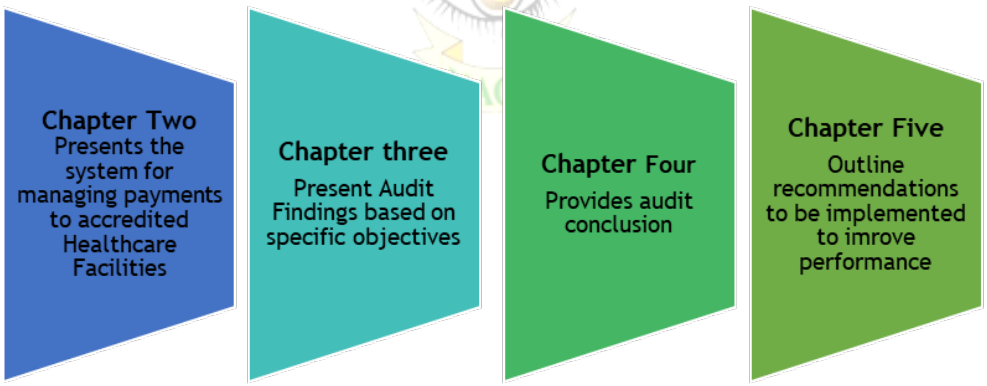
Furthermore, the information was cross-checked and discussed with experts so as to further ensure validation of the information obtained.

1.6 Standards Used for the Audit

The audit was conducted in accordance with the International Standards for Supreme Audit Institutions (ISSAIs) on Performance Auditing issued by the International Organization of Supreme Audit Institutions (INTOSAI). The standards require the Supreme Audit Institution (SAI) to plan and perform the Audit so as to obtain sufficient and appropriate audit evidence as well as provide a reasonable basis for findings and conclusions based on audit objective(s)[9].

1.7 Structure of the Audit Report

The subsequent Chapters of this report cover the following:



[9]The International Standards of Supreme Audit Institutions (ISSAI) are benchmarks for auditing public entities. They are developed by the International Organization of Supreme Audit Institutions (INTOSAI), which is a worldwide affiliation of governmental entities. The INTOSAI's members are the Chief Financial Controllers, Comptrollers, or Auditor General Offices of nations.

CHAPTER TWO

SYSTEM FOR MANAGING PAYMENTS TO ACCREDITED HEALTHCARE FACILITIES

2.1 Introduction

This chapter presents NHIF systems for managing claims made by healthcare facilities. It covers policies and laws governing provision of health insurance in particular claim processing. Further, it covers the functions and obligations of the key players and processes in relation to claim processing.

2.2 Policies, Strategies, Guideline and Governing Laws on the Managing Claims Made by Accredited Healthcare Facilities

There are Policies, Strategies and Governing Laws which govern the systems for managing claims made by accredited healthcare facilities as follows;

2.2.1 Policies

There are four Policy documents that were used to establish the controls in place on the Payments made by NHIF to accredited healthcare facilities as highlighted below;

The National Health Policy, 2007

During 1970s and 1980s economic recession adversely affected the provision of health care services. As a result, the Health Sector experienced inadequate allocation of resources leading to deterioration of health care services. In addressing this shortfall, the Government in its reform process, introduced Cost-Sharing in 1993 and thereafter, other financing options such as Community Health Fund and National Health Insurance were introduced.

Health Policy in Tanzania aimed to improve the health and well-being of all Tanzanians with a focus on those most at risk, and to encourage the health system to be more responsive to the needs of the people. The Policy targeted to facilitate the provision of equitable, quality and affordable basic health services, which are gender sensitive and sustainable, delivered for the purpose of achieving improved health status.

Further, the policy required establishment of a mechanism to ensure medical protection of employees in the formal sector. Both private and public Health Insurance Schemes will continue to be encouraged to develop health Insurance schemes. However, the Government will continue to develop policy guidelines for developing different types of Health Insurance Schemes.

The Anti-Fraud Policy, 2018

The Anti-Fraud Policy intends to guide the Fund to put in place preventive and mitigation measures against all possible fraud in the Fund across all core and supportive business lines.

Therefore, the Policy ensures that the Fund has a zero tolerable level towards fraudulent malpractices; and is taking an aggressive stance against health insurance fraud by undertaking sensitization programs to all stakeholders on the negative impacts of fraud. Also, through this policy the Fund intends to pursue fraudulent cases in the courts of law for all who committed fraudulent practices.

The Whistle Blowing Policy, 2018

The Policy intends to address matters relating to misconduct of employees of the Fund or its related parties. It is designed to enable employees of the Fund and other interested parties to raise their concerns and disclose information which is believed to show prevalence of malpractice.

The National Health Insurance Fund (NHIF) aimed to promote a sound corporate culture of the highest standards of legal and ethical conduct. The policy requires the highest ethical standards to be exhibited in all business processes, management oversight and controls. In addition, the Fund targeted to nurture an environment in which violations, circumventions or bypassing of these standards, are without fear reported for investigation and for corrective action.

The Information and Communication Technology Policy, 2019

This Policy provides the highest level of ICT directives for NHIF. The main purpose of this Policy is to ensure that NHIF's ICT related investment,

operations and maintenance processes and usage are well directed. The specific objectives of this policy are:

a) To ensure ICT governance is an integral part of the institutional governance;
b) ICT service provision are in line with NHIF's business requirements;
c) All the institution information resources and service are well secured using appropriate controls; and
d) To ensure the members of the institution use ICT facilities and services in an appropriate and responsible manner and to ensure that other persons do not misuse those ICT facilities and services.

2.2.2 Governing Laws and Regulations

The National Health Insurance Fund Act, Cap 395 [R.E. 2015]

The Act gives mandate to the National Health Insurance Fund to administering the scheme and formulating and promulgating policies for sound administration of the scheme.

It further, establishes monitoring mechanism where the Fund enters into a contract with each healthcare facilities to safeguard against; over-utilization of health care services; under-utilization of healthcare services; unnecessary diagnostic and therapeutic procedures and intervention; irrational medication and prescription and inappropriate referral practices.

According to the Act, the fund may deny or reduce the payment of claims which are false or incorrect or when the claimant fails without justifiable causes to comply with the rules or regulations pertaining to payment of claims.
In addition, the Act explain that a healthcare has to take part in programs of quality assurance utilization review and technology assessment. This will ensure the quality healthcare services is delivered in accordance with the standards specified by the Ministry from time to time; acquisition and use of scarce and expensive medical technology and equipment are in consonance with actual needs and standards of medical practice; and the performance of medical procedure and administration of medicine are appropriate and consistent with accepted standards of medical practice and ethics.

2.2.3 Strategies

NHIF's Five Years Strategic Plan 2015/16 to 2019/20

The Strategy is an ambitious and broad-ranging plan focusing mainly on the need for the Fund to Abe steered in a direction that will achieve universal coverage in the country. The priority areas are achieving targeted membership base, fraud and cost containment, business automation and quality improvement, risk management and public education.

Table 2.1: Summary of Objectives, Rationale, Strategy and Targets of NHIF's Medium Strategic Plan from 2015/16 to 2019/20

Objective	Rationale	Strategies	Target
To increase membership coverage	The Fund aimed at ensuring that at least half of the Tanzanian population enjoys health insurance services hence getting easy access to health services and to reduce the burden facing the society in financing health services.	• Intensify recruitment of prospective members, organized groups and employers. • Enhance public education awareness of the Fund.	6,814,153 beneficiaries registered by 2020
To improve accessibility and quality of services to beneficiaries and providers by June, 2020	ensure that the Fund has a wide network of certified facilities providing quality services to members and beneficiaries of the Fund	• Undertake strategic accreditation of health facilities • Improve quality assurance functions (reimbursement rate, supportive supervision, health facility surveillance, claims processing audit and pre-accreditation inspection)	• Accredit at least 60% of the available facilities • Number of Inspection to facilities 100%
To increase efficiency of claims	Ensure that health service providers are reimbursed	• Ensure e-claim system is rolled over to all	• Average of 30 days

Objective	Rationale	Strategies	Target
reimbursement from average ageing of 70 days to 30 days by June, 2020	timely for them to run their facilities for and enable them to deliver quality services to NHIF beneficiaries.	facilities with supporting infrastructure • Improve knowledge of system's usage by all users responsible in the claim processes chain and providers; and • Ensure efficient claims processing.	• All facilities submit claims through e-claims • All facilities equivalent to National, Zonal and Regional Referral Hospital paid through e-payment
To re-engineer the Fund's business processes and automation by June, 2020	Ensure that business functions of the Fund are ultimately improved and therefore impacting service provision to members.	• Revamping of the identifications system • Enhance ICT usage in all Funds support operations	• New IDs with improved security features in place • Number of Service Providers linked with NHIF Service Portals

Source: *NHIF's Strategic Plan (2015/16-2019/20)*

NHIF's Medium Term Strategic Plan for the Period from 2020/21 to 2024/25

The Five Years Strategic Plan maps out the strategic direction for enhancing Fund's responsibility of formulating and implementing its objectives. It focuses on the functions of the Fund as the main implementer of health insurance in the country.

Table 2.2: Summary of Objectives, Rationale, Strategy and Targets of NHIF's Medium Strategic Plan from 2020/21 to 2024/25

Objective	Rationale	Strategy	Target
Membership Coverage of the Fund Expanded	The Fund is entrusted to providing the community with access to health services through a social health insurance scheme	Intensifying members recruitment in all sectors	• 9,590,000 beneficiaries registered by 2025 • 80% of members retained annually by June 2025
Access and quality of services provided enhanced	The Fund prioritizes the interests of its beneficiaries who expect to receive quality health services when they visit health facilities and the Fund as well.	• Enhance members access to services • Enhance usage of technology in service provision	• Claims aging reduced to 30 days by June, 2025 • Online claims submission rolled out to all facilities above dispensary level by June, 2025
Revenue collection and Fund's sustainability enhanced	The Fund has to ensure its sustainability so that it continues serving the current beneficiaries and the future generations	Strengthening fraud deterrence measures Enhancing risk management	• Fraudulent practices during utilization of the Fund's services reduced by June, 2025 • Membership verification scaled up to all certified health facilities by June 2025

Source: *NHIF's Strategic Plan of (2020/21-2024/25)*

2.2.4 Standard Treatment Guidelines of 2021

The Standard Treatment Guidelines (STG) provides standardized guidance to health professionals on diagnosis and treatments. STG are systematically developed statements to assist practitioners/prescribers in making decisions about appropriate treatment for specific clinical conditions. The statements contain information on: clinical conditions, diagnosis criteria, non-pharmacological, medicines of choice (and alternatives) for the medical condition, important prescribing information—dose, duration, contraindications, side effects, warnings, medicine interactions and the referral criteria.

2.3 Key Players and their Roles in Managing Claims

2.3.1 The National Health Insurance Fund

The National Health Insurance Fund is an important player in Governments strategies towards the achievement of Universal Health Coverage (UHC). The Fund's main functions derived from its mandate are to;

a) Register members and issue identity cards to beneficiaries;
b) Certify heath service providers and provide a broader network of health facilities;
c) Undertake quality assurance processes;
d) Collect monthly and periodic contributions;
e) Process and reimburse health service providers claims; and
f) Provide health insurance education to the public.

Specifically, in managing service agreement between the Fund and Service Provider, the Fund has to perform the following obligations:

a) Identify all members by giving them NHIF identification cards or temporary identity cards thereby enabling the service provider to provide services to beneficiaries;
b) Effect payment of all genuine claims arising from services rendered to members and beneficiaries within 60 days from the date of submission;
c) Provide operational tools and prescribed forms referred in this agreement which shall be used to fill in data for supporting claim submitted;
d) Conduct inspection, supervision, on verification and fraud investigation with or without prior information and report its findings to the ministry responsible for health and other relevant authorities were deemed necessary;
e) Facilitate installation of Fund's information and communication systems at the facility;
f) Report to relevant authorities in case of misconduct, malpractice of fraud; and
g) Notify the service provider in case of delay on claims reimbursement

2.3.2 Healthcare Facilities

In managing service agreement, the Healthcare Facility as service provider has to perform the following obligations:

a) Provide medical services as per Standard Treatment Guideline and other guidelines and protocols which may be issued by the Ministry from time to time;
b) Make effective use of the Fund's installed information and communication systems in claims processing;
c) Provide service to eligible beneficiaries who have been properly identified by the Fund;
d) Submit claim forms in an orderly manner by arranging and assigning folio numbers serially;
e) Submit to the Fund genuine claims on monthly basis, the claim forms should be submitted within thirty days of the succeeding month;
f) Ensure that beneficiaries sign NHIF claim form 2A&B acknowledging receipt of health care services after receiving the service and not otherwise;
g) Prevent possible commission of fraud and inform the Fund on any matter that require intervention;
h) Manage and maintain true and proper patient's records in all points of service in accordance with the guidelines provided by the Ministry responsible for health;
i) Ensure all claims forms are filled by attending registered medical practitioners and not otherwise;
j) Not to prescribe medicines or services which are not in the current price schedule; and
k) Submit claims electronically and required to de-ploy e-claims system provided by the Fund or through own hospital management information system.

2.2.3 Beneficiaries

Beneficiaries are obliged to;

a) Present Valid Membership Card or NHIF Identification Letter while accessing medical services at a certified health facility;
b) Adhere to service access procedures set by the certified health facility;

c) Sign claim forms (physical and electronic) to certify receipt of claimed medical services;
d) Avoid moral hazard and abuse of medical services; and
e) Report to the Fund any malpractices observed at the Facility.

2.4 Processes for Managing Claims Made by Healthcare Facilities

In managing claims from healthcare facilities there are two stages involved namely; claims management at healthcare facilities; and claim management at the Fund.

2.4.1 Claim Management at Healthcare Facilities

The Fund has predefined procedures that the facility has to follow prior to and during provision of medical services to its beneficiaries. These procedures are:

a) Identification of Members

A healthcare facility has to make sure that, the person accessing medical service through NHIF has a valid NHIF identification card which shows proof of membership and entitlement of benefits under the scheme. The Fund has provided a mechanism, through the use of ICT to verify and authorize valid member. Only claims for valid members shall be reimbursed by the Fund.

b) Provision of Services

Certified service providers are obliged to provide quality medical services as stipulated in the service agreement between the Fund and the certified facility. Moreover, the service provider is required to provide service in accordance with the Standard Treatment Guideline and other guidelines offered by the Ministry of Health. After accessing health services, patients are obliged to sign NHIF Forms (physical or electronic forms) in order to certify that they have received the services filled in the claim form.

c) Compilation and Submission of Claims

After provision of medical services to a valid NHIF beneficiary, the service provider through appointed Claims Officers compile and submit respective claims to the Fund for payment process. Respective claims may be submitted in the following ways:

(i) Submission of Physical Claim Forms

In the course and after provision of services, the officials responsible for identification of beneficiaries at the certified health service providers is required to dully fill in NHIF claims form (2A, & B, 2C, 2E, 6 and 6A); and to make sure that the forms have been signed by the health facility stamp. Only authentic claims should be prepared and submitted to the Fund for payment process. Claims Officers at the certified service provider are required to compile claims on a monthly basis and submit to the Fund. The claims should be submitted to the Fund within 60 days from the date of service provision.

(ii) Online Claim Submission

An electronic claim is a paperless patient claim form generated by computer software that is transmitted electronically over to the Fund for processing and payment of claims. The claims Officer from the certified service provider is required to submit electronically on a daily basis or as per agreement between the Fund and the facility, after completion of patient's management (completion patient visits).

2.4.2 Processing of Claims at the Fund Offices

Processing of claim is a multistage cascaded activities executed in a conveyor belt manner that involves staff of different cadres, departments and locations. This chain of processing was set to ensure that before payment, the submitted claims are checked for authenticity, correctness and completeness to avoid loss of funds by paying unjustified claims. Furthermore, as stipulated in NHIF Act, claims have to be paid within 60 days. First In First Out (FIFO) mode of priority in processing of claims should be enforced. There are eight stages that a claim has to pass through before and after payments, these are:

a) Claims Registration

This is the initial stage whereby claims lodged by claims officer from the certified healthcare service providers are acknowledged by the Fund. Registration of Claims files at the Fund is the role of staff of claims cadre. This stage involves registration of claims details into the physical register and assigning of claims batch number, into the Claims Management Information System (CMIS) before being moved into the next steps.

For online submitted claims, at the end of the month after the claims batch has been closed and moved the online workflow to the normal claims register, the CMIS automates the process of claims receipt and forwarding them to subsequent stage.

b) Data Verification

This is the stage whereby e-claim presented data are uploaded into CMIS, all information in the claim forms for non-medical issues shall be checked and verified. All claims processing procedures and FIFO system shall be adhered to be monitored through CMIS. A data entrant/claim officer is required to process a minimum of 1,500 folios per working day or otherwise as directed by Director responsible for Medical Services.

On the other hand, verification also is done on daily basis through the online submission of claims which the Fund has introduced. Through this system facility submits to the Fund respective claims folio on daily basis through the established communication platform. Where claims data are analyzed and then transferred to the normal claim window for further payment process.

c) Uploading e-claim data and Checking Claims Data

This stage is very crucial, as it finally determine what will ultimately be paid in by the Fund, after processing of the claim. It mainly involves checking of data which have been entered by the data entrant or service provider versus the physical form. Registration of all incoming claims to the claims unit should be supervised by Claims officer.

This stage involves overseeing whether there has been adherence to the set standards in claims processing in the previous stage. The Claims Officer processing the claim ensures that meaningful and comprehensive notes/minutes are written on the salient findings of the particular claim in the system. Claim Officers/Claims Assistant Officers and Data entrants should process a minimum of 1,500 folios per working day.

d) Quality Assurance

This is a core stage whereby major decisions are made on what is to be paid by the Fund for a particular claim. Inserting reasons for deduction or

adjustments and rejections were done by Quality Assurance Staff in the respective folio, as well as the corresponding amount through CMIS.

This stage mainly involves checking whether the treatment given to beneficiaries followed the set guidelines and standards, as well as to ensure that NHIF benefit package has been adhered to and non-adherence lead to rejection/adjustments to the claimed services. Quality Assurance staff processing the claim ensures that meaningful and comprehensive notes or minutes are written on the salient findings of the Particular claim.

e) Claims Verification

This is a process of validating claims with the intention of authenticating where there are anomalies by Quality Assurance and Claims Officer. It is a second eye as a gate-keeper in the quality assurance system before payment of the claims. It aims at confirming whether the submitted claims are genuine for the medical services rendered to NHIF beneficiaries. Claims verification is conducted to all folios in a claim, after quality assurance stage. This is done during claim processing (first and second verification) and after claim has been paid which is referred to as post claim verification.

Claims that have the recommended payable amounts higher than the regional threshold were subjected to further verification at the Funds Head Office.

f) Preparation and Recommendation

1. Preparation

This stage is supervised by claims officer or a responsible officer before payment is made and the following must be taken into consideration;

a) Check authorization status
b) Check claims trend including any indications of fraud
c) Observe non-contributing and unregistered beneficiaries
d) Deducting monthly loan recovery amount, fraud and any other deductions

2. **Recommendation**

This stage is supervised by quality assurance officer or a responsible officer before payment and the following must be taken into consideration;

a) Determining the NHIF actual computation amount
b) Any amount to be paid that exceeds the claimed amount should have a detailed explanation
c) Overall analysis of claims including checking for tendencies of over-utilization of services
d) The officers should write proper minutes to any salient features observed

3. **Payment Approval**

This stage involves overall assessment (scan-checking) of the claim and authentication of the amount to be paid. It also implies that the claim has to be assessed whether all stages were followed as required before recommending/ approving a claim. Levels set have to be adhered to. In addition, any officer acting in a position has to declare the title when recommending or approving a claim that is not in/her level. It should be noted that, the approving authority bears the full accountability for the amount approved. The Director General may from time to time upon recommendations and requirements, review and vary the approval levels as need arises.

4. **Payment Processing (Accounts) and Closing**

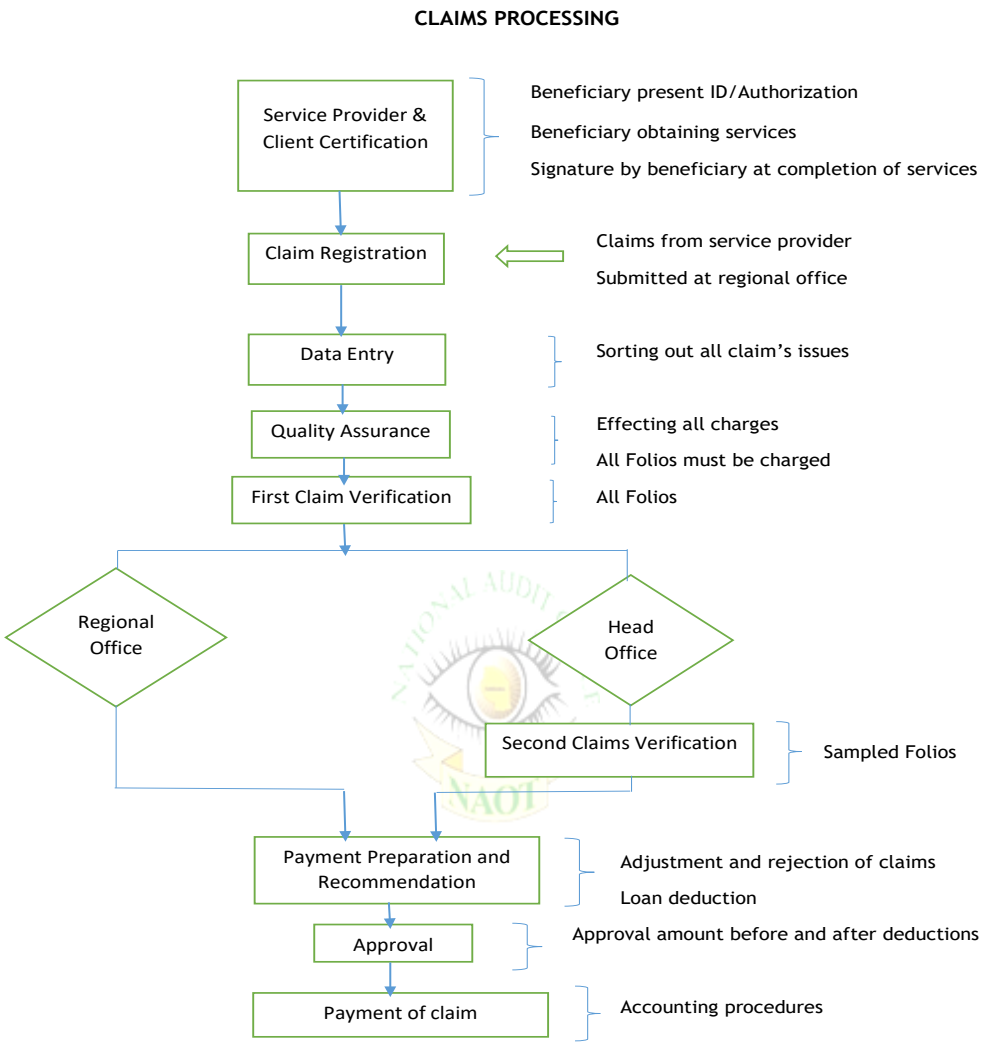
This is a precursor stage before actual cheque is prepared. It also involves authentication of payments. Depending on the amount to be paid and or administrative arrangements, vouchers are prepared in the Account Units. Any prepared voucher has to pass through different levels of recommendation and approved by the authorized officer or Director General before payments are affected. Thereafter, the officer prints and attaches analysis of approved sheet and claims history to the respective claims file.

5. Payment Advice

Payment advisory note shall be prepared during the exit point of a claim. It involves informing the healthcare providers on the essential details of payment via letters or electronic notification.

Figure 2.1 presents claim processing pathway from Facility level up to NHIF level as indicated below.

Figure 2. 1: Claim Processing Pathway



***Source**: Auditors' Analysis on the Claims Processing Pathway (2022)*

Figure 2.1 provides general procedures to be followed during claim processing. At every level, these claim processing procedures explain what is supposed to be done as per laws, regulations, service agreement, and quality assurance manual.

2.5 Levels of Healthcare Facilities

The audit covered all eight level of Healthcare Facilities as registered by the Ministry of Health and Public Health Accreditation Board. These levels include: National Hospital, Zonal Hospital, Regional Hospital, District Hospital, Health Center, Dispensary, Specialized Clinics (Polyclinic) and Pharmacy.

2.6 Resources Employed during Payment of Claims Management to Accredited Healthcare Facilities

In order to ensure implementation of the above highlighted activities, NHIF uses both human and financial resources to execute the planned activities.

Financial Resources

NHIF makes valid payments to healthcare facilities based on the health services provided to beneficiaries who contributed to the Fund. The Contribution collected from beneficiaries and benefits paid to healthcare facilities for the past 3 years were summarized as shown below;

Table 2.3: Contribution Collected and Benefits Paid between 2019/20 to 2021/22 (Amount in Billion TZS)

Financial Year	Contributions Collection		Benefits Payments	
	Budgeted	Actual	Budgeted	Actual
2019/20	476	467	457	499
2020/21	528	489	521	540
2021/22	559	552	540	674
Total	**1,563**	**1,508**	**1,518**	**1,713**

Source: *Annual Implementation Report (2019/20-2021/22)*

NHIF paid benefits expenses to beneficiaries based on the contributions received. **Table 2.3** shows that, benefit paid exceeded the contributions income in all three financial years. The benefits expenses exceeded contribution income by TZS 32 billion, TZS 51 billion and TZS 122 billion in financial year 2019/20, 2020/21 and 2021/22 respectively.

Human Resource

For the Period ending on June 2022, the Fund had 692 staff out of which 180 staff were stationed at Head Office and 512 in regional offices as shown in **Table 2.4** below.

Table 2.4: Staff allocated at NHIF Head Quarter and Regional Offices

Office	Financial Year	No. of Required Human Resources	No. of Available Human Resources	% of Deficit
NHIF HQ	2019/20	180	181	-
	2020/21	180	179	0.5
	2021/22	180	180	0
NHIF Regional Offices	2019/20	510	485	4.9
	2020/21	520	519	0.2
	2021/22	522	512	1.9

Source: *Human Resource Status for the period (2019/20-2021/22)*

CHAPTER THREE

AUDIT FINDINGS

3.1 Introduction

This chapter presents audit findings regarding performance of National Health Insurance Fund on controls of payments made to accredit Healthcare Facilities.

The findings covered aspects such as: overall picture of claims processing; the extent NHIF ensured healthcare facilities adhere to Standard Treatment Guideline (STG) and contractual agreements during the provision of health services to the NHIF beneficiaries; effectiveness of existing control mechanisms at NHIF and healthcare facilities; remedial actions taken on unauthentic claims; and performance evaluation of NHIF on processing payments on claims from Healthcare Facilities.

3.2 Existence of Unauthentic Claims and Incorrect Payments

Section 3 of the Claim Management Manual, 2021 requires the Fund to scrutinise, authenticate and pay claims for services which have been done at healthcare facilities and NHIF offices. Also, clause 11.2 of the Template Contract between NHIF and Service Provider requires the Fund to effect payment of all genuine claims arising from services rendered to members and beneficiaries within 60 days from the date of submission.

Review of Anti-Fraud Reports for the period covered from 2019/20 to 2021/22 noted existence of unauthentic and incorrect claims raised from healthcare facilities.

Review of NHIF Financial Statements for the period from 2019/20 to 2020/21 showed that, a total of TZS 1.71 trillion was paid to the Healthcare Facilities in the last three financial years from 2019/20 to 2021/22. Whereas, review of Anti-Fraud Reports covered from 2019/20 to 2021/22 noted that TZS 14.46 billion out of TZS 1.71 trillion was due to unauthentic and incorrect claims. However, it was noted that NHIF established recovery mechanism in place to ensure recovery of TZS 14.46 billion.

Table 3.1 provides analysis on the amount that were reimbursed to Healthcare Facilities and amount that was due to unauthentic and incorrect.

Table 3.1: Unauthentic and Incorrect Payments made to HCF from 2019/20 to 2021/22

Financial Year	Total Amount Paid to Healthcare Facilities (In Million TZS)	Unauthentic and Incorrect Payments made (In Million TZS)	Percentage (%)
2019/20	499,414.32	4,319.10	0.86
2020/21	540,550.50	4,551.26	0.84
2021/22	674,254.93	5,594.56	0.83

***Source**: Auditors' Analysis from Audited Financial Statements and Anti-Fraud Reports for the Period (2019/20-2021/22)*

Analysis from **Table 3.1** above shows that, during the period under review there was a gradual increase of unauthentic and incorrect claims from TZS 4.32 billion in 2019/20 to TZS 5.59 billion in 2021/22. However, on percentage basis, there was a decrease from 0.86% in 2019/20 to 0.83% in 2021/22.

The existence of unauthentic and incorrect payments made to healthcare facilities was caused by submission of physical claims which delayed up to 60 days from the date of provision of services, this attracts additional and substitution of investigation or medicines provided. Also, it was caused by inadequate installation of online claims submission system (which allow submission of claims within 24 hours). Audit noted that online claim system was installed in only 153 out of 8,073 healthcare facilities, which is less than three percent of total healthcare facilities contracted by NHIF.

Payment of unauthentic claims was noted at all levels of healthcare facilities and ownership categories as further described below:

3.2.1 Noted Unauthentic and Incorrect Payments of Claims at Different Levels of Healthcare Facilities

Review of Anti-fraud Reports for the period from 2019/20 to 2021/22 showed that Specialized Clinics, Regional, District and Zonal hospitals were noted to have unauthentic and incorrect payments of more than TZS 2 billion. The noted unauthentic and incorrect payments at specialized Clinic, Regional hospital, Zonal hospital and District hospital were TZS 3.52 billion, TZS 3.18 billion, TZS 2.95 billion and TZS 2.74 billion respectively.

Table 3.2 shows the extent of unauthentic and incorrect payments made to all levels of healthcare facilities.

Table 3.2: Unauthentic Claims and Paid to all levels of Healthcare Facilities (Amount in Million TZS)

Financial Year	National	Zonal	Regional	District	Dispensary	Health Center	Pharmacy	Specialized Clinic (Polyclinic)
2019/20	0	192	2,188	381	61	360	62	1,072
2020/21	0	789	162	2,030	25	295	188	1,060
2021/22	339	1,969	831	334	18	123	593	1,384
Total	**339**	**2,951**	**3182**	**2,746**	**105**	**778**	**844**	**3,516**

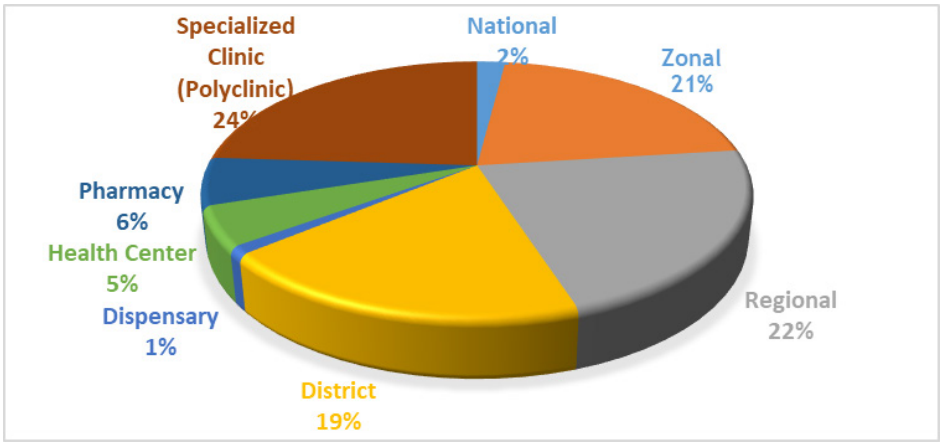
Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

Analysis from **Table 3.2** showed that unauthentic claims were observed in all levels of healthcare facilities for the period from financial year 2019/20 to 2021/22. Also, it was noted that for the period from financial year 2019/20 to 2021/22 Specialized clinics were paid high amounts of unauthentic claims followed by Regional, Zonal and District hospitals.

Table 3.2 further shows increase of unauthentic claims in Zonal Hospitals, Pharmacy and National hospital; and fluctuating trends in Regional hospitals, District hospitals and Specialized clinic. For the case of Dispensaries and Healthcare centres it was noted that unauthentic payments were decreasing.

Figure 3.1 provides an analysis on the percentage of total unauthentic claims paid in healthcare facilities for the period from 2019/20 to 2021/22.

Figure 3.1: Percentage of Total Unauthentic Claims Paid to all levels of Healthcare Facilities



Source: *Anti-Fraud Reports and Post Verification Reports from (2019/20-2021/22)*

Analysis from **Figure 3.1** showed Specialized Clinics are submitting high amount in unauthentic claims to NHIF followed by Zonal Hospitals and Regional Hospitals. It was noted that Specialized Clinics have high amounts of unauthentic claims because the amount of claims submitted and paid were normally higher compared to other levels which attracted the need for onsite verification regularly.

Audit further noted that, the reason for decrease of unauthentic claims at Dispensaries and Healthcare centres was due to decrease in number of such facilities that committed malpractices from 2019/20 to 2021/22.

3.2.2 Noted Unauthentic and Incorrect Payment of Claims at Various Ownership Categories of Healthcare Facilities

Further analysis was done to establish payments of unauthentic claims at different categories of ownership i.e. Government, private and Faith Based Organizations (FBOs) healthcare facilities. Audit noted that private owned healthcare facilities had high amounts of paid unauthentic claims compared to government and FBOs. More than TZS 10.38 billion were paid to Private Healthcare Facilities for the period from 2019/20 to 2021/22. Amount of unauthentic claims paid to Faith Based Organization and Government healthcare facilities was TZS 2.49 billion and TZS 1.57 billion respectively as shown in **Table 3.3.**

Table 3. 3: Unauthentic Payments to Government, Private and FBOs Healthcare Facilities

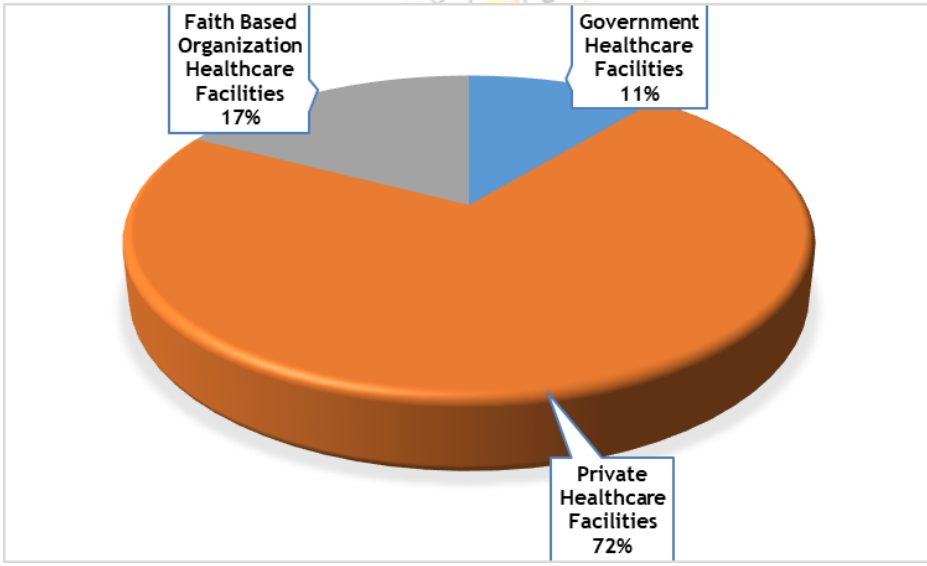
Financial Year	Government (Million TZS)	Private (Million TZS)	FBO (In Million TZS)
2019/20	475.51	2,497.34	1,346.29
2020/21	188.83	4,024.95	337.62
2021/22	912.78	3,866.98	814.44
Total	**1,577.12**	**10,389.27**	**2,498.35**

Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

Table 3.3 shows that NHIF processed and paid higher unauthentic claims to private healthcare facilities compared to Faith Based healthcare facilities and Government healthcare facilities.

Additionally, the cumulative percentage of unauthentic and incorrect payments that were paid to the Private, Government and Faith Based Organization healthcare facilities were 72%, 17% and 11% respectively as shown in **Figure 3.2.**

Figure 3.2: Unauthentic Payments Based on the Ownership Category of Healthcare Facilities



Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

Figure 3.2 shows that, private healthcare facilities contributed the highest percent of loss to the Fund because they claimed and were paid 72% of

unauthentic and incorrect amount compared to Faith Based Organization healthcare facilities and government healthcare facilities.

The existence of unauthentic and incorrect claims was noted to be associated with malpractices during identification and registration of patients; consultation services; investigation and diagnostic procedures; dispensing process; and non-adherence to Standard Treatment Guidelines.

For instance, the audit team noted that, out of TZS 14.46 billion of unauthentic and incorrect claims paid, TZS 2.38 billion equivalent to 16% originated from weakness during identification and verification of beneficiaries; TZS 877 million equivalent to six percent was caused by weaknesses from consultation services; TZS 6.78 billion equivalent to 47% was caused by weaknesses from investigation and diagnostic procedures; TZS 2.36 billion equivalent to 16% was noted during dispensing of medicines; and TZS 2.04 billion equivalent to 15% from non-adherence to Standard Treatment Guideline by healthcare facilities.

Table 3.4 shows the extent and percentage of malpractices conducted by healthcare facilities contracted by NHIF to provide healthcare services to its beneficiaries.

Table 3. 4: Extent of Malpractices Conducted by Healthcare Facilities and Related Amount of Fund (2019/20 -2021/22)

Category of Malpractices	Amount (In Million TZS)	Percentage (%)
Identification and Verification of the Registered Patients	2,383	16
Consultation Services	877	6
Investigation and Diagnostic Procedures	6,786	47
Dispensing of Medicines	2,369	16
Adherence to Standard Treatment Guideline (STG)	2,047	15
Total	**14,465**	**100**

Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

Analysis from **Table 3.4** shows that, the high level of malpractices was attributed to investigation and diagnostic procedures, identification and verification of the registered patients and dispensing of medicines. Such malpractices were highly caused by addition of un-provided medicines or tests and substitution of medicines and tests that were claimed by staff from unfaithful healthcare facilities.

Below are detailed explanations on unauthentic payment made due to malpractices that were based on identification and registration of Patients; Consultation Services; Investigation and Diagnostic Procedures; Dispensing Process; and Non adherence to Standard Treatment Guidelines and Contractual Agreements.

(a) Unauthentic Claims Paid due to Inadequate Verification of NHIF Beneficiaries' during the Registration for Health Services

Despite the fact that, NHIF used biometric verification for members who accessed health service for dialysis beneficiaries before accessing services; the audit noted misuse of NHIF Cards as non-beneficiaries were using NHIF cards to access health services.

The misuse of the NHIF cards were noted to be attributed to collusion between unfaithful attendants at the various healthcare facilities and NHIF beneficiaries, and inadequate mechanisms to identify true NHIF beneficiaries' prior to accessing health services.

Weaknesses on adequate identification and verification of genuine beneficiaries during registration contributed to payment of unauthentic claims to healthcare facilities amounting to TZS 2.4 billion as indicated in **Table 3.5.**

Table 3. 5: Unauthentic Claims Paid Related to Weaknesses on Identification and Registration of Patients

Financial Year	Total Unauthentic and Incorrect Payments made during the year (In Million TZS)	Unauthentic and Incorrect related to Identification and Registration of Patients (In Million TZS)	Percentage (%)
2019/20	4,319.11	97.55	2
2020/21	4,551.26	537.01	12
2021/22	5,594.55	1,748.83	31

***Source**: Anti-Fraud Reports and Post Verification Reports (2019/20-2021/22)*

Analysis from **Table 3.5** shows that, there was general increase in malpractices related to incorrect identification and registration of patients from two percent of the total unauthentic and incorrect payments made during the year 2019/20 to 31% in 2021/22.

It was noted that, under this category pharmacies were highly involved in payment of unauthentic claims because, in case of unavailability of dispensed medicines, patients were referred to pharmacies to collect medicines. **Table 3.6** shows unauthentic claims paid because of the weaknesses on identification and registration for various levels of healthcare facilities.

Table 3. 6: Unauthentic Claims Paid Related to Weaknesses on Identification and Registration of Patients based on level of Healthcare Facilities (Amount in Million TZS)

Financial Year	National	Zonal	Regional	District	Dispensary	Health Center	Pharmacy	Specialized Clinic
2019/20	-	-	0.074	43.48	-	-	54.00	-
2020/21	-	251.88	84.20	2.75	-	1.25	187.57	9.36
2021/22	51.48	563.18	335.76	25.42	-	25.25	584.61	163.11
TOTAL	51.48	815.06	420.03	71.64	-	26.50	826.18	172.48

***Source**: Auditors' Analysis from Anti-Fraud Reports from 2019/20 to 2021/22*

Table 3.6 shows that zonal hospitals were highly paid unauthentic claims related to weaknesses on identification and registration of NHIF beneficiaries for the period from 2019/20 to 2021/22.

However, the audit noted that, in July 2022, the use of form 2C was prohibited by the Ministry of Health. This form was the main cause on the unauthentic claims paid related to weaknesses on identification and registration of patients.

Furthermore, private owned healthcare facilities were noted to have more malpractices compared to Government and FBOs healthcare facilities as shown in **Table 3.7.** This is because unauthentic claims paid to private healthcare facilities stood at 64% while government and FBO's, has 23% and 13% of noted unauthentic claims.

Table 3. 7: Unauthentic Claims Paid Related to Weaknesses on Identification and Registration of Patients based on Ownership of Healthcare Facilities (Amount in Million TZS)

Financial Year	Government HCF	Private HCF	FBO HCF
2019/20	43.07	54.07	0.41
2020/21	98.80	151.43	286.79
2021/22	419.60	1,315.73	13.50
Total	**561.47**	**1,521.23**	**300.70**

Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

(b) Unauthentic Claims Paid due to Overbilling of Consultation Services

The audit noted up-coding of clinician qualifications during provision of consultation services to NHIF beneficiaries and claims paid for exaggerated consultation services. For instance, the audit noted that, Healthcare facilities claimed consultation fee for Specialist consultations while NHIF beneficiaries were attended by general practitioners (GPs). Further, general practitioners' consultation services were claimed while the beneficiaries were attended by clinical officers and consultations provided by unqualified staff.

Table 3.8 presents analysis of unauthentic claims paid due to anomalies related to consultation services.

Table 3.8: Unauthentic Claims Paid due to Anomalies related to Consultation Services (In TZS)

Noted Anomalies	Claimed Amount in 2019/20	Claimed Amount in 2020/21	Claimed Amount in 2021/22
Specialist consultations provided by General Practitioners	347,568,130	72,218,000	39,728,000
Consultation fees charged for Clinical Officer while provided by health practitioner	0	0	34,355,990
General practitioner consultations provided by Assistant Medical Officers	2,299,000	0	13,456,190
Un-provided Consultation Services	0	647,000	0

Noted Anomalies	Claimed Amount in 2019/20	Claimed Amount in 2020/21	Claimed Amount in 2021/22
Consultations provided by wrong clinician qualification	0	376,730,394	2,159,000
Claims Paid for Consultations while patients attended for drug re-fill	0	1,167,500	0
Total	**349,867,130**	**450,762,894**	**77,146,830**

Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

Analysis from **Table 3.8** shows that, for the period under review TZS 877 million were paid due to anomalies related to consultation services. In the financial year 2019/20 about 99% of unauthentic claimed paid were related to specialist consultations being provided by general practitioners, while in financial year 2020/21 about 84% of unauthentic claimed paid were related to consultation services being provided by unqualified staff. Also **Table 3.8** shows there was significant decrease of amount claimed related to consultation services anomalies from TZS 349 million in financial year 2019/20 to TZS 77 million in financial year 2021/22.

Further it was noted that different levels of healthcare facilities were involved in payments of unauthentic claims which were related to weaknesses of consultation services as indicated in **Table 3.9**.

Table 3. 9: Unauthentic Claims Paid Related to weaknesses on Consultation Services based on level of Healthcare Facilities (Amount in Million TZS)

Financial Year	National	Zonal	Regional	District	Dispensary	Health Center	Pharmacy	Specialized Clinic
2019/20	0	0	171.65	4.25	0	8.42	0	165.55
2020/21	0	2.16	0.46	249.06	0	181.82	0	17.26
2021/22	1	9.03	11.72	16.87	2.16	33.16	0	3.17
Total	1	11.19	183.85	270.18	2.16	223.4	0	185.97

Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

Analysis from **Table 3.9** noted that, there was decrease in malpractices related to consultation services where in financial years 2019/20 and 2021/22 unauthentic claims paid were TZS 349 million and TZS 77 million respectively. Also, it was noted that there was increase in unauthentic

claimed to national level, zonal level and dispensary level as shown in **Table 3.9.**

Further, based on the level of ownership of healthcare facilities it was noted that, private hospitals were involved more in malpractices related to consultation services whereby it accounted for 85%; followed by FBO's healthcare facilities which accounted for 14% and Government healthcare facilities which accounted for one percent.

(c) Unauthentic Claims Paid for Investigation and Diagnostic Procedures which were not Provided

The audit noted that healthcare facilities claimed investigations and diagnostic procedures which were not provided to NHIF beneficiaries and substitution of tests. For the period from 2019/20 to 2021/22 paid unauthentic claims related to investigation and diagnostic procedures was TZS 6.80 billion as shown in **Table 3.10**.

Table 3. 10: Paid Unauthentic Claim Related to Investigation and Diagnostic Procedures

Financial Year	Additional of Tests (TZS)	Substitution of Tests (TZS)	Total (TZS)
2019/20	2,009,386,368	152,580,000	2,161,966,368
2020/21	2,104,134,340	201,218,100	2,305,352,440
2021/22	1,873,782,365	451,488,720	2,332,718,905

Source: *Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

From **Table 3.10** it was noted that 88% of claimed unauthentic payments were from additional tests which were not performed to NHIF beneficiaries. Also, 12% of the unauthentic claims originated from substitution of tests.

(d) Unauthentic Claims Paid for Medicines which were not Dispensed

The audit noted healthcare facilities claimed medicines which were not provided to NHIF beneficiaries. Also, healthcare facilities dispensed medicines to NHIF beneficiaries which were not in NHIF packages. **Table 3.11** provides analysis on the identified paid claims for additional and substituted medicines for the period from 2019/20 to 2021/22.

Table 3.11: Unauthentic Claims Paid related to Dispensed Medicines to NHIF beneficiaries

Financial Year	Additional claimed medicines (TZS)	Substitution claimed medicines (TZS)	Total (TZS)
2019/20	745,392,230	399,255,810	1,144,648,040
2020/21	350,981,295	52,020,000	403,001,295
2021/22	802,307,958	20,016,000	822,323,958

***Source**: Auditors' Analysis from Anti-Fraud Reports (2019/20-2021/22)*

From **Table 3.11** it was noted that 80% of claimed unauthentic payments were caused by adding medicines to NHIF beneficiaries forms while those medicines were not provided to respectives beneficiries. 20% of claimed unauthentic payments resulted from substitution of medicines i.e healthcare facilities claimed for medicines that were in the NHIF packages while the dispensed medicines were not from the packages.

(e) Unauthentic Claims Paid due to Non adherence to Standard Treatment Guidelines (STG)

The audit noted that healthacre facilities did not adhere to STG when providing health services during the period under review. The common non adherence to STG included billing dosage of Heligo Kits. Also, widal tests done without adhering to government circular; Brucella tests done without adhering to manufacturer's Guideline; and Prescription of medicines above authorized level.

For the period from 2019/20 to 2021/22 it was noted that NHIF paid a total of TZS 2.04 billion to heathcare facilities which did not adhere to Standard Treatment Guideline. Whereas, TZS 566.11 million, TZS 855.12 million and TZS 627.35 million were paid in financial years 2019/20, 2020/21 and 2021/22 respectively.

Non adherence to Standard Treatment Guidelines by healthcare facilities was mainly observed in medical investigations as well as dispensing of medicines to NHIF beneficiaries.

In relation to level of healthcare facilities, districts and regional hospitals were noted to be highly involved in payments of unauthentic claims related to weaknesses in non-adherence to STG as highlighted in **Table 3.12**.

Table 3. 12: Unauthentic Claims Paid Related to Non-adherence to STG Based on level of Healthcare Facilities (Amount in Million TZS)

Financial Year	National	Zonal	Regional	District	Dispensary	Health Center	Pharmacy	Specialized Clinic
2019/20	0	0	366.7	74.98	10.38	7.15	0	105.91
2020/21	-	173.62	2.14	643.00	-	7.25	-	39.65
2021/22	0	224.54	159.55	142.42	0.29	8.67	0	62.49
Total	0	398.16	528.39	860.4	10.67	23.07	0	237.16

Source: *Auditors' Analysis from Anti-Fraud Reports from (2019/20-2021/22)*

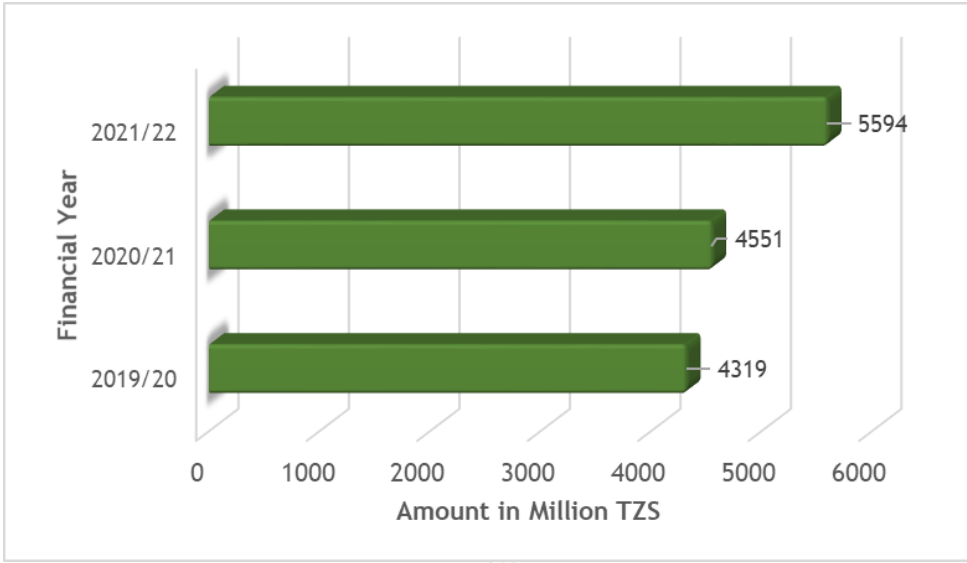
Table 3.12 shows that District hospitals had highly paid unauthentic claims related to non-adherence of STG compared to other level of healthcare facilities for the period from 2019/20 to 2021/22.

Furthermore audit noted that, private healthcare facilities were more involved in non-compliance with STG as it accounted for 67% of total claims paid. This was followed by FBO's healthcare facilities which account for 29% while Government healthcare facilities account for five percent.

3.2.3 Consequences of the Malpractices Conducted by Healthcare Facilities

The above analysis on unauthentic claims paid to the healthcare facilities at different levels may result into financial loss to the Fund. Review of Fraud Reports for the period from 2019/20 to 2020/21 revealed that, there was gradual increase in unauthentic claims paid to healthcare facilities from TZS 4.31 billion to TZS 5.59 billion. Whereas, a total of TZS 14.46 billion was paid to healthcare facilities which may result into financial loss to the Fund if it will not be recovered accordingly. Eventually it will affect sustainability of the Fund. **Figure 3.3** shows the anticipated financial loss for the Fund.

Figure 3. 3: Anticipated Financial Loss of the Fund due to Malpractices by Healthcare Facilities



***Source**: Auditor's Analysis of Unauthentic Claims Paid to HCF of December (2022)*

The audit further noted that, existence of unauthentic and incorrect claims was mainly caused by:

(a) Inadequate adherence to standard treatment guidelines and contractual agreements by healthcare facilities during the provision of health insurance services to the entitled beneficiaries;
(b) Inadequate existing control mechanisms at NHIF to ensure claims processed and paid were authentic, correct and complete;
(c) Remedial actions were not taken on unauthentic claims in order to reduce financial losses; and
(d) Inadequate monitoring and evaluation of claims processing.

These are further detailed below:

3.3 Healthcare Facilities Did Not Adhere to STG and Contractual Agreements During the Provision of Healthcare Services

Various efforts were made to ensure compliance with STG and contractual agreements such as conducting supportive supervision, onsite claims verifications, clinical audit and advocacy; ensuring healthcare facilities charge agreed price; and maintaining true and proper patients' records.

However, the audit noted weaknesses which indicated that NHIF did not adequately ensure healthcare facilities were adhering to the established STG and contractual agreements during provision of healthcare services to NHIF beneficiaries as highlighted below:

3.3.1 100% of the Visited Healthcare Facilities Did Not Adhere to STG and Contractual Agreements

Section 2(b) of the Claim Management Manual, 2021 requires certified health service providers to provide quality services to the entitled beneficiaries in accordance with the Standard Treatment Guidelines (STG) and basic standards for health facilities as set by the Ministry responsible for Health matters and Service Agreement.

Interview held with NHIF management noted that, the Fund enforce adherence of STG by healthcare facilities through conduct of supportive supervision; certification and recertification inspection; advocacy; pre and post verification of claims; and claim processing.

Review of Post Verification Reports for the period from 2019/202 to 2020/21 indicated that, for the period under review 100% of 131 visited healthcare facilities based on the number of onsite verifications case in Mwanza, Mbeya and Dodoma regions did not adhere to STG as indicated in **Table 3.13**.

Also, review of Anti-Fraud Reports for the period between 2019/20 to 2021/22, noted the existence of healthcare facilities which did not adhere to STG and contractual agreements as detailed in section 3.2.2(2) of this report.

Table 3. 13: Visited Healthcare Facilities Did Not Adhere to STG

Region	2019/20	2020/21	2021/22
Dodoma	0	11	62
Mwanza	0	7	17
Mbeya	0	16	18

Source: *Post Verification Reports (2019/20-2021/22)*

Table 3.13 shows that, high number of healthcare facilities which did not adhered to STG were noted in financial year 2021/22 in Dodoma Region.

This was caused by inadequate enforcement of contractual agreements and related guidelines issued to the healthcare facilities. For instance, audit

noted absence of risk registers that would support effective conduct of verification and supportive supervision as required in section 4.2 of Quality Assurance Manual, 2021. Also, in the visited regions it was noted that, the number of healthcare facilities planned and covered by NHIF during supportive supervision, and post verification exercises were less than 10% of all registered facilities in visited regions.

Non-adherence to STG by healthcare facilities may resulted into financial losses to the Fund. For instance, audit noted unrecovered unauthentic claims which were identified through onsite verifications conducted during the period under review in Mbeya, Mwanza and Dodoma as shown in **Table 3.14.**

Table 3. 14: Unrecovered Unauthentic Claims Identified through Onsite Verifications

Region	Unrecovered Amount (In TZS)
Mbeya	69,518,206.67
Mwanza	61,302,549.62
Dodoma	26,697,960.09
Total	**157,518,716.38**

***Source**: Onsite verification Reports for the period (2019/20-2021/22)*

Table 3.14 above shows that Mbeya Region has high unrecovered unauthentic claims. This was caused by inadequate follow up by respective NHIF Regional Office to ensure the fund that was supposed to be deducted were effected to the respective healthcare facilities based on conducted onsite verification.

3.3.2 Weaknesses on Pricing of the NHIF Packages

NHIF established controls on prices in the Claim Management Information System (CMIS) whereby each item was coded before processed and indicative price appear automatically on the item to be paid according to the particular benefit packages and level of HCF.

Section 5.4.1 of Quality Assurance Manual, 2020 requires the Health Service Committee to review benefits package after every three (3) years or when there are other directives from the Management, Board of Directors or Ministry of Health. Also the committee is required to carry out ad hoc review of any component of the Benefits Package as and when needed.

Also, the manual requires the price schedules for services such as medicines and medical consumables, investigations, medical and surgical procedures, admission and other health care services to be frequently reviewed, regulated or enhanced in the period to be defined by the Fund's Management. The review should go in line with the market forces, beneficiary demands, state of the art medical developments and discoveries as well as the Fund's capability to pay as determined by periodic actuarial assessment and valuations.

Despite the controls set in the CMIS regarding prices, review of the Price Market Research (2021), standards, and supplementary packages showed that, the existing prices were not reviewed for more than 6 years. This gap created variations between market and actual prices charged by the Fund to healthcare facilities.

Audit noted that, during 2021, NHIF conducted market survey which aimed at measuring market prices of the medicine in order to update NHIF prices in line with the prevailing market prices of the selected medicines. However, the survey did not cover other medical services in NHIF benefit package such as consultation, diagnostic examinations, surgery and procedures.

The result of the market survey showed that, the 2016 pricelist which was in use, led the Fund to pay TZS 100.79 billion in the financial year 2018/19 instead of TZS 93.9 billion if the prevailing market prices would have been used. This would cut the cost for those items by TZS 6.84 billion equivalent to seven percent.

Audit further noted that, by using 2016 pricelist the Fund paid TZS 111.10 billion for a similar list of medicines in 2019/20. However, if the prevailing market prices were adopted, the Fund would cut benefit cost by 8.6 billion, equivalent to eight percent by paying only TZS 102.50 billion.

Further review of NHIF Pricelist of 2016 and Market Survey Report of 2021 indicated significant variation between prices which ranged from -25% to 149% as indicated in **Table 3.15**.

Table 3. 15: Price Comparison on Median Retail Prices and NHIF Prices of 2016 for NHIF Top 20 Most Utilized Medicines

Generic name	Strength (edit accordingly)	Dosage form(edit accordingly)	Median (Retail) (A)	NHIF 2016 (B)	Difference (NHIF 2016/ Retail)[C=(A-B)/A]
Erythropoietin/Nanokine/Epo/Wepox	4,000 IU	Inj	26,500	66,000	149%
Atorvastatin Solid Oral Dosage Form	20mg	Tabs	500	800	60%
Trustuzumab/Herceptin	150mg	Inj	1,835,000	2,930,000	60%
Pregabalin Solid Oral Dosage Form	75mg	Caps	1,000	1,350	35%
Rabeprazole Solid Oral Dosage Form	20mg	Tabs	800	1,000	25%
Amoxycillin + Clavulanic Acid Solid Oral Dosage Form	500mg + 125mg	Tabs	1,000	1,250	25%
Telmisartan + Hydrochlorothiazide Solid Oral Dosage Form	80mg + 12.5mg	Tabs	975	1,200	23%
Ketoprofen Cream Or Gel	30gm	Cream/ gel	10,000	12,000	20%
Amlodipine Solid Oral Dosage Form	10mg	Tabs	300	350	17%
Bevazicumab/Avastin	Injection: 100mg	Vial/Ampule	1,155,000	1,300,000	13%
Ferrous And Folic Acid Solid Oral Dosage Form	200mg+ 5mg Tablet	Tabs	100	90	-11%
Clarythromycin + Tinidazole + Lansoprazole Solid Oral Dosage Form	250mg/500mg/30mg	Tabs	881	952	8%
Hydrochlorthiazide + Losartan Solid Oral Dosage Form	12.5mg + 50mg	Tabs	700	750	7%
Metformin + Glimipride Solid Oral Dosage Form	500mg + 2mg	Tabs	950	1,000	5%
Ampicillin + Cloxacillin Solid Oral Dosage Form	250mg + 250mg	Caps	200	190	-5%
Cough Mixture	100ml/12	Solution	3,000	2,600	-13%

Generic name	Strength (edit accordingly)	Dosage form(edit accordingly)	Median (Retail) (A)	NHIF 2016 (B)	Difference (NHIF 2016/ Retail)[C=(A-B)/A]
Solution	5ml				
Ceftriaxone	1000mg	Injection	3,000	2,500	-17%
Vitamin B1, B6, B12, Folic Acid Solid Oral Dosage Form	150mg	Caps	600	500	-17%
Glucosamin + Chondrioting Solid Oral Dosage Form	20mg	Caps	1,000	750	-25%

Source: *Market Survey Report (2021)*

Furthermore, the results of the market survey which was focused on prices for collected sample of anticancer medicines indicated that out of the seven collected samples of anticancer medicines, NHIF prices were higher than the prevailing market prices in six anticancer medicines (refer to **Table 3.16** below). Table further shows that, NHIF prices of 2016 for three anticancer medicines were on average above market prices by 55%.

Table 3. 16: Variation between NHIF Prices of 2016 and Prevailing Market Prices for Anticancer Medicines

Generic name	Strength (edit accordingly)	Dosage form(edit accordingly)	NHIF 2016 (A)	Market Prices (Median Price) (B)	Variation (NHIF 2016 Prices/Market Prices)[C=(B-A)/B]
Docetaxel	Injection: 120mg	Vial/Ampule	574,300	200,000	187%
Rituximab	Injection: 500mg/ml	Vial/Ampule	4,230,000	2,000,000	112%
Anastrazole	10mg	Tablet	8,000	4,333	85%
5-Fluorouracil	Injection: 250mg	Vial/Ampule	3,500	3,000	17%
Bevazicumab /Avastin	Injection: 100mg	Vial/Ampule	1,300,000	1,155,000	13%
Rituximab	Injection: 100mg/ml	Vial/Ampule	846,000	787,500	7%

Generic name	Strength (edit accordingly)	Dosage form(edit accordingly)	NHIF 2016 (A)	Market Prices (Median Price) (B)	Variation (NHIF 2016 Prices/Market Prices)[C=(B-A)/B]
5-Fluorouracil	500mg/10 ml	Vial/Ampule	3,300	5,100	-35%

Source: *Market Survey Report (2021)*

As shown in **Table 3.16,** the maximum price variation (i.e. for items with NHIF prices above market prices) was 187% which was noted in Docetaxel Injection, 120mg and the minimum variation was seven percent which was noted in Rituximab Injection, 100mg/ml.

Audit noted that, the significant variation between market prices and NHIF pricelist was caused by lack of comprehensive review of benefit packages in order to reflect current market conditions. Due to significant variation between market prices and NHIF pricelist of 2016, the Fund lost money which was caused by overpayments resulting from using 2016 NHIF pricelist. For the period from 2019/20 to 2021/22, the Fund could have saved TZS 11.06 billion on the paid claims to the healthcare facilities, if market prices were adopted for 20 selected medicines and anticancer medicines as indicated in **Appendix 6A** and **6B**.

Moreover review of letter EA.35/269/01-A/23 dated on 15th June, 2022 submission of proposed benefit package to Ministry of Health noted that, the Fund has conducted review of the benefit package for selected services such as medical investigations, common surgical services, dialysis, cancer medicines, normal medicine and cardiac services. This survey was conducted in order to update the list of items, prices of services and to facilitate implementation of various controls on utilization of benefit package. During 2020/21 the Fund paid TZS 132.38 billion for reviewed services. Nevertheless, had it adopted the proposed reviewed prices, the Fund could have instead paid TZS 84.51 billion and therefore saved TZS 47.87 billion. But, it was noted that, the reviewed benefit package was still under approval process at the Ministry of Health. The Fund continue to remind the Ministry of Health to facilitate approval of the reviewed benefit package to ensure medical services are provided as per the Standard Treatment Guideline and prevailing market prices.

3.3.3 Healthcare Facilities Did Not Manage and Maintain True and Proper Patients' Records at all Points of Services

Clause 11.30 of the Template Contract between NHIF and Service Provider requires Healthcare facility to manage and maintain true and proper patients' records in all points of service in accordance with the guidelines provided by the Ministry responsible for health.

Review of Anti-Fraud Investigation Report of financial years 2019/20 to 2021/22 noted inadequate record keeping on provided services at healthcare facilities. This was observed during fraud investigations which indicated missing of documents, improper handling and record keeping of patient case notes, ghost records for justification of fictitious claims, false stock of medicines and dispensing records.

For the period from financial year 2019/20 to 2021/22, fraud investigations were conducted to healthcare facilities and noted that, healthcare facilities with inadequacy of records keeping on provided services had ranged from 11% and 28% per annum. **Table 3.17** shows the healthcare facilities investigated and noted with anomalies of inadequate records keeping.

Table 3. 17: Inadequate records keeping during provision of health services

Financial Year	Number of Healthcare Facilities	Number of Healthcare Investigated	Healthcare with Record Keeping Anomalies	Percentage (%age)
2019/20	8,442	118	31	26
2020/21	9,037	112	12	11
2021/22	9,556	65	18	28

Source: *Healthcare Facilities Database and Anti-Fraud Investigation Reports of (2019/20-2021/22)*

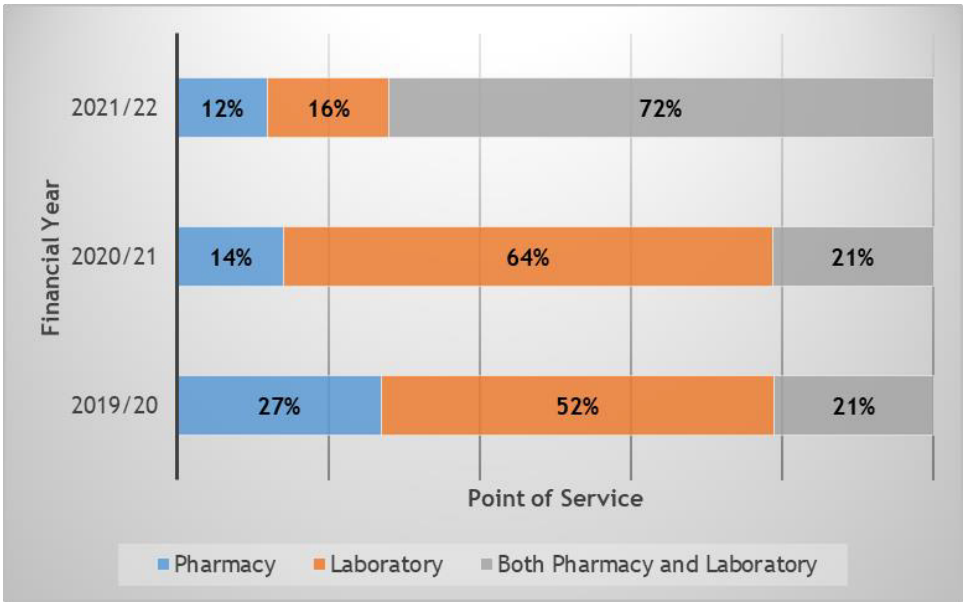
Table 3.17 shows that, there is an increase in percentage of healthcare facilities with anomalies of inadequate records keeping from 26% in 2019/20 to 28% in 2021/22. This is based on the sample of fraud and post verification reports.

Further analysis shows weakness in record keeping at all categories of healthcare facilities point of services namely pharmacy and laboratory.

With regards to the healthcare facilities covered by Anti-Fraud Investigation the audit noted that, inadequacy of record keeping was 44% during Investigation only, 35% in all point of services (both Laboratory and Pharmacy) and 21% in pharmacies during dispensing of medicines. But improvement in records keeping was noted in pharmacies.

Figure 3.4 provides analysis on the inadequate records keeping based on Point of Provision of Healthcare services.

Figure 3. 4: Inadequate record keeping based on Point of Provision of Healthcare services



Source: *Anti-Fraud Investigation Reports (2019/20-2021/22)*

The audit noted that, the causes for inadequate management and maintenance of proper records was lack of clear contractual consequences on non-compliance with the requirement for medical records for provided services. However, it was noted that, up to the time of this audit, there were no progress made regarding having clear contractual consequences.

Unavailability of records at various point of services led to inconsistency of information between the submitted claims from healthcare facilities and actual services provided. This created a room for payments for services that were not provided.

3.3.4 Inadequate use of the Information and Communication Systems by Health facilities

According to Strategic Plan (2020/21), NHIF set a target to roll out online claims submission to all facilities above dispensary level by June, 2025. This target was broken down for each year as indicated in **Table 3.18.** This effort aimed at improving claims reimbursement as well as curb fraudulent activities.

Review of Action Plans and Annual Performance Reports noted that, as at October 2022, 153 out of 409 healthcare facilities above dispensary level, which signed contract with the Fund for provision of healthcare insurance services equivalent to 37%, kept health service records in MHIS and submitted their claims online. The remaining 256 healthcare facilities, equivalent to 63% did not submit their claims online which implied that they kept health services records manually.

Table 3. 18: Rolling Over of Online Submission of Claims by Healthcare Facilities

Year	Target HCF	Actual HCF	% of achievement
2019/20	0	5	0
2020/21	200	5	4.5
2021/22	100	84	84
December 2022	60	69	116

Source: *Action Plans and Performance Reports (2019/20-2021/22)*

Further analysis noted that not all healthcare facilities in the NHIF regional offices in the country keep health services records in HMIS and submit their claims online. In 20 regions a total number of 153 out of 8,073 healthcare facilities keep their health services records in MHIS and submit their claims online, while in 9 regions there were no healthcare facilities out of 2,207 that either keep records in MHIS or submit their claims online as shown in **Table 3.19.**

Table 3. 19: Regions with healthcare facilities that keep records and submit their claims online

Region	No. of Available Healthcare Facilities	Number of Healthcare Facilities that keep records and submit their claims online
Kinondoni	292	41
Ilala	202	21
Mbeya	360	15
Arusha	377	12
Kilimanjaro	346	12
Mwanza	394	11
Temeke	178	8
Dodoma	425	7
Morogoro	394	6
Njombe	282	4
Zanzibar	63	3
Kigoma	273	2
Manyara	217	2
Pwani	375	2
Tanga	415	2
Geita	174	1
Tabora	344	1
Mara	302	1
Songwe	220	1
Iringa	233	1
Kagera	320	0
Simiyu	220	0
Shinyanga	242	0
Katavi	97	0
Rukwa	223	0
Singida	237	0
Lindi	260	0
Mtwara	251	0
Ruvuma	357	0
Total	**8,073**	**153**

Source: *List of Facilities submitting claims online and Healthcare Facilities database (2022)*

Existence of low number of healthcare facilities which were connected with ICT was caused by inadequate prioritization by NHIF to ensure attainment of the established target that aimed to ensure all HCF above district level managed to submit online claims before 2025.

3.4 Control Mechanisms at NHIF do not Ensure Claims Processed and Paid to Healthcare Facilities are Authentic and Accurate

In order to ensure the claims processed and paid to HCF were authentic and accurate, NHIF established controls such as verification and authorization of NHIF beneficiaries before they access healthcare services, segregation of duties, quality check of the claims and controls through CMIS to every processed claim.

However, the audit noted the following weaknesses which indicated control mechanisms at NHIF did not ensure claims processed and paid to healthcare facilities were authentic and accurate.

3.4.1 Membership Verification and Authorization at Healthcare Facilities was not adequately Conducted

Section 3.4.9 of Quality Assurance Manual, 2021 requires beneficiaries to physically show their NHIF Identity to the health provider who will identify and treat the actual beneficiary portrayed on the photograph. Use of IDs by any other person is strictly prohibited and liable to legal prosecution. Similarly, acceptance and offering of services to a client not identified with the picture on the ID is equivalent to 'collusion to defraud' the Fund and it is liable to legal prosecution.

Furthermore, for proper client certification, healthcare facilities have to do the following before submitting claims to the Fund's offices otherwise the claim forms will be rejected forthwith: Beneficiary is supposed to sign the form at the completion of obtaining services, and not before; Illiterate beneficiary's thumbprint will be accepted and in case of a child, quadriplegic and mental derangement, an authentic guardian's signature will be accepted, but it should be clearly spelled out as 'Guardian'; and Initials will not be accepted as signatures.

However, audit noted various weaknesses regarding verification and authorization of NHIF beneficiaries at the point of services which include the following:

(a) Existence of Beneficiaries who Accessed Healthcare Services Using Initials as Signature

Review of Claim Files at the visited NHIF regional offices revealed that, after completion of obtaining healthcare services, 186 beneficiaries signed Form 2(a) with initials, which is against the requirement**. Appendix 7** shows folios approved and paid with initials.

This implied that, there is possibility that health services were provided to persons other than actual beneficiaries.

This was caused by weak controls at healthcare facilities especially during registration of beneficiaries and at completion of services. For example, audit noted existence of NHIF cards with no beneficiary signatures which could help service providers to crosscheck them with the ones signed in Form 2 (a) for the purpose of identifying actual members.

Another reason was weaknesses on the CMIS and Health Information Systems used by facilities to capture important beneficiary's information such as signatures, fingerprints, photos of beneficiaries which may help in identification of beneficiaries.

(b) Most of the Features in the NHIF Membership Cards were not Sufficient to support Identification and Verification of Beneficiaries during Provision of Service

The audit noted that, during a visit to the healthcare facility a patient/beneficiary has to submit NHIF card prior accessing medical services. Healthcare facility through the use of ICT verify and authorize valid member to make sure that, the person accessing medical service through NHIF has a valid NHIF identification card which shows proof of membership and entitlement of benefits under the scheme. Also, the facility captures verbally information of the beneficiaries such as place of domicile, tribe, occupation etc. and thereafter issue authorization number to beneficiaries if the membership card is active.

However, the audit noted that, NHIF membership cards used for verification of the patient prior provision of the healthcare services lacked important security features such as member's signature which was used in form 2A during provision of health services.

The audit further noted that, most of the features included in the NHIF identification card cannot suffice identification process at healthcare facilities during provision of services as most were for the Fund's purposes as shown in **Table 3.20**.

Table 3. 20: Features Found in NHIF Membership Cards versus its Uses

Available Features	Purpose	Remarks
Details of the card which include; • Membership Number • Sex • Vote number • Date of Birth • Card Expiry Date (for the case of Students, Toto Afya Kadi (TAK), Private Voluntary Members, Mutual (KIKOA) members and Councillors)	For member Identification	Can identify if the beneficiary card is in use
Member Photo with the cheque number/ PF number on the top of it	Member Identification	Cannot identify if the beneficiary is genuine
The signature of the Fund director and date of the card issuance on the bottom.	For fund purpose	Cannot identify if the beneficiary is genuine

Source: *NHIF Membership Card and Auditors Analysis (2022)*

As it can be seen from **Table 3.20,** out of three noted features, only one had sufficient features for the identification and verification of beneficiaries during provision of health services.

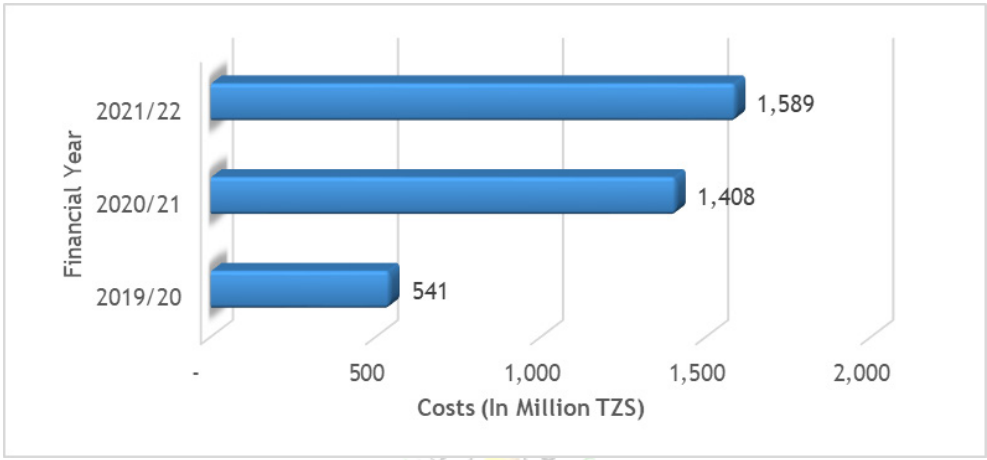
This may provide loophole to patients or service providers to misuse the cards. For instance, review of Fraud Investigation Reports from Pwani and Dar es Salaam NHIF Regional Offices for the year 2020 indicated that, two members with card Nos. 205501647575 and 101701647034 were subjected to investigation due to suspicion on misuse of NHIF card that caused financial losses to the Fund.

(c) Presence of Ineligible Beneficiaries who Accessed Healthcare Services

Review of Anti-Fraud Reports for the financial years 2019/20 to 2022 noted ineligible members who accessed dialysis services from certified healthcare facilities. It was noted that, for the period under review a total of TZS 3.53

billion was paid to healthcare facilities for ineligible beneficiaries at Ilala, Mwanza and Geita. **Figure 3.5** below provide analysis of the ineligible members who accessed dialysis services but they were not registered beneficiaries.

Figure 3. 5: Costs Incurred by Ineligible Beneficiaries Attended Dialysis Services (In Million TZS)



Source: *Anti-Fraud Reports (2019/20-2021/22)*

As a result of weaknesses on verification of beneficiaries during services provision, NHIF may reimburse money to the service providers for services which were not provided to the beneficiaries, ultimately leading the Fund to losses.

3.4.2 Unfavourable Claim Processing Aging

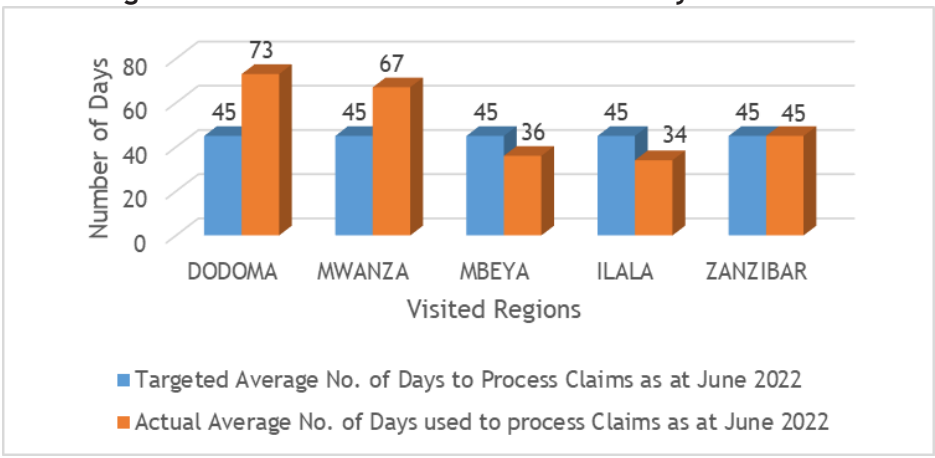
According to Strategic Plan (2020/21-2024/25), the Fund intends to reduce the average claims aging to 30 days by June, 2025. Through Annual Action Plans, the target was broken down into 30, 30, and 45 days for financial years 2019/20, 2020/21 and 2021/22 respectively.

However, review of Annual Performance Report of financial year 2021/22 indicated that the Fund recorded an average of 62 days claims aging to all 30 regions. Compared to a similar period in the past financial year where average aging was 57 days, it means that, the number of days for processing claims increased by eight percent.

Furthermore, for the visited regions claims aging were ranging from 34 days to 73 days, whereas Dodoma and Mwanza recorded claims aging above set

targets. **Figure 3.6** shows the analysis of the extent of time for processing claims in the visited regions.

Figure 3.6: Time Taken to Process Claims by June 2022



Source: *Claim Management Information System (2022)*

From the **Figure 3.6** above, it was noted that three regions namely Mbeya, Ilala and Zanzibar met the target of time taken to process claims. Dodoma and Mwanza recorded above the target timeline by 28 and 22 days respectively.

The high claims aging was attributed by a number of factors including: suspension of claims by Quality Assurance Officers in regional offices due to various reasons hence recording high aging in regional offices; claims with fraudulent indicators hence taking longer time to process and verify; and shortage of staff in regional offices while there was an increase in the number of claims including supplementary claims.

Untimely processing of claims led to inadequate financial capacity of healthcare facilities to run their facilities that enable them to deliver quality services to NHIF beneficiaries.

3.4.3 Inadequate Quality Check of Items Claimed by Healthcare Facilities

Section 4.3.3 of the Quality Assurance Manual of 2021 requires NHIF to ensure claims submitted were quality checked before making payment.

During processing of claims from healthcare facilities, NHIF developed various quality control mechanisms so as to ensure payments made to

healthcare facilities were based on health services provided to authorized beneficiaries.

Despite of the established controls during the provision of healthcare services at healthcare facilities in the process of identifying genuine NHIF members, still inactive NHIF beneficiaries[10] were noted to have access to health services. Also, audit noted that, there were claims paid for inactive NHIF beneficiaries, which indicate inadequate quality check at NHIF Offices before making payment.

Further, it was noted that for the period from financial year 2019/20 to 2021/22 there were payments made to healthcare facilities in respect to healthcare services provided to the ineligible NHIF members amounting to TZS 3.53 billion as shown in **Section 3.4.1 (c)** of this report. Also as indicated in **section 3.2** of this report, unauthentic and incorrect payment were made to healthcare facilities amounting to TZS 14.46 billion which were mainly caused by inadequate quality check for the claimed items**.**

3.4.4 Claim Information Management System Did Not Ensure Claims Processed were Authentic and Correct

NHIF uses CMIS to process claims among other systems. CMIS has controls to ensure claims processed are authentic and correct. However, the review of CMIS noted various weaknesses which indicated that the system used did not ensure processed claims were authentic and correct as explained below:

(a) Quality Assurance Officers were not assigned with a Role to Establish Delays on Claims Submission by Healthcare Facilities

Section 4.3.10 Quality Assurance Manual, 2021 requires for enhance efficiency in processing claims and reduce aging i.e. ensure claims are submitted online on a daily basis and consequently processed daily and with accuracy.

Claims Management Manual of 2021 required healthcare facilities to submit claims online within 24 hours after complete patient visit.

[10] Inactive NHIF beneficiaries are those who were not contributed to the Fund for more than 3 months according to Compliance Manual.

Review of CMIS indicated that, Quality Assurance Officers were not assigned with the role to establish delays on the claims submitted online by health facilities. Interviewed Quality Assurance Officers responded that, they only rely on notices which facilities send to NIHF when they failed to submit claim on time.

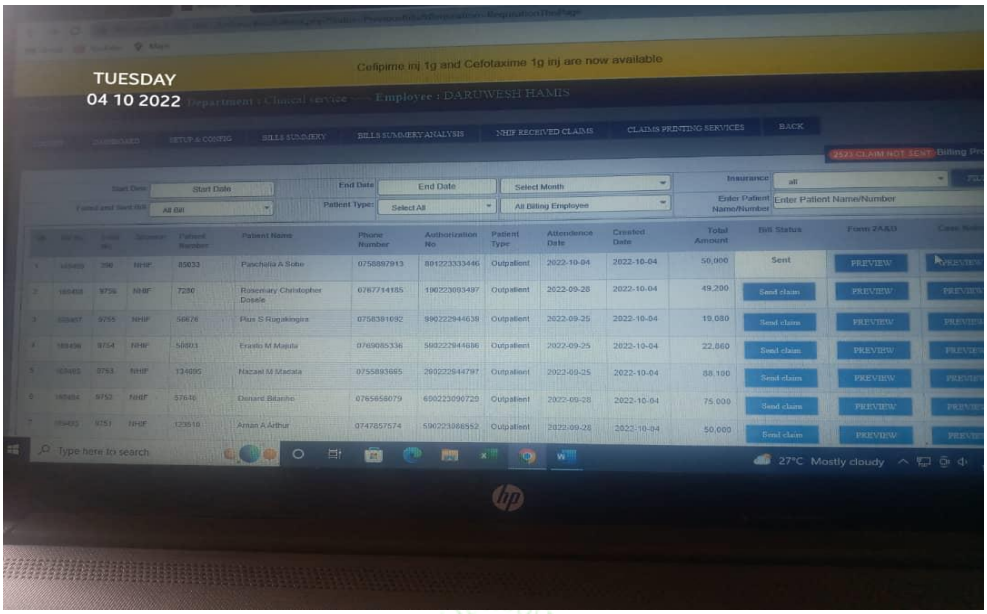
This condition was caused by lack of regular reviews of the CMIS. As a result, it is difficult for the Quality Assurance Officers to carry out monitoring and enforce compliance to NHIF requirements for timeliness of submitting claims.

(b) Online Claims Submitted by Healthcare facilities Did Not Show Results of the Investigations

Review of CMIS and eHMIS at visited healthcare facilities such as Kamanga Hospital and Bugando Medical Center in Mwanza region noted that, claims/folios which were submitted online lacked results of the investigations on patients receiving healthcare services. The submitted claims/folios only attached form 2 (a) and (b) and case notes. **Photo 3.1** shows eHMIS window for approval and posting claims to CMIS.

This condition led to manual works for Quality Assurance Officers when processing claims/folios which resulted into delays of processing claims. For the Quality Assurance Officers had to be given access in eHMIS by healthcare facilities to check in results of investigations performed in order to quality check in CMIS the submitted folios.

Photo 3.1: eHMIS window for Approval and Submission of Claims/Folios



***Source**: Photo 3.1 only form 2 2 (a) and (b) and case note were attached in the folio sent to CMIS for processing. Photo taken by Auditors on 4th October, 2022*

This was caused by the fact that NHIF does not have sufficient server to store large volume of data. This resulted to delay in processing of claims which in turn may affect service delivery by healthcare facilities to NHIF beneficiaries.

(c) Lack of integration between MCT link and Claim Management Information Systems

Section 52 (3) of the Medical, Dental and Allied Health Professionals Act, 2017 states that "a person who practices as a medical, a dental or an allied health professional and practitioner or receives payment without a valid practicing license, commits an offence and shall, upon conviction, be liable to a fine of not less than one million shillings but not exceeding two million shillings or to imprisonment for a term of not less than three months but not exceeding five months or to both".

When processing claims submitted by healthcare facilities, Quality Assurance Officer check whether practitioners were registered and allowed to practice by opening MCT link and check their licensing status. However, audit noted that, due to lack of integration between MCT link and claim management information systems, this exercise was done manually whereby

the Quality Assurance Officer open MCT link window and CMIS window separately and cross check relevance of practitioner information.

Due to this, it was noted that, some practitioners who were not permitted to practice by MCT attended NHIF beneficiaries at their healthcare facilities in Dodoma, Mbeya and Mwanza regions as indicated in **Appendix 8 (A, B &C).** In addition to that, claims that involved those practitioners were paid by NHIF contrary to the Section 52 (3) of The Medical, Dental and Allied Health Professionals Act, 2017.

3.5 Inadequate Remedial Actions Taken by NHIF on Unauthentic Claims Submitted by Healthcare Facilities

Clause 23 of the Template Contract between NHIF and Service Provider states that, acts of the fraud stipulated in the contract may result into rejection of claims, termination of contract or lead the Fund to seek legal remedy.

However, the audit noted various weaknesses regarding remedial actions taken by NHIF on submitted unauthentic claims by services providers which include the following:

3.5.1 Verification and Fraud Investigation Did Not Adequately Mitigate Submission of Unauthentic Claims

Audit team assessed effectiveness of on-site verification and fraud investigations. Whereas Section 4.4.2 of the Quality Assurance Manual, 2021 states that, onsite claim verification acts as one of controls for mitigating submission of fraudulent or unauthentic claims intentions among providers.

Also, Quality Assurance Manual of 2021 elaborates that, in order to ensure health services provided to standard treatment guidelines and contractual agreements during the provision of services to entitled beneficiaries, NHIF is expected to conduct supportive supervision, onsite claims verifications, Clinical Audit and Advocacy. Section 3 of the Claim Management Manual, 2021, also requires the Fund to scrutinise, authenticate and pay claims for services which have been done at healthcare facilities and NHIF offices.

Review of Annual Action Plan and Implementation reports for the period from 2019/20 to 2021/22 revealed that, NHIF managed to conduct onsite claims verifications, supportive supervision and advocacy to healthcare facilities on average of 95%, 115% and 157% respectively.

Despite the noted achievement to conduct supportive supervision, onsite claims verifications and advocacy for the period from 2019/20 to 2021/22, the audit noted existence of fraud activities in the visited regions.

Review of Anti-Fraud reports for the period from 2019/20 to 2021/22 revealed that there was an increase in fraud activities in the visited regions (Ilala, Mbeya, Dodoma, Mwanza and Unguja). Fraud practices may lead to financial losses to the Fund amounting to TZS 5.41 billion if it will not be recovered accordingly. Unauthentic claims increased from TZS 448 million in 2019/20 to TZS 2.59 billion in 2021/22. The following **Table 3.21** provide analysis of the anticipated financial losses to the Fund.

Table 3. 21: Anticipated Financial Loss due to Existence of Unauthentic claims in the Visited Regions

Region	2019/20	2020/21	2021/22
Dodoma	344,771,885	36,384,930	168,228,750
Mwanza	0	287,551,390	1,499,497,623
Mbeya	0	1,485,487,120	0
Ilala	103,535,710	27,062,950	926,150,390
Zanzibar	0	537,931,425	0
Total	**448,307,595**	**2,374,417,815**	**2,593,876,763**

***Source**: Anti-Fraud reports for the period (2019/20-2021/22)*

Table 3.21 above shows an increase of unauthentic claims in the visited regions from TZS 448 million in 2019/20 to TZS 2.59 billion in 2021/22.

Auditors' analysis on the total number of malpractice incidents that occurred in the visited regions noted that, unauthentic claims resulted from fraud activities mostly occurred in Zonal hospitals, Specialized Clinics and District Hospitals while there were no cases reported from Pharmacies and Dispensaries.

The noted increase on the amount of authentic claims was due to an increase of reported number of fraud cases uncovered by the Anti - Fraud Unit at NHIF.

3.5.2 Weaknesses on Recovery Mechanisms for Post Payment Verifications and Fraud Investigations

Clause 23 of the Contract between NHIF and Service Provider states that, "the acts [11] and omissions by the Service Provider shall amount to default and their occurrence may result into rejection of claims, termination of contract or lead the Fund to seek legal remedy".

However, audit noted the following weaknesses which indicated that the recovery mechanisms due to post payment verifications and fraud investigations were not adequately done:

a) Inadequate Recovery of the Unauthentic Claims

Section 4.4.1 of Quality Assurance Manual, 2021 requires necessary adjustments to be done and allotted amount to be either recovered by the Fund or refunded to the healthcare facilities.

The purpose of onsite claim verification was to validate and authenticate if submitted claims were valid or not. This helps to mitigate risks of paying for fraudulent claims or malpractices among service providers.

Despite various efforts in recovering unauthentic claims identified through onsite verifications and fraud investigations, the audit noted that recovery of the unauthentic claims was not adequately done.

Review of Annual Performance, Anti-fraud, and Onsite Verification reports and Loan/Fraud/Verification Recovery Schedule as at December, 2022 noted that, fraud cases amounting to TZS 7.56billion were not recovered as indicated in **Appendix 9 (A).** It was revealed that, these cases were submitted for recovery and NHIF management has ensured recovery mechanism of the stated amount through deductions. Out of TZS 7.56 billion unrecovered amount, TZS 3.63 billion was due to service utilizations of NHIF members whose NHIF through internal mechanism were discovered to be

[11] 23.1 Non adherence to the Standard Treatment Guidelines issued by the Ministry of Health and Social Welfare from time to time; 23.8 submission of claims contrary to the attached Price Schedule; and 23.14 charging the beneficiaries additional payments in respect of services which are payable by the Fund under this agreement.

unqualified beneficiaries therefore, criminal proceedings are underway with Case No OB/IR/3119/2022, CD/RB255/2022 and GE/RB/2414/2022.

Similarly, review of the same documents revealed that unauthentic claims amounting to TZS 157 million identified through onsite verifications were not recovered as indicated in **Appendix 9 (B).**

Furthermore, review of Internal Audit report[12] revealed that, onsite claims verification deductions amounting to TZS 2,075,515 were delayed to be effected by 6 months from the agreed deduction date in Njombe NHIF Regional Office. The deduction processes were not yet initiated up to the time when the audit team conducted exit meeting to Njombe NHIF Regional Office on 24th September 2021. Also, deductions amounting to TZS 1,098,630.00 were not yet effected upon onsite verification done by the Head office at Afya Medicare Health Center, located in Njombe.

This was due to ineffective monitoring of repayment schedules. Also, it was caused by lack of consistence on management of fraud cases and onsite verifications. Weaknesses in recovery of onsite verification and fraud investigations led into financial loses to the Fund.

b) Inadequate Measures were Taken to Staff Involved in Malpractices

Section 4.7.1 of NHIF Strategic Plan (2020/21 – 2024/25), set indicator of number of staff corruption cases to be zero for the period of the plan. This indicator measures staff corruption by fraud cases convicted.

Review of letters to the Ministry of Health and Summons of staff from healthcare facilities and NHIF to attend Investigation Committee and their respective Professional Boards revealed that 148 staff from both NHIF and healthcare facilities were involved in fraudulent activities as indicated in **Table 3.22**.

In managing fraud cases, Anti-fraud Unit reported 19 NHIF officials involved in fraudulent activities to the NHIF Disciplinary Committees/Investigation Committee for proceedings. On the other hand the Unit reported 129 staff

[12] Internal Audit Report on the Benefit Claims Payment and Loans to Service Providers Processes for the Period Ended March 2021

from healthcare facilities to the Ministry of Health and their professional boards.

Table 3. 22: Number of Officials from NHIF and healthcare facilities involved in Fraudulent Activities

Indicator	Target	Actual			
		2019/20	2020/21	2021/22	Total
Number of staff with Fraudulent Activities from NHIF	0	17	1	1	19
Number of staff with Fraudulent Activities from Healthcare Facilities	0	0	49	80	129
Total	**0**	**17**	**50**	**81**	**148**

Source: *Calls to attend Investigation Committee, 2019/20 to 2021/22, letter No. CAG.143/191/01/263, CAG.143/191/01/259-01, CAG.143/191/01/170, and CAG.143/191/01A/33*

Analysis from the **Table 3.22** showed that, about 88% of reported staff involved in fraudulent activities for the period under review come from healthcare facilities whereas staff from NHIF offices represent 12%.

Out of the 19 staff from NHIF, it was noted that 12 staff were dismissed from work, two staff were given warning letters, and one staff was temporarily suspended. However, with regard to the other four staff, there was no evidence provided on disciplinary measures taken against them. It was further noted that, no measures were taken against the 129 staff from healthcare facilities by either the Ministry of Health and/or their professional boards.

Inadequate disciplinary actions taken to staff involved in fraudulent activities was caused by insufficient follow-up on the proceedings of the identified cases. Also, NHIF management responded that, professional boards failed to take action on its members involved in fraudulent activities even if the reported cases were within their mandate.

Moreover, lack of coordination between NHIF, Ministry of Health and professional boards regarding staff involved in the fraudulent activities was noted to be another reason for not taking adequate disciplinary action.

c) Recurring Anomalies without Remedial Actions

Review of Settlement reports for the period from 2019/20 to 2021/22 noted that, Healthcare Facilities continuously repeated the same malpractices notably overutilization of investigation tests, non-adherence to NHIF pricing, double claiming, improper dosage and quantities, missing details of services and non-adherence to STG throughout the period under review.

Despite the warning letters NHIF sent to facilities requiring them to take remedial actions to prevent repetition of the observed anomalies in future, these malpractices were still performed by both private and government healthcare facilities of all levels.

Furthermore, it was noted that, NHIF did not step further into termination of the contracts or seeking legal remedy for the same. **Appendix 10** shows facilities claims with recurring anomalies identified through pre-verification.

This was caused by lack of clear criteria on the actions to be taken when the facility committed such misconduct under clause 23 of the contract between NHIF and Service Provider. The clause does not state to what extent of conducted malpractices, the facility will be subjected to warning letter, recovery of fund or termination of the contract.

This resulted into financial loss to the Fund as detailed in **Section 3.2** of this report.

3.6 Inadequate Performance Evaluation Regarding Processing and Payment of Claims from Healthcare Facilities

Section 4.6.6 of Quality Assurance Manual, 2020 require establishment of monitoring system in order to achieve the intended objectives. The monitoring system is supposed to include the following activities among others: Periodic and continuous inspection of facilities; continuous verification of availability, accessibility and quality of services; review of patients information in relation to facility records; periodic and continuous assessment of the performance of all healthcare facilities; client satisfaction surveys; and regular review and checking of functionality of controls put in place.

Quality Assurance Manual 2021, requires medical surveillance to be conducted to continuous monitoring of accessibility to medical services in terms of righteous beneficiaries and quality of services aiming at improving authenticity of claimed services and level of satisfactions to Fund's beneficiaries. This includes intervention towards any identified anomaly in real time which in turn improves service practicality and assures customer satisfaction.

The audit noted that, performance evaluation regarding processing and payment of claims from healthcare facilities were inadequately conducted due to observed anomalies as explained below:

3.6.1 Systems in Place did not ensure Capturing of Real Time Data during Provision of Healthcare Services

Section 3.1.9 of Guidelines and Standards for Integrated Health Facility Electronic Management Systems (iHFeMS), 2016 states that, the iHFeMS should provide managers with a dashboard that offers real time, at-a-glance personalized information related to various activities. The system shall be able to dig deep in the system and come up with real-time reports to support immediate decision-making.

It was noted that, after provision of services to beneficiaries, healthcare facilities submit their claims to NHIF in two ways namely, online submission and offline submission. The online submissions (e-claims) are submitted on a daily basis to the Fund with the attachment documents that include case notes to facilitate claims processing and verification by the Fund; and the offline submission are submitted to NHIF for payment on monthly basis whereby the healthcare facilities are required to compile their claims with an attachment of form 2A, 2 B, 2C, 2E, 6 and 6A.

Review of HMIS maintained by the visited healthcare facilities in Mwanza, Dodoma, and Mbeya Regions and CMIS maintained by NHIF noted that, the HMIS used by healthcare facilities during provision of healthcare services to NHIF beneficiaries were not able to share data at the real time to CMIS for claim processing.

The audit found that lack of real time data sharing between CMIS and HMIS was attributed by:

- Differences of data ownership and privacy policies between

stakeholders who are responsible for the management of CMIS and HIMS systems; and

- HIMs and CMIS were developed to capture different data whereby the HIMS was designated to keep health records in healthcare facilities while the CMIS was developed for the purpose of claim management for provided health services.

Failure of HMIS and CMIS to exchange data at real time limits NHIF efforts to reduce and prevent risk of fraudulent practices conducted by healthcare providers because, it gives opportunities to healthcare facilities to make amendments on folio items. As a result there was high risk of paying for unauthentic claims.

3.6.2 Periodical Monitoring and Evaluation of the Performance of Processing and Payment of Claims were Inadequately Conducted

Quality Assurance Manual 2021, requires medical surveillance to be conducted continuously to monitor accessibility to medical services in terms of righteous beneficiaries and quality of services aiming at improving authenticity of claimed services and level of satisfactions to Fund's beneficiaries.

The audit noted that, NHIF conducted pre and post payment onsite verification as a means of monitoring the processed claims by the healthcare facilities.

Pre verification is done during processing of claim where all (100%) claims submitted to NHIF are verified for their authenticity. Post verification (also referred as onsite verification) is done after payment of the healthcare facility claims whereby 10% of all submitted claims are subject for verification, and it is mainly focusing to high risk[13] healthcare facilities. This helps to mitigate risks of paying for fraudulent claims.

However the audit noted that, onsite claim verification was not adequately conducted to assess the authenticity of submitted claims prior to reimbursement in the period under review as indicated in **Table 3.23** below:

[13] Refer to high reimbursement rate, average monthly claim of five (5) Millions per month Claim trend – significant increase (>10%) on the monthly amount claimed, Comparison of claim trend between facilities located in the same area, History of fraud, non-compliance with issued Guidelines and Standards High number of registered complaints from members/customers, high rate of Out-of-Stock of medicines (>50%).

Table 3. 23: Status of Planed Onsite verification Vs Actual Conducted at NHIF Headquarters

Financial Year	Planned onsite Verification	Actual Conducted Onsite Claim Verification	Variance	Percentage of not conducted (%)
2019/20	12	Not Provided	Not provided	-
2020/21	20	13	7	65
2021/22	28	11	17	39

Source: *Auditors analysis on Annual Performance Reports (2019/20-2021/22)*

Table 3.23 above indicates that, for the financial year 2019/20 none of the 12 planned onsite verification was conducted. For the financial year 2020/21, NHIF conducted 13 onsite claim verification out of 20 planned, which is equivalent to 65%. Likewise, in financial year 2021/22, NHIF conducted 11 onsite claims verification out of 28 planned, which is equivalent to 39%.

Furthermore, through the review of Bugando onsite verification report of November 2019, December 2019 and January 2020 it was revealed that, the facility was not subjected to any onsite claim verification for two calendar years i.e. 2018 and 2019, despite its rapid growth of claims to the tune of TZS 2.8 billion in October 2019 from TZS 1.8 billion in October 2018. The Audit noted that, the average claimed amount per month was TZS 2.4 billion making it a second highly reimbursed facility by NHIF.

Further analysis was conducted to show status of onsite claims verification conducted in visited NHIF regional offices from the financial years 2019/20 to 2021/22 as indicated in **Table 3.24** below.

Table 3. 24: Status of Planed Onsite verification Vs Actual Conducted in Visited NHIF Regional Offices

Region	Financial Year	Planned onsite Verification	Actual Onsite Claim Verification conducted	Percentage of conducted (%)
Dodoma	2019/20	32	39	122
	2020/21	66	62	94
	2021/22	40	46	115
Mwanza	2019/20	32	39	122
	2020/21	20	27	135
	2021/22	24	24	100

Region	Financial Year	Planned onsite Verification	Actual Onsite Claim Verification conducted	Percentage of conducted (%)
Mbeya	2019/20	0	0	0
	2020/21	40	20	50
	2021/22	40	26	65
Ilala	2019/20	32	54	169
	2020/21	48	0	0
	2021/22	96	87	91
Unguja	2019/20	17	17	100
	2020/21	32	24	75
	2021/22	25	23	92

Source: *Auditors Analysis on Annual Action Plans, Implementation Reports (2019/20-2021/22)*

Table 3.24 indicates promising status on conduct of onsite verification at Dodoma, Mwanza, Ilala and Unguja NHIF regional offices. In these regions the conduct of onsite verification ranged from 50% to 169% of the planned numbers.

Interviewed NHIF officials from the visited NHIF region offices indicated that, among the reasons for exceeding the set target for onsite verification for financial year 2019/20 and 2020/21 was the introduction of the use of authorization number to the health facilities especially those under LGA's which necessitated frequent visits to confirm whether beneficiaries receive health services.

Inadequate conduct of onsite verification was attributed to insufficient budget. This was verified through review of Annual Performance report for the financial year 2021/22 which showed that, financial constraints were an obstacle for undertaking onsite verifications.

Other noted reasons for inadequate verification were inadequate staff and ambitious planned number of onsite verifications compared to the resources available.

As a result, NHIF reimburse fund to the service provider for services which were not provided to the beneficiaries as indicated in **section 3.2** of this report. Also, review of Internal Audit report[14] indicated that, 433 out of 314,399 procedures/surgeries worth TZS 46,990,000 were paid for, while these services were not performed. The same was noted on the verification done to various visited facilities in Njombe and Kilimanjaro regional offices and NHIF Head office.

3.6.3 Delay in Developing the M&E Framework for Processing Claims

NHIF is required to have a functioning monitoring framework to monitor the implementation of Strategic Plan which include ensuring improvement in processing of claims.

Review of NHIF Performance report of financial year 2020/21 and 2021/22 showed that, the Fund planned to complete preparation of the Monitoring and Evaluation (M&E) framework by June of the respective years. However, the Fund did not manage to develop monitoring and evaluation framework for two consecutive financial years (2020/21 and 2021/22).

Further review of NHIF Performance report (2021/22) indicated that, the reason for the delay to develop M&E framework was due to issuance of new projects and programs guideline by the Ministry of Finance and Planning. This led the finalization of the framework to be extended to 2022/23. The postponement of the activity to the next financial year 2022/23 was due to overlapping of activities. This implies that establishment of monitoring and evaluation framework was not given high priority, and that is why it has been postponed two times i.e., for financial years 2020/221 and 2021/22.

Audit review of Budget Implementation and Monitoring Booklets for the financial year 2019/20 to 2021/22 noted that, NHIF uses these documents as the guideline for monitoring funds activities including activities for improving claims processing. The developed budget implementation and monitoring booklet comprises action plans and targets of the fund's directorates, units and regional offices. The document serves as a point of

[14] Internal Audit Report on the Benefit Claims Payment and Loans to Service Providers Processes for the Period Ended March 2021

reference for quarterly monitoring of budget performance as well as during the preparation of performance reports.

Nevertheless, the Audit noted that the Monitoring and Evaluation Framework was finalized in December 2022, which was a delay of more than two years.

3.6.4 Key Performance Indicators for Monitoring Claims Processing Activities were not adequately achieved

Review of NHIF Strategic plans for 2015/16-20/21 and 2020/21-2024/25 indicated key performance indicators used for monitoring the performance of planned activities.

It was noted that, these indicators were developed to ensure improvement in claim processing. The developed key performance indicators for claim processing include reduction of staff fraud activities, decrease of fraud cases and increasing beneficiaries' satisfaction with NHIF services.

The audit noted that the set indicators were not adequately implemented as detailed below:

a) Persistence Involvement of Staff in Fraud Cases

Review of NHIF Strategic Plan for the financial year 2020/21 to 2024/25 indicated that corruption deprives customer's rights by creating red tapes, inefficiencies and hence limiting them from accessing services provided by the Fund. Furthermore, most fraud activities led to Fund's loss of revenue of undelivered health services and registering members who do not meet the requirements which may lead to increased expenditure to cover their treatment costs.

However, review of Ant-Fraud Performance reports and various anti-fraud correspondences for financial year 2019/20 to 2021/22 revealed that, there were a number of NHIF staff who colluded with unfaithful healthcare facilities to defraud the fund for personal gain. Further review indicated that a total of 19 NHIF staff were reported for engaging in fraud activities by different service providers for the financial years 2019/20 and 2020/21 as indicated in **Section 3.5.3 (b)** of this report.

b) Persistence of Fraudulent Practices to Healthcare Facilities

Review of Anti-Fraud Annual performance reports for financial years 2019/20 to 2021/22 showed that, the fund conducted antifraud investigations both preventive and detective, to the healthcare facilities suspected with malpractices. The investigations found a total of 301 facilities which defrauded the fund during services provision. The breakdown includes 117 facilities found in financial year 2019/20, 112 in financial year 2020/21 and 72 in financial year 2021/22. Furthermore, it was noted that Health facilities were repetitively defrauding the Fund more than once within a year as indicated in **appendix 10**.

c) Level of Satisfaction of Beneficiaries with NHIF Services

According to NHIF Strategic Plan 2020/21 to 2024/25, the fund is required to measure the level of customer's satisfaction through surveys which should be conducted semi - annually. Customer's satisfaction is assessed in terms of the accuracy and timely claim reimbursement, extent on the availability of medicines and extent to which benefit package suit the expectations.

Based on NHIF Strategic Plan (2020/21 to 2024/25) the set target for attaining customer satisfaction were 83% in the year 2019, 85% in 2020, 87% in 2021 and 90% in 2022.

However, review of customer satisfaction and awareness survey report (2020) indicates that, health service provider's satisfaction stood at 75.9% which is below the target of 83%. The report further states the reason for Healthcare provider's dissatisfaction on NHIF services, among others was failure to communicate changes in their products and services on time.

Furthermore, the audit noted that customer satisfaction surveys were not adequately conducted. This was because in the year 2021 a survey on customer satisfaction was not conducted as per requirement due to budget constraints.

CHAPTER FOUR

AUDIT CONCLUSION

4.1 Introduction

This chapter presents the audit conclusion based on the audit objectives and findings presented in Chapters one and three respectively.

4.2 General Conclusion

The Audit recognizes the efforts made by the National Health Insurance Fund (NHIF) towards improving the control of payments made to healthcare facilities for the purpose of ensuring continuity in accessibility of health care services to the general public. These efforts include: verification and authorization of NHIF beneficiaries before they access healthcare services; conducting supportive supervision; carrying out onsite claims' verifications, undertaking clinical audit and advocacy; ensuring healthcare facilities charge agreed prices; and maintaining of true and proper patients' records.

However, more interventions are still needed to further improve the control of payments made by NHIF to accredited healthcare facilities. This is because, based on the findings, the National Health Insurance Fund (NHIF) has not adequately managed control of payments made to accredited healthcare facilities.

This was evidenced through payments made for unauthentic and incorrect claims which were raised from all levels of healthcare facilities and ownership categories. The Audit, further, indicated that, for the period under review there was a gradual increase of unauthentic and incorrect claims.

All stages of provision of healthcare services were noted to be associated with unauthentic and incorrect claims which include: identification and registration of patients; consultation services; investigation and diagnostic procedures; and dispensing process.

Generally, the audit concludes that, there is inadequate controls during provision of health services to NHIF beneficiaries at healthcare facilities and processing of claims at NHIF. Inadequate control of payments made by NHIF to healthcare facilities is associated with: inadequate compliance to

standard treatment guidelines and contractual agreement during the provision of health insurance services to the entitled beneficiaries; failure of existing control mechanisms at NHIF to adequately ensure claims processed and paid were authentic, correct and complete; failure to timely take remedial actions on unauthentic claims in order to reduce financial losses; and inadequate performance evaluation.

4.3 Specific Conclusions

4.3.1 NHIF has Not Adequately ensured Healthcare Facilities Adhere to STG and Contractual Agreements during the Provision of Services

It is concluded that NHIF did not adequately ensure that certified health service providers provide quality services to the entitled beneficiaries in accordance with the Standard Treatment Guidelines (STG), and basic standards for health facilities as set by the Ministry responsible for Health matters and Service Agreement.

This is because, as the audit noted, for the period under review, 100% of the visited healthcare facilities did not adhere to STG due to inadequate enforcement of contractual agreements and related guidelines issued to the healthcare facilities. In addition, healthcare facilities did not adequately maintain proper patients' records at all points of services; and Information and Communication Systems were not adequately used in claim processing by health facilities.

The Audit further revealed weaknesses in pricing of NHIF packages as compared to prevailing market prices. Variations between market and actual prices charged by the Fund to healthcare facilities was mainly caused by the failure to review the existing prices for more than 6 years.

4.2.2 Established Control Mechanisms at NHIF did not Ensure Claims Processed and Paid to Healthcare Facilities are Authentic and Accurate

It is concluded that, established controls such as verification and authorization of NHIF beneficiaries before they access healthcare services, segregation of duties, quality check of the claims and controls through CMIS to every processed claim did not adequately prevent NHIF from making payment for unauthentic and inaccurate claims raised by healthcare facilities.

This was due to inadequate implementation of the established controls. This was manifested through (i) inadequate verification and authorization of claims; (ii) inadequate segregation of duties during claims processing in the Claims Management Information system which was caused by failure for the system to restrict the officers to verify their own processed claims; and (iii) inadequate quality check of items claimed by healthcare facilities.

It is concluded that, with inadequate implementation of the established controls, NHIF will continue paying unauthentic and incorrect claims which may, in the long run jeopardize the liquidity of the Fund.

4.2.3 NHIF did not Adequately Take Remedial Actions on Unauthentic Claims Submitted by Healthcare Facilities

It is concluded that, NHIF did not take expected remedial actions against healthcare facilities when the later submitted unauthentic claims. The Contract between NHIF and Service Provider gives NHIF the opportunity to reject the claims, terminate the contracts or seek legal remedy in case of acts of fraud.

The Audit found various weaknesses regarding remedial actions taken by NHIF on submitted unauthentic claims by services providers which include: failure to do the reconciliation and adjustments of the doubtful claims within three months from the time when the Fund's decision was effected; failure to recover unauthentic claims; and failure to take actions on the 19 staff from NHIF and 129 staff from healthcare facilities reported to be involved in malpractices.

This laxity resulted in recurring of similar anomalies which include overutilization of investigation test, non-adherence to NHIF pricing, double claiming, improper dosage and quantities, missing details of services and non-adherence to STG throughout the period under review. All these noted anomalies affected the quality of provided healthcare services through NHIF packages and threatens the long-term sustainability of the Fund.

4.2.4 Performance Evaluation Regarding Processing and Payment of Claims was Inadequately Done

Establishment of monitoring system in order to achieve the intended objectives is very crucial. Among others, the monitoring system is supposed to include; (i) periodic and continuous inspection of facilities; (ii) continuous verification of availability, accessibility and quality of services;

(iii) review of patients' information in relation to facility records; (iv) periodic and continuous assessment of the performance of all healthcare facilities; (v) conducting client satisfaction surveys; and (vi) carrying out regular reviews and checking of functionality of controls put in place.

However, performance evaluation regarding processing and payment of claims from healthcare facilities were inadequately conducted because of various weaknesses which were revealed by this audit.

The Audit indicated that (i) The HMIS in use by healthcare facilities was unable to share the real time data with NHIF for further processing; (ii) onsite claim verification prior to reimbursement was inadequately conducted to assess the authenticity of submitted claims; (iii) M&E Framework to ensure improvement in processing of claims was not developed; and; (iv) key performance indicators as developed in the strategic plan were inadequately implemented.

Due to the noted shortcomings, the accessibility to medical services for rightful beneficiaries and quality of services will continue to be affected.

CHAPTER FIVE

AUDIT RECOMMENDATIONS

5.1 Introduction

This chapter contains recommendations to the National Health Insurance Fund (NHIF) regarding the controls of payments made by the Fund to Accredited healthcare facilities.

The audit acknowledges the Government efforts through NHIF towards improving the performance of the established controls of payments. However, more interventions are needed to improve the observed gaps. The National Audit Office expects that based on the principles of 3Es of Economy, Efficiency and Effectiveness, these recommendations need to be fully implemented to ensure improvements in the control of payments made by NHIF to Accredited healthcare facilities.

The recommendations are specifically addressed to the NHIF.

5.2 Audit Recommendations

5.2.1 Adherence to Standard Treatment Guidelines and Contractual Agreement

In order to ensure healthcare Facilities adhere to STG and contractual agreements in the provision of health insurance services to the entitled beneficiaries, NHIF is urged to:

1. Collaborate with Ministry of Health and PO - RALG on strategies that will ensure facilities follow Standard Treatment Guidelines.

5.2.2 Control Mechanisms on Claims Processed and Paid

In order to improve the existing control mechanisms on claims processed and paid to ensure payments made were authentic and correct, NHIF is urged to:

1. Carry out regular reviews of price schedules for all items to reflect current market situation;
2. Set control mechanisms which will ensure claims/folios are submitted for processing on real time upon service delivery;

3. Set and implement strong and cost effective controls for beneficiaries verification and authorization at health facilities to ensure genuine NHIF beneficiaries are obtaining health services; and

5.2.3 Remedial Actions on Unauthentic Claims in order to Reduce Financial Losses

In order to reduce financial losses based on malpractices conducted by healthcare facilities and staff, NHIF is urged to:

1. Collaborate with the Ministry responsible for health and other key stakeholders (such as professional boards, Police, PCCB and professional bodies) to take appropriate actions to staff and healthcare facilities involved in fraudulent activities during provision of health insurance services; and

2. Strengthen recovery mechanism that will ensure the stated amount were recovered from the Healthcare Facilities with malpractices.

5.2.4 Performance Evaluation of NHIF on Processing Payment Claims

In order to enhance periodic performance evaluation of payment claims processing, NHIF is urged to:

1. Ensure Harmonization of ICT systems and make sure that the systems are used by healthcare facilities throughout provision of healthcare services; and

2. Collaborate with e-GA to certify ICT systems used by Health facilities.

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APPENDICES

Appendix 1: Responses from National Health Insurance Fund

This part provides details of the responses from the National Health Insurance Fund regarding provided audit recommendations.

General Responses

The Fund is acknowledging the Performance Audit on Benefit Payment which has just concluded. The Fund believe that all those issues which have been observed by auditors will be used for further improvement and increase Funds' efficiency in provision of health insurance services to her stakeholders.

Specific Responses

N/o	Recommendation	NHIF Comments	Action	Timelines
1	Collaborate with Ministry of Health and PO-RALG on strategies that will ensure facilities follow Standard Treatment Guidelines.	The Fund will continue to advise the Ministry of Health and PO-RALG on the need to monitor implementation of the approved Standard treatment Guidelines. Further to that, the Fund will continue to align its benefit package with approved treatment protocols and reimburse claims from certified healthcare providers in line with the set standards.	Advise the Ministry of Health and PO-RALG to enforce the use of Standard Treatment Guidelines for all healthcare facilities in the country.	By June,2023
2	Set and implement strong	The Fund has	• To enforce	By

	and cost effective controls to all facilities with the required ICT infrastructures" starting with Clinics, Regional hospitals, Zonal and National Hospitals to ensure that only genuine NHIF beneficiaries are accessing health services.	already started to implement the use of biometric (fingerprint) verification for all beneficiaries accessing Dialysis Services as strategy to enhance identification system for rightful beneficiaries. In addition, with effect from 1st April 2023, all students in middle and higher learning institutions will be verified by use of biometric system (fingerprints) before access to medical services. Further to that, the Fund has started piloting the use of facial verification for beneficiaries before access to medical services and the exercise has started in Arusha Region.	the use of National Identification Number (NIN) as mandatory requirement during membership enrollment process for all principal members. • To enforce all certified facilities starting with Clinics, Regional, Zonal and National Hospitals to use biometric system before allowing beneficiaries to access medical services.	June,2024
3	Carry out regular reviews of price schedules for all items to reflect current market	The Fund will continue to carry out the review of	• Undertake market survey	By July,2023

	situations.	benefit package on yearly basis or after every three years as per benefit package guidelines in order to reflect the prevailing market prices in country.	periodically in order to align NHIF price list with prevailing market prices • Conduct actuarial assessment for benefit package review.	
4	Set control mechanisms which will ensure claims/folios are submitted for processing on real time basis upon service delivery.	The Fund will continue to reduce the allowable set 24 hours for submission of claims from certified healthcare providers to real time as a strategy to enforce compliance for online claims submission system.	• Enforce certified healthcare facilities to submit claims on real time. • Enforce membership enrollment process to require capturing of mobile numbers as mandatory. • Provide awareness to certified healthcare	By June,2024

			providers on the importance of real time submission of claims.	
5	Strengthen the collaboration with the Ministry responsible for health and other key stakeholders (such as professional boards, Police, PCCB and Regulatory Authorities) to take appropriate actions to staff and healthcare facilities involved in fraudulent activities during provision of health insurance services.	Since its establishment in 2001, the Fund has been collaborating with government machinery on preventing and combatting fraudulent acts committed by different actors.		
6	Ensure Harmonization of ICT systems and make sure that the systems are used by healthcare facilities throughout all stages of provision of healthcare services.	Health facilities' process workflow differ with that of the Fund (NHIF). As such, harmonization of NHIF system and certified healthcare providers is not practical. However, the Fund will continue to enhance its ICT systems by ensuring it captures and access necessary information available at the facility during	Identify system requirements for continual enhancement of Claims Management Information System (CMIS)	By June,2024

		claims processing.		
7	Collaborate with e-GA to certify ICT systems used by Health facilities.	The Fund will collaborate with e-GA on the issue of system Certification.	Consult e-GA in order to seek guidance on the issue of certification of ICT systems used by healthcare providers in the Country.	By June,2023

Appendix 2: Audit Questions and Sub-questions

This part provides details for the questions which were used during the Audit

S/No.	Main Audit question
Audit Question 1	**To what extent does NHIF ensure claims processed are authentic, correct and complete?**
Sub-question 1.1	Are the claims processed by NHIF authentic and correct?
Sub-question 1.2	Are the payments made to healthcare facilities authentic, correct and complete?
Sub-question 1.3	Does NHIF ensure authenticity of claims before payments are prepared?
Sub-question 1.4	Are control mechanisms ensuring correctness and completeness of the claims?
Audit Question 2	**Does the NHIF ensure healthcare facilities adhere to standard treatment guidelines and contractual agreements during the provision of services to entitled beneficiaries?**
Sub-question 2.1	Does NHIF ensure health services provided by Health Facilities adhered to the established standards on clinical conditions, diagnostic criteria, non- pharmacological, medicines of choice for the medical condition and important prescribing information?
Sub-question 2.2	Does NHIF ensure Health Facilities provide health services as per agreed price schedule?
Sub-question 2.3	Does NHIF ensure Health Facilities manage and maintain true and proper patients' records in all points of service in accordance with the guidelines provided by the Ministry responsible for health?
Sub-question 2.4	Does NHIF ensure Health Facilities make effective use of the Fund's installed information and communication system in claims processing?
***Audit Question* 3**	**Do control mechanisms at NHIF ensure claims processed and paid to healthcare facilities are authentic and accurate?**
Sub-question 3.1	Are mechanisms for verification and authorization of valid members ensure genuine payments are made based on health services provided to beneficiaries?
Sub-question 3.2	Does claim processing at NHIF consider segregation of duties?
Sub-question 3.3	Does the aging level of claims adhere to the Funds strategic targets?

Sub-question 3.4	Do the items claimed and paid quality checked to ensure are in line with the service provided?
Sub-question 3.5	Do claim information management systems ensure claims processed are authentic and correct?
***Audit Question* 4**	**Does NHIF take remedial actions on unauthentic claims to reduce financial losses?**
Sub-question 4.1	Does NHIF make timely reconciliation and adjustments of doubtful claims?
Sub-question 4.2	Do verification and fraud investigation mitigate submission of unauthentic claim?
Sub-question 4.3	Are recovery mechanisms for post payment verification and fraud investigation effective?
Audit Question 5	**Does the NHIF conduct the Performance evaluation regarding processing and payment of claims from healthcare facilities?**
Sub-question 5.1	Are systems in place ensure capturing data at real time during provision of health services?
Sub-question 5.2	Does NHIF conduct periodical monitoring and evaluation on the performance of processing and payment of claims?
Sub-question 5.3	Does the established M&E framework ensure improvement in processing of claims?
Sub-question 5.4	Does NHIF develop and monitor key performance indicators on claims processing activities?

Source: *Auditor's analysis (2022)*

Appendix 3A: Claims Ranking

This part provides details of Claims from NHIF Regional Offices which were ranked based on the amount claimed and paid.

Claims Intervals	Region	Claims Paid	Percentage of Claims Paid
High (TZS 100 to 149 billion)	Ilala	121,617,686,716.49	54
	Kinondoni	102,415,486,755.00	46
		224,033,173,471.49	**100**
Medium (TZS 50 to 99 billion)	Mwanza	50,960,037,625.00	100
		50,960,037,625.00	**100**
Low (TZS 0 – 49 billion)	Kilimanjaro	30,169,329,295.00	13
	Arusha	24,398,413,040.00	11
	Manyara	3,975,075,515.00	2
	Tanga	11,137,862,618.00	5
	Singida	5,235,047,310.00	2
	Dodoma	27,137,625,728.00	12
	Tabora	7,402,677,465.00	3
	Katavi	873,063,670.00	0
	Kigoma	5,505,887,685.00	2
	Iringa	6,288,446,930.00	3
	Ruvuma	6,897,504,560.00	3
	Njombe	5,371,629,760.00	2
	Mbeya	26,540,033,780.00	12
	Songwe	1,652,507,215.00	1
	Mtwara	4,646,246,440.00	2
	Lindi	1,991,610,780.00	1
	Kagera	7,532,072,070.00	3
	Mara	6,206,164,040.00	3
	Geita	5,300,806,955.00	2
	Shinyanga	2,987,916,991.00	1
	Rukwa	2,411,968,850.00	1
	Simiyu	1,180,402,565.00	1
	Temeke	20,172,707,891.00	8
	Morogoro	9,868,344,310.00	4

Claims Intervals	Region	Claims Paid	Percentage of Claims Paid
	Pwani	4,380,953,050.00	2
		226,852,329,663.00	**100**
High	Zanzibar (Unguja)	10,560,256,662.00	98
	Kusini Pemba	85,776,080.00	1
	Kaskazini Pemba	70,024,725.00	1
		10,716,057,467.00	**100**

Appendix 3B: Availability of all categories of healthcare facilities

This part provides status of visited healthcare facilities from each level.

Region	National	Zonal	Regional	District	Dispensary	Health Center	Pharmacy	Specialized Clinic
Arusha	X	∫	∫	∫	∫	∫	∫	∫
Kilimanjaro	∫	∫	∫	∫	∫	∫	∫	∫
Manyara	X	X	∫	∫	∫	∫	∫	∫
Tanga	X	X	∫	∫	∫	∫	∫	∫
Morogoro	X	X	∫	∫	∫	∫	∫	∫
Pwani	X	X	∫	∫	∫	∫	∫	∫
Kinondoni	∫	∫	∫	∫	∫	∫	∫	∫
Ilala	∫	∫	∫	∫	∫	∫	∫	∫
Temeke	X	∫	∫	∫	∫	∫	∫	∫
Singida	X	X	∫	∫	∫	∫	∫	∫
Dodoma	∫	∫	∫	∫	∫	∫	∫	∫
Tabora	X	X	∫	∫	∫	∫	∫	∫
Katavi	X	X	∫	∫	∫	∫	∫	∫
Kigoma	X	X	∫	∫	∫	∫	∫	∫
Shinyanga	X	X	∫	∫	∫	∫	∫	∫
Kagera	X	X	∫	∫	∫	∫	∫	∫
Mwanza	X	∫	∫	∫	∫	∫	∫	∫
Mara	X	X	∫	∫	∫	∫	∫	∫
Simiyu	X	X	∫	∫	∫	∫	∫	∫
Geita	X	∫	∫	∫	∫	∫	∫	∫
Iringa	X	X	∫	∫	∫	∫	∫	∫
Ruvuma	X	X	∫	∫	∫	∫	∫	∫
Njombe	X	X	∫	∫	∫	∫	∫	∫
Mbeya	X	∫	∫	∫	∫	∫	∫	∫
Songwe	X	X	∫	∫	∫	∫	∫	∫
Mtwara	X	∫	∫	∫	∫	∫	∫	∫
Lindi	X	X	∫	∫	∫	∫	∫	∫
Kusini Pemba	X	X	∫	∫	∫	∫	∫	∫

Region	National	Zonal	Regional	District	Dispensary	Health Center	Pharmacy	Specialized Clinic
Zanzibar (Unguja)	∫	∫	∫	∫	∫	∫	∫	∫
Kaskazini Pemba	X	X	∫	∫	∫	∫	∫	∫
Rukwa	X	x	∫	∫	∫	∫	∫	∫

Appendix 3C: Ownership of Healthcare Facilities in Regions

This part provides status of visited healthcare facilities based on their category of ownership

Region	Government	Private	Faith Based
Arusha	√	√	√
Kilimanjaro	√	√	√
Manyara	√	√	√
Tanga	√	√	√
Morogoro	√	√	√
Pwani	√	√	√
Kinondoni	√	√	√
Ilala	√	√	√
Temeke	√	√	√
Singida	√	√	√
Dodoma	√	√	√
Tabora	√	√	√
Katavi	√	√	√
Kigoma	√	√	√
Shinyanga	√	√	√
Kagera	√	√	√
Mwanza	√	√	√
Mara	√	√	√
Simiyu	√	√	√
Geita	√	√	√
Iringa	√	√	√
Ruvuma	√	√	√
Njombe	√	√	√
Mbeya	√	√	√
Songwe	√	√	√
Mtwara	√	√	√
Lindi	√	√	√
Kusini Pemba	√	√	√
Zanzibar (Unguja)	√	√	√

Region	Government	Private	Faith Based
Kaskazini Pemba	√	√	√
Rukwa	√	√	√

Appendix 4: Documents reviewed during the audit

This part provides details of the documents that were reviewed and the reasons for reviewing them.

Organisation	Name of Document	Reason
NHIF	Claim Files	• To identify authenticity of the items claimed. • To establish whether non-members obtained services from healthcare facilities
	Settlement Reports	• To establish reasons for adjustment and rejection of claims • To establish and assess corrective measures taken by NHIF due to malpractices committed by healthcare Facilities
	Claim History	• To establish whether segregation of duties was observed during processing of claims • To establish aging level of claim processing
	Pre-verification Reports	• To establish extent of malpractices committed by healthcare facilities • To establish reasons for rejections and adjustments • To establish and assess corrective measure taken by NHIF to address anomaly noted the verification exercise.
	Post-Verification Reports	• To establish extent of fraudulent practices • To establish whether healthcare observe STG and contractual agreement • To establish impact of verification exercises
	Fraud Investigation Reports	• To establish extent of fraudulent practices • To assess reasons for fraudulent practices by healthcare facilities • To assess corrective measure taken by NHIF
	Budget Implementation Reports	• To establish performance of the set targets • To establish effectiveness of the budgetary controls
	Cash books	• To establish claim trend to the respective facilities
	Payment Vouchers	• To establish effective payment controls
	Beneficiaries database	• To assess beneficiaries' status

Organisation	Name of Document	Reason
	Facilities Database	• To establish contractual status of healthcare facilities
Healthcare Facilities	Form 2 (a) (b) (c)	• To establish whether items recorded in the forms are the ones recorded in the MTUHA and provided to the entitled beneficiaries.
	MTUHA (1-18)/Registers	• To establish whether all investigation claimed were provided to the entitled beneficiaries
	Case Note	• To investigate authenticity of the prescription provided by the clinician/medical officer
	System Reports	• To establish timing of data sharing to NHIF and other key stakeholders • To establish effectiveness of the system controls

Source: *Literature Review and Auditor's analysis (2022)*

Appendix 5: List of Officials Interviewed during the Audit

This part provides details of the Officials who were interviewed and the reasons for interviewing them.

Organisation	Interviewee	Reason(s)
NHIF	Claim Manager	• To assess whether data captured in the systems are similar to the ones summited in physical claims. • To assess how they check and adjust on-medical issues. • To assess how they conduct monthly reconciliation of payment records between claims and accounts.
	Quality Assurance Manger	• To assess how they ensure management given to the NHIF members by Facilities followed the standards set by the Ministry of Health. • To assess how they note and document any indicative feature of fraud and other malpractices. • To assess how they make adjustments and rejections through CMIS.
	Regional Managers	• To assess how they preview main features of respective claim files and prepare and recommend or approve claim files. • To assess how they preview information provided in the particular claim file in the previous stages. • To assess how they reverse claim files to previous stages for rectification of any noted anomaly.
	Membership Manager	• To assess how membership status are managed. • To assess how they record, maintain and share member information to the key stakeholders.
	Anti-fraud Manager	• To assess remedial actions taken due to proven fraud cases • To establish impact of fraud investigation on mitigation of fraudulent practices
	Manager actuarial	• To assess impact of actuarial valuation of the Fund

Organisation	Interviewee	Reason(s)
	services and of statistics	
	Accountant	• To assess how they make payment, deduct and refund healthcare facilities. • To understand how they make reconciliations with claim submitted and paid.
	ICT officer	• To establish how they upgrade ICT system to address challenges associated with claim processing. • To assess the functionality and challenges of the set controls in ICT systems.
Healthcare Provider	Medical Officer	• To assess how they adhere ethics and guidelines issued by medical councils. • To understand how they adhere STG and contractual agreement.
	Pharmacist	• To assess how they keep records based on MTUHA and dispense medicine to beneficiaries.
	Laboratory Technician	• To assess how they maintain MTUHA and carryout investigations. • To ascertain whether STG and contractual agreements are adhered to.

Source: *Literature Review and Auditor's analysis (2022)*

Appendix 6 A: Decrease in Total Benefit Payment for Top 20 Medicines If Market Prices Were Adopted

This part provides details on Decrease in Total Benefit Payment for Top 20 Medicines

Item code	Generic name	Strength	Dosage form	Unit Price (NHIF Pricelist 2016)		Total Quantity			Amount Paid (NHIF Pricelist 2016)			Amount Paid (Median (Retail)		
					Median (Retail)	2019-2020	2020-2021	2021-2022	2019 - 2020	2020-2021	2021-2022	2019 - 2020	2020-2021	2021-2022
11226	Bevazicumab/Avastin	Injection: 100mg	Vial /Ampule	50,000	1,155,000			-						
11226	Bevazicumab/Avastin	Injection: 100mg	Vial /Ampule	1,300,000	1,155,000	39	1,579	2,082	50,700,000	2,052,700,000	2,706,600,000	45,045,000	1,823,745,000	2,404,710,000
11439	Amlodipine Solid Oral Dosage Form	10mg	Tabs	350	300	181,184	765,155	1,388,762	63,414,400	267,804,250	486,066,700	54,355,200	229,546,500	416,628,600
11107	Amoxycillin + Clavulanic Acid Solid Oral Dosage Form	500mg + 125mg	Tabs	1,250	1,000	128,340	567,362	1,109,169	160,425,000	709,202,500	1,386,461,250	128,340,000	567,362,000	1,109,169,000
11107	Amoxycillin + Clavulanic Acid Solid Oral Dosage Form	500mg + 125mg	Tabs	2,500	1,000	465	672	1,080	1,162,500	1,680,000	2,700,000	465,000	672,000	1,080,000
11113	Ampicillin + Cloxacillin Solid Oral Dosage Form	250mg + 250mg	Caps	190	200	150,450	305,855	602,052	28,585,500	58,112,450	114,389,880	30,090,000	61,171,000	120,410,400
11489	Atorvastatin	20mg	Tabs											

	Solid Oral Dosage Form			800	500	132,752	876,215	1,252,314	106,201,600	700,972,000	1,001,851,200	66,376,000	438,107,500	626,157,000
11127	Ceftriaxone	1000mg	Injection	2,500	3,000	21,947	87,946	132,061	54,867,500	219,865,000	330,152,500	65,841,000	263,838,000	396,183,000
11100	Clarythromycin + Tinidazole + Lansoprazole Solid Oral Dosage Form	250mg/500mg/30mg	Tabs	33,750	881	8	5	6	270,000	168,750	202,500	7,048	4,405	5,286
11100	Clarythromycin + Tinidazole + Lansoprazole Solid Oral Dosage Form	250mg/500mg/30mg	Tabs	40,000	881	3,716	9,057	13,410	148,640,000	362,280,000	536,400,000	3,273,796	7,979,217	11,814,210
12242	Cough Mixture Solution	100ml/125ml	Solution	2,600	3,000	15,782	69,611	171,077	41,033,200	180,988,600	444,800,200	47,346,000	208,833,000	513,231,000
12242	Cough Mixture Solution	100ml/125ml	Solution	3,000	3,000	2	1		6,000	3,000	-	6,000	3,000	-
12242	Cough Mixture Solution	100ml/125ml	Solution	7,000	3,000	67	86	143	469,000	602,000	1,001,000	201,000	258,000	429,000
11291	Erythropoietin/ Nanokine/Epo/ Wepox	4,000 IU	Inj	66,000	26,500	6,856	19,570	31,396	452,496,000	1,291,620,000	2,072,136,000	181,684,000	518,605,000	831,994,000
11411	Ferrous And Folic Acid Solid Oral Dosage Form	200mg+ 5mg Tablet	Tabs	90	100	40,652	79,475	398,361	3,658,680	7,152,750	35,852,490	4,065,200	7,947,500	39,836,100
11410	Ferrous And	200mg + 5mg	Caps									-	-	-

	Folic Acid Solid Oral Dosage Form Capsules			250		503	300	538	125,750	75,000	134,500			
11410	Ferrous And Folic Acid Solid Oral Dosage Form Capsules	200mg + 5mg	Caps	500		78,494	504,661	772,886	39,247,000	252,330,500	386,443,000	-	-	-
11425	Glucosamin + Chondrioting Solid Oral Dosage Form	20mg	Caps	750	1,000	92,254	446,123	721,952	69,190,500	334,592,250	541,464,000	92,254,000	446,123,000	721,952,000
11463	Hydrochlorthiazide + Losartan Solid Oral Dosage Form	12.5mg + 50mg	Tabs	750	700	161,268	810,834	1,720,095	120,951,000	608,125,500	1,290,071,250	112,887,600	567,583,800	1,204,066,500
355631	Ketoprofen Cream Or Gel	30gm	Crea m/g el	11,500	10,000			11	-	-	126,500	-	-	110,000
11617	Metformin + Glimipride Solid Oral Dosage Form	500mg + 2mg	Tabs	15,000	950	1,473	5,619	13,060	22,095,000	84,285,000	195,900,000	1,399,350	5,338,050	12,407,000
12066	Pregabalin Solid Oral Dosage Form	75mg	Caps	1,150	1,000	446	790	684	512,900	908,500	786,600	446,000	790,000	684,000
12066	Pregabalin Solid Oral Dosage Form	75mg	Caps	1,350	1,000	231,426	968,993	1,779,749	312,425,100	1,308,140,550	2,402,661,150	231,426,000	968,993,000	1,779,749,000
12066	Pregabalin Solid Oral Dosage Form	75mg	Caps	1,650	1,000		30		-	49,500	-	-	30,000	-
11587	Rabeprazole Solid Oral Dosage Form	20mg	Tabs	1,000	800	41,081	113,54	276,014	41,081,000	113,549,00	276,014,00	32,864,800	90,839,200	220,811,20

							9			0	0			0
12196	Telmisartan + Hydrochlorothiazide Solid Oral Dosage Form	80mg + 12.5mg	Tabs	1,200	975	107,160	718,852	862,216	128,592,000	862,622,400	1,034,659,200	104,481,000	700,880,700	840,660,600
11279	Trustuzumab/Herceptin	150mg	Inj	2,930,000	1,835,000	49	437	110	143,570,000	1,280,410,000	322,300,000	89,915,000	801,895,000	201,850,000
12247	Vitamin B1, B6, B12, Folic Acid Solid OralDosage Form	150mg	Caps	500	600	104,503	905,779	1,313,918	52,251,500	452,889,500	656,959,000	62,701,800	543,467,400	788,350,800
12247	Vitamin B1, B6, B12, Folic Acid Solid OralDosage Form	150mg	Caps	750	600			11	-	-	8,250	-	-	6,600
Grand Total						**1,500,917**	**7,258,556**	**12,563,157**	**2,041,971,130**	**11,136,841,020**	**16,226,281,400**	**1,355,470,794**	**8,254,012,272**	**12,242,295,296**
Saving if market survey was adopted									**686,500,336**	**2,882,828,748**	**3,983,986,104**			

Appendix 6 B: Decrease in Total Benefit Payment for 7 Anticancer Medicines If Market Prices Were Adopted

This part provides details on Decrease in Total Benefit Payment for 7 Anticancer Medicines

Item	Quantity			Unit Price		Amount paid (TZS) under NHIF price 2016 (A)			Amount could be Paid (TZS) under Market Price (B)		
	2019/20	2020/21	2021/22	NHIF 2016	Market Price	2019/20	2020/21	2021/22	2019/20	2020/21	2021/22
5-Fluorouracil	82.72727	329.8485	414.697	3,300	5,100	273,000.00	1,088,500.00	1,368,500.00	421,909.09	1,682,227.27	2,114,954.55
5-Fluorouracil	903.2571	1587.771	2217.6	3,500	3,000	3,161,400.00	5,557,200.00	7,761,600.00	2,709,771.43	4,763,314.29	6,652,800.00
Anastrazole® Arimidex	1664	2560	3378	8,000	4,333	13,312,000.00	20,480,000.00	27,024,000.00	7,210,112.00	11,092,480.00	14,636,874.00
Bevazicumab /Avastin	1916	3890	4788	1,300,000	1,155,000	2,490,800,000.00	5,057,000,000.00	6,224,400,000.00	2,212,980,000.00	4,492,950,000.00	5,530,140,000.00
Docetaxel	672	1630	1873	574,300	200,000	385,929,600.00	936,109,000.00	1,075,663,900.00	134,400,000.00	326,000,000.00	374,600,000.00
Rituximab	22.2	45.4	29.8	4,230,000	2,000,000	93,906,000.00	192,042,000.00	126,054,000.00	44,400,000.00	90,800,000.00	59,600,000.00
Rituximab	495	1275	1165	846,000	787,500	418,770,000.00	1,078,650,000.00	985,590,000.00	389,812,500.00	1,004,062,500.00	917,437,500.00
Total						**3,406,152,000.00**	**7,290,926,700.00**	**8,447,862,000.00**	**2,791,934,292.52**	**5,931,350,521.56**	**6,905,182,128.55**
Saving (A-B)									614,217,707.48	1,359,576,178.44	1,542,679,871.45

Appendix 7: Folios Approved and Paid with Initials

This part provides details on folios approved and paid with initials

S/N	File number	Card Number	Authorization Number	Amount (TZS)
1	P2584/TMK/07/2021/2107	404501759698	260123627149	29,000
2	P2584/TMK/07/2021/2107	405101757217	560123816933	35,000
3	P2584/TMK/07/2021/2107	409500115341	460123817616	17,500
4	P2584/TMK/07/2021/2107	101700759554	160123717206	9960
5	P2584/TMK/07/2021/2107	107300370991	360123082259	129,340
6	P2584/TMK/07/2021/2107	059185700	960123424888	33,350
7	P2584/TMK/07/2021/2107	402601810079	560123599964	65,800
8	P2584/TMK/07/2021/2107	403101317887	160123575180	67,700
9	P2584/TMK/07/2021/2107	029424452	860123705434	35,000
10	P2584/TMK/07/2021/2107	406700119501	260123769470	37,000
11	P2584/TMK/07/2021/2107	511200361660	760123794224	61,300
12	P2584/TMK/07/2021/2107	210800506364	760123728546	40,000
13	P2584/TMK/07/2021/2107	101902450444	460123259425	327,275
14	P2584/TMK/07/2021/2107	101502092077	660123504105	40,000
15	P2584/TMK/07/2021/2107	302402040053	960123591872	110,980
16	P2584/TMK/07/2021/2107	107300242342	160123788835	69,000
17	P2584/TMK/07/2021/2107	406100906310	960123811501	27,750
18	P2584/TMK/07/2021/2107	05106222441	160123806569	60,000
19	P2584/TMK/07/2021/2107	101102533651	560123598437	65,000
20	P2584/TMK/07/2021/2107	106100806695	360123691550	38,000
21	P2584/TMK/07/2021/2107	402301208187	560123618298	103,500
22	P2584/TMK/07/2021/2107	1011702327881	260123791176	82,200
23	P2584/TMK/07/2021/2107	104900508598	260123294886	58,960
24	P2584/TMK/07/2021/2107	101102474854	760123125693	20,500
25	P2584/TMK/07/2021/2107	404401753435	660123179057	36,700
26	P2584/TMK/07/2021/2107	101802432432	860123302206	40,200

S/N	File number	Card Number	Authorization Number	Amount (TZS)
27	P2584/TMK/07/2021/2107	03-10817544	760123741147	102,800
28	P2584/TMK/07/2021/2107	407400371340	660123616075	61,500
29	P2584/TMK/07/2021/2107	404101669800	660123336706	39,600
30	P2584/TMK/07/2021/2107	05-11801652	960123335647	39,600
31	P2584/TMK/07/2021/2107	102602239374	560123336431	54,600
32	P2584/TMK/07/2021/2107	101902375822	760123795157	56,000
33	P2584/TMK/07/2021/2107	101602322977	260123572287	7,000
34	P2584/TMK/07/2021/2107	204101233285	360123708087	50,600
35	P2584/TMK/07/2021/2107	101400949273	660123832303	29,250
36	P2584/TMK/07/2021/2107	101102450989	460123832479	30,150
37	P2584/TMK/07/2021/2107	101402474360	600034036012	78,035
38	P2584/TMK/07/2021/2107	01-10979433	860122941662	72,300
39	P2584/TMK/07/2021/2107	101402141729	660123748662	27,000
40	P2584/TMK/07/2021/2107	403401146039	260123293148	42,000
41	P2584/TMK/07/2021/2107	101902475249	560123011583	26,6000
	Sub total			**2,597,450**
1	P2584/TMK/07/2021/2107	03-10817544	860123789371	27,100
2	P2584/TMK/07/2021/2107	202601487172	760122796515	20,850
3	P2584/TMK/07/2021/2107	101102103786	160123189741	73,120
4	P2584/TMK/07/2021/2107	101102103786	260122870773	18,250
	Sub total			**139,320**
1	P2584/TMK/05/2021/2377	02RT9168824	840121321331	15,700
2	P2584/TMK/05/2021/2377	101902379707	240121332162	56,700
3	P2584/TMK/05/2021/2377	202701518839	140121314504	47,700
4	P2584/TMK/05/2021/2377	406101499149	440121230167	44,000
5	P2584/TMK/05/2021/2377	204602007492	840121227071	63,220
6	P2584/TMK/05/2021/2377	02-8598811	340121229171	81,200
7	P2584/TMK/05/2021/2377	208900242041	140121323705	34,200
8	P2584/TMK/05/2021/2377	101502502439	740121264167	18,185
9	P2584/TMK/05/2021/2377	101800713014	940121199115	14,250

S/N	File number	Card Number	Authorization Number	Amount (TZS)
10	P2584/TMK/05/2021/2377	101202450454	540121238522	21,800
11	P2584/TMK/05/2021/2377	402100805537	140121343196	23,700
12	P2584/TMK/05/2021/2377	504400484477	240121290899	41,500
13	P2584/TMK/05/2021/2377	403701664772	640121290264	67,000
14	P2584/TMK/05/2021/2377	101502502439	140121288516	9,600
15	P2584/TMK/05/2021/2377	01-3742697	640121262742	133,300
16	P2584/TMK/05/2021/2377	402900809978	140121314121	49,500
17	P2584/TMK/05/2021/2377	403200583727	940121334071	58,000
18	P2584/TMK/05/2021/2377	101902042724	840121092169	159,000
19	P2584/TMK/05/2021/2377	104601396656	140120918451	28,000
20	P2584/TMK/05/2021/2377	405700312315	840121115437	91,500
21	P2584/TMK/05/2021/2377	407900083217	740121147938	127,900
22	P2584/TMK/05/2021/2377	06-7105513	640121115727	87,200
23	P2584/TMK/05/2021/2377	101302474406	840121036518	15,360
24	P2584/TMK/05/2021/2377	01-9588275	540120908428	19,410
25	P2584/TMK/05/2021/2377	202901460505	140120865368	55,000
26	P2584/TMK/05/2021/2377	305900740738	140120890427	37,000
27	P2584/TMK/05/2021/2377	04-10796368	640120924658	55,500
28	P2584/TMK/05/2021/2377	03-11416645	640120449416	10,000
29	P2584/TMK/05/2021/2377	101502506437	340120866432	63,500
	Sub total			**1,528,925**
1	P2584/TMK/05/2021/2377	01-9426146	340120975233	30,400
2	P2584/TMK/05/2021/2377	03-12010029	140120605729	53,800
3	P2584/TMK/05/2021/2377	204901421629	140120908704	20,450
4	P2584/TMK/05/2021/2377	101902335659	340120715907	15,000
5	P2584/TMK/05/2021/2377	202301218803	740120474936	112,700
6	P2584/TMK/05/2021/2377	403601195312	140120455559	21,960
7	P2584/TMK/05/2021/2377	409700372777	840120468303	62,700
8	P2584/TMK/05/2021/2377	04-9817878	740120457838	13,500
9	P2584/TMK/05/2021/2377	107300370991	340120493793	30,710

S/N	File number	Card Number	Authorization Number	Amount (TZS)
10	P2584/TMK/05/2021/2377	103600802242	440120538400	76,000
11	P2584/TMK/05/2021/2377	101102283463	440120463764	75,000
12	P2584/TMK/05/2021/2377	205201302693	340120539521	20,700
	Sub total			**532,920**
1	P2584/TMK/07/2021/2107	101102533651	8601223071153	68,900
2	P2584/TMK/07/2021/2107	101102493757	360123065599	15,000
3	P2584/TMK/07/2021/2107	101802534990	660122939704	18,960
4	P2584/TMK/07/2021/2107	101102628769	460122943839	78,960
5	P2584/TMK/07/2021/2107	1012022420112	7601227783386	31,360
6	P2584/TMK/07/2021/2107	105801171233	960122874394	30,110
7	P2584/TMK/07/2021/2107	03-10829642	860122858528	23,100
8	P2584/TMK/07/2021/2107	101602533922	960122872608	28,850
9	P2584/TMK/07/2021/2107	402400970666	6601233211672	70,000
10	P2584/TMK/07/2021/2107	101202193078	160123221835	75,000
11	P2584/TMK/07/2021/2107	101902628942	860123203516	20,000
12	P2584/TMK/07/2021/2107	101702389117	260123153462	89,360
13	P2584/TMK/07/2021/2107	101102347524	260123189496	22,400
14	P2584/TMK/07/2021/2107	402900096040	660123165647	92,750
15	P2584/TMK/07/2021/2107	101902334065	660123235685	19,400
16	P2584/TMK/07/2021/2107	405401328756	460123062290	66,600
17	P2584/TMK/07/2021/2107	101302498433	460123048117	38,000
18	P2584/TMK/07/2021/2107	101902450444	760122789643	15,000
19	P2584/TMK/07/2021/2107	404502231001	460122797140	76,200
20	P2584/TMK/07/2021/2107	404502231001	460122797140	30,000
21	P2584/TMK/07/2021/2107	403700678770	360122801626	26,500
22	P2584/TMK/07/2021/2107	403602554668	260122790800	18,700
23	P2584/TMK/07/2021/2107	03-11229870	7601230332492	21,000
24	P2584/TMK/07/2021/2107	102602239374	460123021514	47,800
25	P2584/TMK/07/2021/2107	102602239374	460123021514	31,500
26	P2584/TMK/07/2021/2107	101402475312	460123020269	29,840

S/N	File number	Card Number	Authorization Number	Amount (TZS)
27	P2584/TMK/07/2021/2107	101402475312	460123020269	17,500
28	P2584/TMK/07/2021/2107	101702628995	760122796218	9,500
29	P2584/TMK/07/2021/2107	101502363825	360122788499	31,580
30	P2584/TMK/07/2021/2107	101602187538	660122790370	27,600
31	P2584/TMK/07/2021/2107	107300370991	1601229998154	44,860
32	P2584/TMK/07/2021/2107	102401974854	860123027846	37,500
33	P2584/TMK/07/2021/2107	202401399459	760123022240	42,500
34	P2584/TMK/07/2021/2107	01-9426146	160122726974	95,000
35	P2584/TMK/07/2021/2107	01-9426146	160122726974	39,500
36	P2584/TMK/07/2021/2107	101302411081	76122717389	25,000
37	P2584/TMK/07/2021/2107	101102323641	560122729025	13,900
38	P2584/TMK/07/2021/2107	208900409505	560122733563	37,500
39	P2584/TMK/07/2021/2107	04-10014572	260123072521	72,000
	Sub total			**1,579,230**
1	P2584/TMK/07/2021/2107	408700123959	860122716721	70,360
2	P2584/TMK/07/2021/2107	101102475364	160122662850	71,500
3	P2584/TMK/07/2021/2107	101102333305	160122671012	44,700
4	P2584/TMK/07/2021/2107	4051011952880	160123061407	17,000
5	P2584/TMK/07/2021/2107	101502158902	560123073260	64,000
6	P2584/TMK/07/2021/2107	101202628914	460122750888	25,360
7	P2584/TMK/07/2021/2107	101702327881	160122667813	36,900
8	P2584/TMK/07/2021/2107	101602457297	160122687684	33,280
9	P2584/TMK/07/2021/2107	208300330995	460122712495	21,200
10	P2584/TMK/07/2021/2107	204101522235	860122860523	19,360
11	P2584/TMK/07/2021/2107	02-9742323	160122673660	20,000
12	P2584/TMK/07/2021/2107	101602533779	860122728317	28,860
13	P2584/TMK/07/2021/2107	406601518678	160122883537	15,000
14	P2584/TMK/07/2021/2107	02-8364560	560122885637	21,999
15	P2584/TMK/07/2021/2107	101402474902	650122611167	35,000
16	P2584/TMK/07/2021/2107	101402474902	650122611167	15,000

S/N	File number	Card Number	Authorization Number	Amount (TZS)
17	P2584/TMK/07/2021/2107	406601518678	160122750197	81,000
18	P2584/TMK/07/2021/2107	406601518678	160122750197	15,000
19	P2584/TMK/07/2021/2107	101602533960	860122746434	18,250
20	P2584/TMK/07/2021/2107	407700269299	560121751817	60,000
21	P2584/TMK/07/2021/2107	101402092601	360122758690	45,000
22	P2584/TMK/07/2021/2107	101401947223	240121340008	26,300
	Sub total			**785,069**
1	P2584/TMK/05/2021/2377	206900627954	140121212870	105,500
2	P2584/TMK/05/2021/2377	01-7204014	940121386423	52,000
3	P2584/TMK/05/2021/2377	101200640413	540121204833	39,100
4	P2584/TMK/05/2021/2377	101400761820	340121040303	80,300
5	P2584/TMK/05/2021/2377	02-7514438	140121186885	149,185
6	P2584/TMK/05/2021/2377	402600153016	340121259996	27,360
7	P2584/TMK/05/2021/2377	302602379094	640120525604	65,900
8	P2584/TMK/05/2021/2377	202901947297	840121376740	39,000
9	P2584/TMK/05/2021/2377	304201731714	740121091617	45,000
10	P2584/TMK/05/2021/2377	1017024505227	140121239278	27,860
	Sub total			**631,205**
1	P2584/TMK/05/2021/2377	101102475417	240120803700	8,500
2	P2584/TMK/05/2021/2377	408801647776	340121376378	33,000
3	P2584/TMK/05/2021/2377	01-RTMNH3275	640121380446	88,860
4	P2584/TMK/05/2021/2377	101701847908	340120735541	367,305
5	P2584/TMK/05/2021/2377	101601830565	240121293096	27,000
6	P2584/TMK/05/2021/2377	106200206466	14011108339	10,000
7	P2584/TMK/05/2021/2377	402600914549	7401210224842	35,000
8	P2584/TMK/05/2021/2377	02-RTMNH6572	640121028511	35,900
9	P2584/TMK/05/2021/2377	101700759554	440121161135	25,900
10	P2584/TMK/05/2021/2377	03-10817544	940120712533	45,900
11	P2584/TMK/05/2021/2377	101102224979	140121319572	25,900
12	P2584/TMK/05/2021/2377	03-10979950	640121362534	26,800

S/N	File number	Card Number	Authorization Number	Amount (TZS)
13	P2584/TMK/05/2021/2377	404200559968	240121415658	27,100
14	P2584/TMK/05/2021/2377	404101669800	140120704074	55,900
15	P2584/TMK/05/2021/2377	01-7220166	840120865517	25,900
16	P2584/TMK/05/2021/2377	202301277534	140120960720	36,050
17	P2584/TMK/05/2021/2377	05-10621673	740120783171	45,000
18	P2584/TMK/05/2021/2377	402101455985	640120438894	91,800
19	P2584/TMK/05/2021/2377	208800296142	840120699198	45,900
20	P2584/TMK/05/2021/2377	05-10215634	340120655786	47,100
21	P2584/TMK/05/2021/2377	405101952880	840120782386	45,000
22	P2584/TMK/05/2021/2377	101702357383	140120566515	35,000
23	P2584/TMK/05/2021/2377	03-10710324	140120705598	49,500
24	P2584/TMK/05/2021/2377	403100072632	540121411800	88,700
25	P2584/TMK/05/2021/2377	403100072632	540121411800	69,500
26	P2584/TMK/05/2021/2377	05-10621673	740121444561	51,200
27	P2584/TMK/05/2021/2377	04-10792762	140121456888	61,200
28	P2584/TMK/05/2021/2377	405601759590	540121391544	96,200
29	P2584/TMK/05/2021/2377	402101360548	640121444663	37,000
	Sub total			**1,638,115**
	Grand Total			**9,432,234**

Source: *Claim Files at Temeke Office, 2020/21*

Appendix 8 (A): List of Registered Practitioners who are not allowed to Practice in Dodoma

This part provides details on List of Registered Practitioners who are not allowed to Practice in Dodoma

S/n	Healthcare Facilities	Practitioner Name	MCT/NHIF number
1	DCMC	Dr. Yohana Masonda	MCTOL2823
2	DCMC	Dr. Diva James Mwakanyamale	MCTOL5845
3	DCMC	Dr. Dorcas Michael Mkanje	6755
4	DCMC	Dr. Beatus Josephat	MCT1731
5	DCMC	Dr. Jamhuri E Kitange	3625
6	DCMC	Dr. Nuru Hamidu Mohamed	MCTPY0138
	UDOM HOSPITAL	Dr. Patrick Lucas Mwamanda	MCT0018
1	UDOM HOSPITAL	Dr. Ramadhan Mohamed Kabotta	MCTOL6006
2	UDOM HOSPITAL	Dr. Ikunda Mushi Dionis	MCT0269
3	UDOM HOSPITAL	Dr. Sarah Clement Nkumbi	MCT0381
4	UDOM HOSPITAL	Dr. David Emmanuel Ng'wenda	MCT0761
5	UDOM HOSPITAL	Dr. Wende Mavis Mwakilufi	MCT0395
6	UDOM HOSPITAL	Dr. Maduta Shabani Kilongola	MCT0440
7	UDOM HOSPITAL	Dr. Asia Mwenjuma Mohamedi	MCT0722
8	UDOM HOSPITAL	Dr. Mohamed Yahaya Mbalazi	MCTOL13153
9	UDOM HOSPITAL	Dr. Honsia Elisa Moshi	5288
10	UDOM HOSPITAL	Dr. Mwanaid Khalid Shabaan	MCT1224
11	UDOM HOSPITAL	Dr. Francis Vicent Mganga	MCT1131
12	UDOM HOSPITAL	Dr. Abdallah Kassim Mwinyihija	MCT1022
13	UDOM HOSPITAL	Dr. Zipora Jacob Mfugale	MCT1638
14	UDOM HOSPITAL	Dr. Halima Mtipula	MCTOL33355

15	UDOM HOSPITAL	Dr. Daudi Jackson Gyunda	2746
16	UDOM HOSPITAL	Dr. George Gabriel Mkumbi	MCT2392
17	UDOM HOSPITAL	Dr. Denis Dominick Katatwire	MCT2264
18	UDOM HOSPITAL	Dr. Happiness Josiah Komogo	MCT2447
19	UDOM HOSPITAL	Dr. Mshamu Abdallah	MCT2694
20	UDOM HOSPITAL	Dr. Antony Gabriel Kingilo	5330
21	UDOM HOSPITAL	Dr. Patrick Bilikundi	MCT3930
22	UDOM HOSPITAL	Dr. Edina Owden	MCT3435
23	UDOM HOSPITAL	Dr. Matobogolo Boaz Masalu	MCTOL39648
24	UDOM HOSPITAL	Dr. Conrad Appolinary Makatu	4599
25	UDOM HOSPITAL	Dr. Edwin S Ochina	MCT6135
26	UDOM HOSPITAL	Dr. Melina Erasto Bonda	6219
27	UDOM HOSPITAL	Dr. Beno Fintan Mnyachi	MCT9938
28	UDOM HOSPITAL	Dr. Sophia Ernest Kuzenza	MCT10627
29	UDOM HOSPITAL	Rehema George Lwabe	MCTER5390
30	UDOM HOSPITAL	Fides Paulo	MCTER5391
1	MVUMI	Dr. Peleus Peter Kato	4191
2		Dr. Peter Nicholaus Kyamba	6962
3		Dr. Dickson Mashaka Baltazar	MCT1093
4		Dr. Mussa Ahmed Bwanguzo	MCT2037
5		Alando Peter Kadeso	MCTOL35361
6		Suzana Malang'u	MCTOL35967
7		Dr. Protas Thomas Shawa	MCT4029
8		Dr. Venance Mgaiga	7008
9		Dr. David Masaba	MCT7969
10		Aboubakar Elifuraha Sawe	NOT DEFINED

1	AGAKHAN MC DOM	Dr. Seraphin Mdara Chaula	MCTOL1467
2		Dr. Mohamed Said Mohamed	4318
3		Dr. Twilumba Edson Lihweuli	MCT1280
4		JUMA PASCHAL MAGANGA	MCT6040, HAYUPO KWENYE MCT LINK
1	APLHA CARE POLYCLINIC	Dr. Gema George Mshana	NOT PROVIDED
1	BOT STAFF CLINIC	Dr. Remmy Andrew	MCTOL3811
2		Dr. Anzibert Andrew Rugakingira	6646
3		Dr. Agnes Sylivester Kameo	MCTOL32200
1	AMANI HEALTH CENTER	Dr. Abdul Pumzi	MCTOL33487
2		Dr. Harryjustin David Mwambe	2002
3		Dr. Nuhu Simon Msamba	MCTOL2117
4		Dr. Marsia Philip Tillya	MCT0406
5		Dr. Kennedy Nchimbi	MCTOL3986
6		Dr. Swabaha Salim Bafadhili	MCT3210
7		Dr. Philipo F Garinga	MCT3949
7			
8	TAZAMA NA TUNZA DISPENSARY	MKUNDE MSHANA	NURSE, NOT IN MCT LINK, REGISTERED BY NHIF
9		GLORIOUS MKUMBO	NOT IN MCT LINK, REGISTERED BY NHIF
10		PAUL HUNGWI	NOT IN MCT LINK, REGISTERED BY NHIF
1	DODOMA REGIONAL REFERAL HOSPITAL	Dr. Mwanaisha Seugendo	4789

2		Dr. Abdul Yasin Ahmed	MCTOL160
3		Dr. Wilbert Stephen Msanya	MCTOL378
4		Dr. Missana Lucas Yango	3880
5		Dr. Peleus Peter Kato	4191
6		Dr. Athanase Gervase Lilungulu	2165
7		Dr. Bavon Njunwa Rwakayonza	MCTOL2912
9		Dr. Asha Omary Bossy	5104
10		Dr. Francis Nkanileka Msagati	MCTOL3309
11		Dr. Still Masharubu Mbaga	6222
12		Dr. James David Mwakipesile	6293
13		Dr. Festo Rainald Mapunda	MCTOL3696
14		Dr. Mwenda Shaban Hintay	5973
15		Dr. Maseto Ponsiano Galikunga	MCT0443
16		Dr. Erasto Kessy Medard	MCT0430
17		Dr. Mwinyimkuu Rajabu Lesso	MCT0468
18		Dr. Sarah Clement Nkumbi	MCT0381
19		Dr. Wende Mavis Mwakilufi	MCT0395
20		Dr. Maduta Shabani Kilongola	MCT0440
21		Dr. Samuel Wambura Stephen	MCTOL11089
22		Dr. Raymond Bariki Lyimo	MCT0791
23		Dr. Gidion Mathew Edwin	MCT0972
24		Dr. Asia Mwenjuma Mohamedi	MCT0722
25		Dr. Elian Lucas Nestory	MCT0763
26		Dr. Thobias Michael Bundala	MCT0782
27		Dr. Elisante Ephata Ayo	6599
28		Dr. Mdoe Gumbo	MCT0897
29		Dr. Lioba Joseph Kimolo	7152

30		Dr. Mohamed Yahaya Mbalazi	MCTOL13153
31		Dr. Samuel Jamson Haule	6534
32		Dr. Edmund Ferdinand Mushumbusi	MCTOL13708
33		Dr. Nancy Bonaventura Urassa	MCT1225
34		Dr. Eunice Kamnde Headcraph	MCT1117
35		Dr. Baraka Ochieng Alphonce	MCT1057
36		Dr. Rosemary Beteka Swai	MCT1422
37		Dr. Warda Omar Mbaraka	MCT1612
38		Dr. Biseko Palapala	MCT1457
39		Dr. Sadiki Mrisho Mandari	MCT1583
40		Dr. Abdallah Juma	MCT1474
41		Dr. Zipora Jacob Mfugale	MCT1638
42		Dr. Maria Florian Mbena	MCT1881
43		Dr. Rosemary Theophilo Mdota	MCTOL32447
44		Dr. Catherine Samwel Mhando	MCT2021
45		Dr. Janeth Stanslaus Masuma	MCTOL33434
46		Dr. Abdul Pumzi	MCTOL33487
47		Dr. Edmund Mgeni	2205
48		Dr. Daudi Jackson Gyunda	2746
49		Dr. Wilson Mushi	NOT PROVIDED
50		Epimack George Marandu	MCTOL33738
51		Dr. George Gabriel Mkumbi	MCT2392
52		Dr. Denis Dominick Katatwire	MCT2264
53		Dr. Johnson Kenneth Ngalliya	MCT2539
54		Dr. Happiness Josiah Komogo	MCT2447
55		Dr. Edward Ketson Msokwa	MCT2289

1	BENJAMINI MKAPA	Dr. Venance John Misago	2531
2		Dr. Amonius Kabundama Rutashobya	6281
3		Dr. Mohamed Said Mohamed	4318
4		Dr. Francis Nkanileka Msagati	MCTOL3309
5		Dr. Still Masharubu Mbaga	6222
6		Dr. Januarius Joseph Hinju	MCTOL3551
7		Dr. Patrick Lucas Mwamanda	MCT0018
8		Dr. Daniel Bariki Gurisha	MCT0414
9		Dr. Maseto Ponsiano Galikunga	MCT0443
10		Dr. Barthazary W Benedicto	MCT0188
11		Dr. Reuben Benjamin Mkinga	MCT0367
12		Dr. Sarah Clement Nkumbi	MCT0381
13		Dr. Wende Mavis Mwakilufi	MCT0395
14		Dr. Emmy Nurdin Mbilinyi	MCT0226
15		Dr. Frank Albert Sandi	MCTOL10520
16		Dr. Amiri Zuberi Kombo	MCT0178
17		Dr. Edson Sifa Ebmeleck	MCT0666
18		Dr. Arafa Ally Momba	MCT0760
19		Dr. Gidion Mathew Edwin	MCT0972
20		Dr. Lina Wilson	6717
21		Dr. Henry Stephen Joseph	6859
22		Dr. Amani Saguda Nilla	7098
23		Dr. Lugano Wilson Mwatumbwe	6900
24		Dr. Abdulmajid Abbas Sadiki	6798
25		Dr. Lioba Joseph Kimolo	7152
26		Dr. Mohamed Yahaya Mbalazi	MCTOL13153
27		Dr. Samuel Jamson Haule	6534

28		Dr. Roida Gerson Lwenge	MCTOL13611
29		Dr. Jimmy Rayzed Ituwe	MCT1358
30		Dr. Alfred Hendry Amede	MCTOL14300
31		Dr. Waziri Augustino Jimmy	MCT1143
32		Dr. Joshua Youze	MCT1530
33		Dr. Lucas Jeremiah Susu	MCT1643
34		Dr. Frank Patrick	MCT1788
35		Dr. Umoja Erasto	MCT1989
36		Dr. Martin Sindani	MCTOL32577
37		Dr. Willfredius Mugishagwe Rutahoile	2302
38		Dr. Ernest Benedictor	MCT2336
39		Dr. Edward Ketson Msokwa	MCT2289
40		Dr. Titus John	MCT2939
41		Dr. Denis Charles Rainer	MCT2263
42		Dr. Sophia Gomba	MCT2903
43		Dr. Hamisi Mohamed Matula	MCT2444
44		Dr. Enock Madaha Daud	MCT2328

Appendix 8 (B) List of Registered Practitioners who are not allowed to Practice in Mbeya

This part provides details on List of Registered Practitioner who are not allowed to Practice in Mbeya

S/n	Healthcare Facilities	Practitioner Name	MCT/NHIF number
1	MARANATHA	Dr. Erica Augustino Balama	MCTOL2415
2	MARANATHA	Dr. Boniphace Steven Balibusa	MCT3355
3	MARANATHA	Dr. Clarkson Nhanga	MCT4299

Appendix 8 (C) List of Registered Practitioners who are not allowed to Practice in Mwanza

This part provides details on List of Registered Practitioners who are not allowed to Practice in Mwanza region

Healthcare Facility	Practitioner Name	MCT/NHIF number
Bugando Medical Centre	Andrew Joseph Luhanga	Null
	Ally Akram	Not in MCT
	Festo Mmanyama	Not in MCT
	Virgilio Acuna Gonzalez	MCTLR392
	Acuna Ediberto	Not in MCT
	Adam Mangombe	Not in MCT
	Agripina Massawe	Not in MCT
	Alexander Sosa	MCTLR395
	Alicia Smasenga	Not in MCT
	Alicia Simon	Not in MCT
	Anthony M Oyekunda	MCTOL42149
	Bernard Desderius	MCTOL13532
	Bernard Gombanila	MCTOL3567
	Bundala Ramadhani	MCTOL49769
	Anastazia Shilembi	Not in MCT
	Ferediana John	MCTOL11593
	Maria Del Rosalia	MCTLR394

Appendix 9 (A): Fraud Cases Not Recovered for the period 2019/20 to 2021/22

This part provides details on fraud cases not recovered for the period 2019/20 to 2021/22

Fraud Verification Reports 2019/20			
Healthcare Facility	**Amount to be recovered (TZS)**	**Recovered Amount (TZS)**	**Balance (TZS)**
Huruma Dispensary	16,569,900.00	9,817,497.34	6,752,402.66
SHM Polyclinic	396,000.00	0	396,000.00
SHM Hospital	88,869,300.00	0	88,869,300.00
TMJ Super Specialized Polyclinic	4,799,872.26	0	4,799,872.26
NHIF Internal Staff			
Agness Mwangota - ID	1,209,260.00	0	1,209,260.00
Allen Mollel And Christine Marealle	9,193,105.00	0	9,193,105.00
IDs Production	11,115,310.00	0	11,115,310.00
IDs Production and Membership	29,065,470.00	0	29,065,470.00
INTERNAL STAFF	60,958,000.00	0	60,958,000.00
Members			
Intern Doctors	887,780.00	510,310.00	377,470.00
William J. Kimarao	253,770,800.00	0	253,770,800.00
Gloria B. Charles	144,292,340.00	0	144,292,340.00
Veronica Masolwa	42,636,500.00	0	42,636,500.00
Janne Mtana	55,045,500.00	0	55,045,500.00
Elirehema Ndossa	44,665,870.00	0	44,665,870.00
Gerald Mbago Paul	1,283,047.00	200,000.00	1,083,047.00
Raphael Beda Ngowi	1,655,480.00	0	1,655,480.00

Employers			
Sami Agency Co. Ltd	54,404,035.00	0	54,404,035.00
Mokha Agency Ltd	36,428,590.00	8,047,621.00	28,380,969.00
Cats Net (T) Ltd	59,889,475.00	0	59,889,475.00
Sub Total	**917,135,634.26**	**18,575,428.34**	**898,560,205.92**
Fraud Verification Reports 2020/21			
Health Facility	**Amount to be recovered (TZS)**	**Recovered Amount (TZS)**	**Balance (TZS)**
Mlandizi Health Centre	304,755.00	0	304,755.00
Charles Kulwa Memorial Hospital	1,042,406,000.19	464,657,391.60	577,748,608.59
K's Hospital	336,301,749.83	275,608,624.20	60,693,125.63
St. Elizabeth Polyclinic	359,462,319.25	84,000,000.00	275,462,319.25
KCMC ZRH	277,461,942.16	161,852,799.64	115,609,142.52
Msafiri Chemist Pharmacy	55,750,577.00	55,728,810.00	21,767.00
Employers			
Global Publishers Co. Ltd	192,545,355.00	0	192,545,355.00
Woiso Original Products	124,229,810.00	0	124,229,810.00
Tanzania Steel Pipes	5,299,785.00	0	5,299,785.00
Buguruni Anglican Health Centre	937,605.00	0	937,605.00
Galco Co. Ltd	144,057,384.30	0	144,057,384.30
Wassha Incorporation	195,261.54	0	195,261.54
Therry Investment Ltd	34,734,820.00	0	34,734,820.00
St.Marys Mazinde Juu Secondary School	8,378,120.76	0	8,378,120.76
Rivertrees Ltd	529,310.00	0	529,310.00
Members			

Ernest Zakayo Membi	16,028,880.00	0	16,028,880.00
John Kamota Naligana	58,282,245.00	0	58,282,245.00
Nuru Y. Mbecho	65,041,535.00	0	65,041,535.00
Damian S. Malley	40,525,115.00	0	40,525,115.00
Sanka H. Bombo	27,519,635.00	0	27,519,635.00
Thadeus Lyamuya	74,485,490.00	0	74,485,490.00
Thadeus Lyamuya	134,111,555.00	0	134,111,555.00
Upendo Laizer	137,569,610.00	0	137,569,610.00
Rajab Juma Kihumpu	212,045,176.00	0	212,045,176.00
Kibakaya Mndeme	2,964,850.00	0	2,964,850.00
Abias Kiwia	133,204,488.00	0	133,204,488.00
Adinanl Bereko	13,209,600.00	0	13,209,600.00
George Simon	186,347,010.00	0	186,347,010.00
Regina Paul	175,321,545.00	0	175,321,545.00
Sophia M Maduhu	99,696,490.00	0	99,696,490.00
Pendo Mangu Suligi	22,531,270.00	0	22,531,270.00
AbdulRahim Kayuni	8,826,250.00	50,000.00	8,776,250.00
Ahazy S. Mwakomo	18,770,000.00	100,000.00	18,670,000.00
Baraka Asulwisye	4,712,450.00	500,000.00	4,212,450.00
Bosijege Kasokela	1,965,450.00	50,000.00	1,915,450.00
Cosmas M. Nditi	13,225,250.00	11,000,000.00	2,225,250.00
Enea J. Mwaikambo	11,949,400.00	100,000.00	11,849,400.00
Frank j Mwaipopo	12,691,850.00	0	12,691,850.00
Kusobile Mwakibinga	22,950,750.00	300,000.00	22,650,750.00
Martha Z Njewa	5,472,750.00	0	5,472,750.00

Nelly Nditolo	22,833,210.00	300,000.00	22,533,210.00
Rachel Mwaisumbe	7,342,050.00	0	7,342,050.00
Rehema Juma	13,810,400.00	100,000.00	13,710,400.00
Suzana Mujibila	5,502,750.00	100,000.00	5,402,750.00
Thobias Mwanjela	14,720,450.00	200,000.00	14,520,450.00
Tumaini Mwakibibi	10,891,100.00	100,000.00	10,791,100.00
Sub Total	**4,157,143,399.03**	**1,054,747,625.44**	**3,102,395,773.59**
Fraud Verification Reports 2021/22			
Health Facility	**Amount to be recovered (TZS)**	**Recovered Amount (TZS)**	**Balance (TZS)**
Cardinal Rugambwa Hospital	13,502,060.00	0	13,502,060.00
Mama Ngoma Hospital	9,399,381.53	0	9,399,381.53
Bunda DDH	35,165,559.17	23,524,534.14	11,641,025.03
Sinza Hospital	4,205,392.00	0	4,205,392.00
Boka Pharmacy	1,603,859.14	301,500.00	1,302,359.14
LB Pharmacy	132,044.04	110,950.00	21,094.04
Monsen Pharmacy	85,882.30	0	85,882.30
Prevon Pharmacy	48,308.79	0	48,308.79
Musoma Regional Referral Hospital	418,430,335.00	0	418,430,335.00
Apricks Pharmacy	437,097,700.00	82,799,901.00	354,297,799.00
Saka A. Family Pharmacy	103,492,709.00	69,196,270.00	34,296,439.00
Nyasho Health Centre	12,509,980.00	0	12,509,980.00
Tarime District Hospital	11,917,440.00	0	11,917,440.00
Moi Hospital	288,441,090.08	0	288,441,090.08
Kiomboi District Hospital	51,362,973.05	10,700,619.40	40,662,353.65

Samaritan Charitable Health Centre	28,946,775.00	0	28,946,775.00
Chato College of Health Sciences and Technology	27,193,705.00	0	27,193,705.00
Aga Khan Polyclinic	11,445,710.78	7,630,473.86	3,815,236.92
Sachita Health Centre	41,928,615.00	0	41,928,615.00
Adrikalo Polyclinic	99,735,546.78	65,969,208.80	33,766,337.98
Members			
Thomas Kivai	19,199,130.00	0	19,199,130.00
Brian Mwalongo	1,906,400.00	0	1,906,400.00
Shameen Khan	1,393,980.00	0	1,393,980.00
Janeth Kafuku	7,645,525.00	0	7,645,525.00
Jeremia Minja	54,117,505.00	0	54,117,505.00
Asia Mustapha Silh	268,748,525.00	0	268,748,525.00
Zulekha A.Zahor	1,130,460.00	0	1,130,460.00
Zamana Mwamba	239,168,480	0	239,168,480
Pachal P Yuda	4,968,330.00	0	4,968,330.00
Daniel Jonas Njilimuyi	3,322,500.00	0	3,322,500.00
Godwin Samwel Matongo	7,660,800.00	0	7,660,800.00
Geita & Mwanza Region Members Eligibility	1,589,163,980.00	0	1,589,163,980.00
Members Eligibility – Kinondoni	32,808,375.00	0	32,808,375.00
Sub Total	**3,827,879,056.66**	**260,233,457.20**	**3,567,645,599.46**
Grand Total	**8,902,158,089.95**	**1,333,556,510.98**	**7,568,601,578.97**

Appendix 9 (B): Unauthentic Claims Not Recovered for the Period 2019/20 to 2021/22

This part provides details on unauthentic claims not recovered for the period 2019/20 to 2021/22

NHIF Mwanza			
Health Facility	**Amount to be recovered (TZS)**	**Recovered Amount (TZS)**	**Balance (TZS)**
TNJ Health Centre	14,212,967.95	1,184,414.00	13,028,553.95
Nyakato Health Centre	11,384,360.00	4,704,246.28	6,680,113.72
SDA Pasiansi Hospital	31,155,800.00	0	31,155,800.00
Bukumbi District Hospital	4,286,928.15	3,062,091.20	1,224,836.95
Sengerema Council Designated Hospital	8,261,220.00	2,753,740.00	5,507,480.00
Zillion Polyclinic	3,705,765.00	0	3,705,765.00
Sub total	**73,007,041.10**	**11,704,491.48**	**61,302,549.62**
NHIF Dodoma			
Health Facility	**Amount to be recovered (TZS)**	**Recovered Amount (TZS)**	**Balance (TZS)**
Fibeko Dispensary	2,077,165.00	1,254,447.16	822,717.84
Alpha Care Polyclinic	4,790,645.00	2,875,700.00	1,914,945.00
Romy Polyclinic	965,446.35	0	965,446.35
Matovolwa Health Centre	26,143,820.00	11,204,494.29	14,939,325.71
Kikombo Health Centre	839,300.00	516,931.08	322,368.92
Mnenia Health Centre	818,490.00	613,867.50	204,622.50
Chemba District Hospital	2,925,500.00	1,462,750.00	1,462,750.00
Kisese Health Centre	453,300.00	113,325.00	339,975.00
Busi Health Centre	1,694,835.00	423,708.00	1,271,127.00

Mauno Health Centre	372,920.00	124,306.67	248,613.33
Bereko Health Centre	232,400.00	0	232,400.00
Kalamba Health Centre	1,640,400.00	820,200.00	820,200.00
Kwamtoro Health Centre	765,650.00	191,412.50	574,237.50
Iman Dispensary	20,011,497.86	19,876,003.60	135,494.26
Shaamam Dispensary	386,250.00	0	386,250.00
Sub total	**64,117,619.21**	**39,477,145.80**	**24,640,473.41**
NHIF Dodoma			
Health Facility	**Amount to be recovered (TZS)**	**Recovered Amount (TZS)**	**Balance (TZS)**
Ihumwa Dispensary	360,000.00	0	360,000.00
Agakhan Health Centre	858,000.00	0	858,000.00
Mundemu Health Centre	1,798,900.00	959,413.32	839,486.68
Sub total	**3,016,900.00**	**959,413.32**	**2,057,486.68**
NHIF Mbeya			
health facility	**Amount to be Recovered**	**Recovered Amount (TZS)**	**Balance (TZS)**
Afya check specialized diagnostic and dialysis clinic	3,894,000.00	3,606,624.72	287,375.28
ST. Bakhita Hospital Centre	1,797,060.00	0	1,797,060.00
Makendza Hospital Clinic	54,486,540.00	27,243,270.00	27,243,270.00
Lwisu Dispensary	7,638,040.00	4,854,401.30	2,783,638.70
Lukomano Polyclinic	19,119,005.00	17,924,285.89	1,194,719.11
Hope Specialized Polyclinic	9,178,630.00	0	9,178,630.00
Genesis Hospital	9,472,560.00	4,228,013.10	5,244,546.90

Afya Specialized Polyclinic	3,267,600.00	0	3,267,600.00
Songwe Health Centre	559,735.00	0	559,735.00
Sub total	**109,413,170.00**	**57,856,595.01**	**51,556,574.99**
NHIF Mbeya			
Health Facility	**Amount to be recovered**	**Recovered Amount (TZS)**	**Balance (TZS)**
Tumaini Dispensary	1,277,180.00	0	1,277,180.00
Paradise Dispensary	1,875,000.00	0	1,875,000.00
New Kiwira Dispensary	837,680.00	0	837,680.00
Mbeya Surgical Dispensary	1,136,675.00	0	1,136,675.00
Jupiter Obgy Specialized Clinic	31,531,450.00	21,756,733.32	9,774,716.68
Rujewa Hospital	2,844,380.00	0	2,844,380.00
Uhai Baptist Health Centre	216,000.00	0	216,000.00
Sub total	**39,718,365.00**	**21,756,733.32**	**17,961,631.68**
Grand Total	**289,273,095.31**	**131,754,378.93**	**157,518,716.38**

Appendix 10: Facilities Claims with Recurring Anomalies Identified through Pre-verification at Health Facilities

This part provides details on facilities claims with recurring anomalies identified through pre-verification at health facilities

Region	Facility Name	Repeated Anomalies	Claim Reference Number	Month
Dodoma	Benjamin Mkapa National Referral Hospital	Overutilization of investigation tests	OR/06852/DOM/JUN-2021	June 2021
			OR/06852/DOM/SEP-2021	September 2021
			OR/06852/DOM/OCT-2021	October 2021
			OR/06852/DOM/NOV-2021	November 2021
			OR/06852/DOM/MAR-2022	March 2022
			OR/06852/DOM/MAY-2022	May 2022
			OR/06852/DOM/JUN-2022	June 2022
		Non-adherence to STG	OR/06852/DOM/JUN-2021	June 2021
			OR/06852/DOM/SEP-2021	September 2021
			OR/06852/DOM/OCT-2021	October 2021
			OR/06852/DOM/NOV-2021	November 2021
			OR/06852/DOM/MAR-2022	March 2022
			OR/06852/DOM/MAY-2022	May 2022
			OR/06852/DOM/JUN-2022	June 2022
		Improper dosage and quantities	OR/06852/DOM/JUN-2021	June 2021
			OR/06852/DOM/SEP-2021	September 2021
			OR/06852/DOM/OCT-2021	October 2021
			OR/06852/DOM/NOV-2021	November 2021
			OR/06852/DOM/MAR-2022	March 2022
			OR/06852/DOM/MAY-2022	May 2022

Region	Facility Name	Repeated Anomalies	Claim Reference Number	Month
			OR/06852/DOM/JUN-2022	June 2022
Mbeya	Mbeya Zonal Referral Hospital	Overutilization of investigation tests	OR/02835/MBY/MAY-2021	May 2021
			OR/02835/MBY/JUN-2021	June 2021
			OR/02835/MBY/JUL-2021	July 2021
			OR/02835/MBY/JAN-2022	January 2022
			OR/02835/MBY/FEB-2022	February 2022
			OR/02835/MBY/MAR-2022	March 2022
			OR/02835/MBY/APR-2022	April 2022
			OR/02835/MBY/MAY-2022	May 2022
		Non-adherence to STG	OR/02835/MBY/MAY-2021	May 2021
			OR/02835/MBY/JUN-2021	June 2021
			OR/02835/MBY/JUL-2021	July 2021
			OR/02835/MBY/JAN-2022	January 2022
			OR/02835/MBY/FEB-2022	February 2022
			OR/02835/MBY/MAR-2022	March 2022
			OR/02835/MBY/APR-2022	April 2022
			OR/02835/MBY/MAY-2022	May 2022
	AGA KHAN POLYCLINIC MBEYA	Overutilization of investigation tests	OR/08941/MBY/APR-2021	April 2021
			OR/08941/MBY/MAY-2021	May 2021
			OR/08941/MBY/JUN-2021	June 2021
			OR/08941/MBY/JUL-2021	July 2021
			OR/08941/MBY/JAN-2022	January 2022
			OR/08941/MBY/FEB-2022	February 2022
			OR/08941/MBY/MAR-2022	March 2022
		Non-adherence to STG	OR/08941/MBY/APR-2021	April 2021

Region	Facility Name	Repeated Anomalies	Claim Reference Number	Month
			OR/08941/MBY/MAY-2021	May 2021
			OR/08941/MBY/JUN-2021	June 2021
			OR/08941/MBY/JUL-2021	July 2021
			OR/08941/MBY/JAN-2022	January 2022
			OR/08941/MBY/FEB-2022	February 2022
			OR/08941/MBY/MAR-2022	March 2022
		Improper dosage and quantities	OR/08941/MBY/APR-2021	April 2021
			OR/08941/MBY/MAY-2021	May 2021
			OR/08941/MBY/JUN-2021	June 2021
			OR/08941/MBY/JUL-2021	July 2021
			OR/08941/MBY/JAN-2022	January 2022
			OR/08941/MBY/FEB-2022	February 2022
			OR/08941/MBY/MAR-2022	March 2022
	Ipinda health centre	Overutilization of investigation tests	OR/01438/MBY/APR-2021	April 2021
			OR/01438/MBY/MAY-2021	May 2021
			OR/01438/MBY/JUN-2021	June 2021
			OR/01438/MBY/JUL-2021	July 2021
			OR/01438/MBY/AUG-2021	August 2021
			OR/01438/MBY/MAR-2022	March 2022
		Non-adherence to STG	OR/01438/MBY/APR-2021	April 2021
			OR/01438/MBY/MAY-2021	May 2021
			OR/01438/MBY/JUN-2021	June 2021
			OR/01438/MBY/JUL-2021	July 2021
			OR/01438/MBY/AUG-2021	August 2021
			OR/01438/MBY/MAR-2022	March 2022

Region	Facility Name	Repeated Anomalies	Claim Reference Number	Month
		Improper dosage and quantities	OR/01438/MBY/APR-2021	April 2021
			OR/01438/MBY/MAY-2021	May 2021
			OR/01438/MBY/JUN-2021	June 2021
			OR/01438/MBY/JUL-2021	July 2021
			OR/01438/MBY/AUG-2021	August 2021
			OR/01438/MBY/MAR-2022	March 2022
Mwanza	Nyamagana District Hospital	Overutilization of investigation tests	OR/04286/MWZ/JUL-2021	July 2021
			OR/04286/MWZ/DEC-2021	December 2021
			OR/04286/MWZ/FEB-2022	February 2022
			OR/04286/MWZ/MAR-2022	March 2022
			OR/04286/MWZ/MAY-2022	May 2022
		Non-adherence to STG	OR/04286/MWZ/JUL-2021	July 2021
			OR/04286/MWZ/DEC-2021	December 2021
			OR/04286/MWZ/FEB-2022	February 2022
			OR/04286/MWZ/MAR-2022	March 2022
			OR/04286/MWZ/MAY-2022	May 2022
		Improper dosage and quantities	OR/04286/MWZ/JUL-2021	July 2021
			OR/04286/MWZ/DEC-2021	December 2021
			OR/04286/MWZ/FEB-2022	February 2022
			OR/04286/MWZ/MAR-2022	March 2022
			OR/04286/MWZ/MAY-2022	May 2022
	Rainbow Polyclinic	Overutilization of investigation test	OR/07892/MWZ/SEP-2021	September 2021
			OR/07892/MWZ/OCT-2021	October 2021
			OR/07892/MWZ/NOV-2021	November 2021
			OR/07892/MWZ/DEC-2021	December 2021

Region	Facility Name	Repeated Anomalies	Claim Reference Number	Month
			OR/07892/MWZ/JAN-2022	January 2022
			OR/07892/MWZ/FEB-2022	February 2022
			OR/07892/MWZ/MAR-2022	March 2022
		Non-adherence to STG	OR/07892/MWZ/SEP-2021	September 2021
			OR/07892/MWZ/OCT-2021	October 2021
			OR/07892/MWZ/NOV-2021	November 2021
			OR/07892/MWZ/DEC-2021	December 2021
			OR/07892/MWZ/JAN-2022	January 2022
			OR/07892/MWZ/FEB-2022	February 2022
			OR/07892/MWZ/MAR-2022	March 2022
		Overutilization of investigation tests	OR/07892/MWZ/SEP-2021	September 2021
			OR/07892/MWZ/OCT-2021	October 2021
			OR/07892/MWZ/NOV-2021	November 2021
			OR/07892/MWZ/DEC-2021	December 2021
			OR/07892/MWZ/JAN-2022	January 2022
			OR/07892/MWZ/FEB-2022	February 2022
			OR/07892/MWZ/MAR-2022	March 2022