IMPLEMENTATION OF NATIONAL HEALTH INSURANCE CLAIMS PROCESS MANAGEMENT IN REGIONAL REFFERAL HOSPITAL

A CASE OF TEMEKE REGIONAL REFERRAL HOSPITAL-TANZANIA

Violeth Solomon Mlay, (BPA-HSM)

Master of Public Health

Muhimbili University of Health and Allied Sciences

October 2021

Muhimbili University of Health and Allied Sciences

School of Public Health and Social Sciences

Department of Development Studies

IMPLEMENTATION OF NATIONAL HEALTH INSURANCE CLAIMS PROCESS MANGEMENT IN REGIONAL REFFERAL HOSPITAL

A CASE OF TEMEKE REGIONAL REFFERAL HOSPITAL - TANZANIA

By

Violeth S.Mlay

A dissertation submitted to the school of public health in partial fulfillment of the requirements for award of the degree of Master of Public Health

Muhimbili University of Health and Allied Sciences.

October 2021.

CERTIFICATION

The undersigned certify that he has read and hereby recommend for acceptance by the Muhimbili University of Health and Allied Sciences (MUHAS), a dissertation entitled **"Implementation of National Health claims process management"** in Temeke Regional Referral Hospital (partial) fulfillment of the requirements for award of the degree of Master of Public Health (MPH) of MUHAS.

____

Dr. Amani Anaeli

(Supervisor)

____

Date

DECLARATION AND COPYRIGHT

I, Violeth Solomon Mlay declare that this **dissertation** is my own original work and it has never been presented and will not be presented to any other University for a similar or any other degree award

Signature………………….…………….. **Date…………………………….**

This dissertation is a copyright material protected under the Berne Convention, the Copyright Act 1999 and other international and national enactments, in that behalf, on intellectual property. It may not be reproduced by any means, in full or in part, except for short extracts in fair dealing, for research or private study, critical scholarly review or discourse with acknowledgement, without the written permission of Directorate Studies, on behalf of both the author and the Muhimbili University of Health and Allied Sciences.

ACKNOWLEDGEMENTS

Firstly, I would like thank the Almighty Lord for giving me energy, wisdom and passion in the whole process of building this work. To my family, thank you for always being there and for supporting me through it all.

Secondly, I would like to thank my supervisor, Dr. Amani Anaeli, for his support, time and expertise in grooming me to accomplish this work. Thank you. Furthermore, I would like to express my gratitude to the teaching and administrative staff of the MUHAS School of Public Health and Social Sciences for their teaching, constructive criticism and guidance that watered the accomplishment of this scholarly work.

Thirdly, I would like to thank Temeke Regional Referral Hospital and the National Health Insurance (NHIF) Temeke regional office for giving me permission to conduct my research in their sites. Me am eternally grateful to study participants – staff working at the NHIF department and Temeke regional office, Temeke Regional Referral Hospital staff and Temeke Regional Referral Hospital Management Team – who spared their precious time to take part during data collection.

Finally, I would like to thank my classmates and my friends for their prayers, support, and understanding during this important journey of attaining my master's degree.

DEDICATION

I dedicate my dissertation work to my beloved brother Engineer William S. Mlay for his enduring moral support and encouragement in my early days at MUHAS and the whole time till he passed away. I believe you would be happy seeing that regardless of your untimely departure, my supervisor Dr. Amani provided kind support and adequate encouragement for me to accomplish successfully sail through the final destination of this challenging scholarly journey.

I hope you can smile back at me that I managed to reach this far. You will always be alive in my heart until we meet again.

ABSTRACT

Background: In 2001, Tanzania started implementing a National Health Insurance Fund (NHIF) Scheme. Through the NHIF Claims Process, services rendered by providers could be reimbursed by the Scheme. In 2012 NHIF established an electronic claims processing system ensure an effective implementation of claims process. Despite such efforts, there is limited information about the service providers' compliance with claims preparation procedures at the health facility level. Essentially, there is little documentation on the implementation of the NHIF claims process management, especially at regional referral hospitals in Tanzania.

Objective: To assess the implementation of the National Health Insurance Fund claims process management in Temeke Regional Referral Hospital.

Materials and Methods: This study employed qualitative case study design to assess the implementation of the NHIF claims process in Temeke regional referral hospital. A purposive sampling method was used to select participants in this study following the principle of saturation level of the information collection. NVivo 12 software was used to code the data into themes for thematic analysis.

Results: This study found that the NHIF claims process management is implemented according to NHIF guideline and service providers were aware of the claims mangment. However, there were several critical challenges that hinder effective implementation of the claims process management. They include noncompliance to claims and submission process, electronic claims system challenges and a discrepancy between NHIF treatment manuals and the national standard treatment guideline.

Conclusion: Although service providers are aware of the NHIF claims preparation and submission procedures. The noncompliance to claims management is the challenge, which negatively affects the provision of high-quality health services to clients insured under the NHIF.

Recommendation: The noncompliance practices to the NHIF claims management among health service providers has a negative impact on the provision of quality health services to NHIF clients and performance of the NHIF scheme. Thus, an effective collaboration among key stakeholders is necessary in order to address the noncompliance practices in the context of collective improvement of health service delivery.

TABLE OF CONTENTS

CERTIFICATION i

DECLARATION AND COPYRIGHT ii

ACKNOWLEDGEMENTS iii

DEDICATION iv

ABSTRACT v

LIST OF FIGURES x

LIST OF TABLES xi

ABBREVIATIONS xii

DEFINITION OF TERMS xiii

CHAPTER ONE 1

1.0 INTRODUCTION 1

1.1 Background Information 1

1.2 Problem Statement 4

1.3 Conceptual framework of the evaluation 5

1.4 The Rationale of the Study 7

1.5 Research Questions 7

1.5.1 Main Study Question 7

1.5.2 Specific Evaluation Questions 7

1.6 Research Objective 8

1.6.1 Main Objective 8

1.6.2 Specific Objectives. 8

CHAPTER TWO 9

2.0 LITERATURE REVIEW 9

2.1 Introduction 9

2.2 The concept of National Health Insurance 9
2.3 Health Financing System in Tanzania 9
2.3.2 Operationalization of NHIF in Tanzania 11
2.3.3 Claims Management Process 12
2.3.4 Use of electronic claims system 12
2.4.1 Service provider’s compliance with claims preparation procedures 13
2.4.2 Implementation of Claims Submission Processes 14
2.4.3 National Heath Insurance Fund adherence to claims assessment process 16
2.4.4 Barriers of e-claims process management 17
CHAPTER THREE 20
3.0 MATERIALS AND METHODS 20
3.1 Introduction 20
3.2 Study Design 20
3.3 Description of the Study area 20
3.4 Study population 20
3.5 Sampling technique and sampling procedure 21
3.6 Data collection methods and tools 21
3.6.1 Data collection methods 21
3.6.2 Data collection tools 21
3.6.3 Data Collection Procedure 22
3.7 Trustworthiness and Reliability 22
3.8 Data management and analysis 22
3.8.1 Data management 22
3.8.2 Data analysis plan 23

3.9 Ethical considerations 24

CHAPTER FOUR 25

4.0. FINDINGS 25

4.1. Demographic characteristics of respondent 27

4.2. Service provider's compliance with claims preparations procedures 27

4.2.1 Claims preparations procedures 28

4.2.2 Compliance with claims preparation procedures 29

4.2.3 Claims quality assurance and fraud control at service provider level 30

4.3.1 Implementation of electronic claims system at facility level 33

4.4. NHIF compliance with e-claims assessment processes 34

4.4.2. Claims quality assurance process at NHIF regional offices 36

4.4.4. Service provider's compliance with claims preparation procedures and submission processes 38

4.5. Barriers of e-claims process management implementation 38

4.5.1 Barriers of e-claims processes management at regional referral hospital 39

4.5.2 Barriers of e-claim processes management from insurer side 40

CHAPTER FIVE 43

5.0. DISCUSSION 43

5.1. Service provider's compliance with claims preparation procedures 43

5.2 Implementation of e-claims submission processes at regional referral hospital 45

5.3. NHIF compliance with claims assessment processes 46

5.4 Barriers of e-claims process management implementation 48

5.5 Study limitations and mitigation plan 50

CHAPTER SIX 51

6.0 CONCLUSION AND RECOMMENDATION 51

6.1 CONCLUSION 51

6.2 RECOMMENDATIONS 51

REFERENCES 53

APPENDIX IA: KEY INFORMANT INTERVIEW GUIDE TO HEALTH CARE PROVIDERS AT TEMEKE RRH..58

APPENDIX IB: INTERVIEW GUIDE TO -MEDICAL OFFICEN INCHARGE, HOSPITAL SECRETARY AND HOSPITAL ACCOUNTANT (RRHMT) 61

APPENDIX IC: KEY INFORMANT INTERVIEW GUIDE TO NHIF STAFF (TEMEKE REGIONAL OFFICE) 64

APPENDIX IIA: INFORMED CONSENT (ENGLISH VERSION).....................................77

APPENDIX II B: RIDHAA YA KUSHIRIKI KATIKA UTAFITI (TOLEO LA KISWAHILI) 79

APPENDIX III : ETHICAL LETTER...82

APPENDIX IV: INTRODUCTION LETTER 84

APPENDIX V: PERMISSION LETER...85

LIST OF FIGURES

Figure 1. The World Health Organisation Health Systems Framework 1
Figure 2. Conceptual Framework for the Implementation of NHIF Service Provider Payment Mechanism a Regional Referral Hospital 6

LIST OF TABLES

Table 1: Thematic analysis process 26

ABBREVIATIONS

MoHCDGEC	Ministry of Health Community Development, Gender, Elderly and Children
HSSP IV	Health sector strategic plan IV
NHIF	National Health Insurance Fund
NHIS	National Health Insurance Scheme
PPM	Provider Payment Mechanism
RRH	Regional Referral Hospital
RRHMT	Regional Referral Hospital Management Team
SHI	Social Health Insurance
SHIS	Social Health Insurance Scheme
WHO	World Health Organization

DEFINITION OF TERMS

Benefit package: Services covered by a health insurance contract or plan and the financial terms of such coverage, including cost sharing and limitations on amounts of services (2).

Claims processing: A process that starts from an insured client's arrival at a health facility to access the health service followed by the facility submitting a claim to the funding scheme and ending with reimbursement of approved true claims according to schedule or unapproved false claims being rejected(3)

Claims rejections: A claim which is not reimbursed based on criteria stipulated by insurer of the service(3)

Claims: A request for payment or reimbursement for one type of service, on one date, by one provider, for one client(3)

Provider payment mechanism: A mechanism used to transfer funds from the purchaser of health care services to the service provider(1).

Reimbursement: A money paid back to service providers or health care facilities for the services provided(4). It is also known as refund.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background Information

Health financing is one of the six building blocks of health systems that can enable progress towards universal health coverage by improving effective service coverage and financial protection. The other building blocks are service delivery, health workforce, health information systems, access to essential medicines, and leadership/governance as indicated in Figure 1 below.

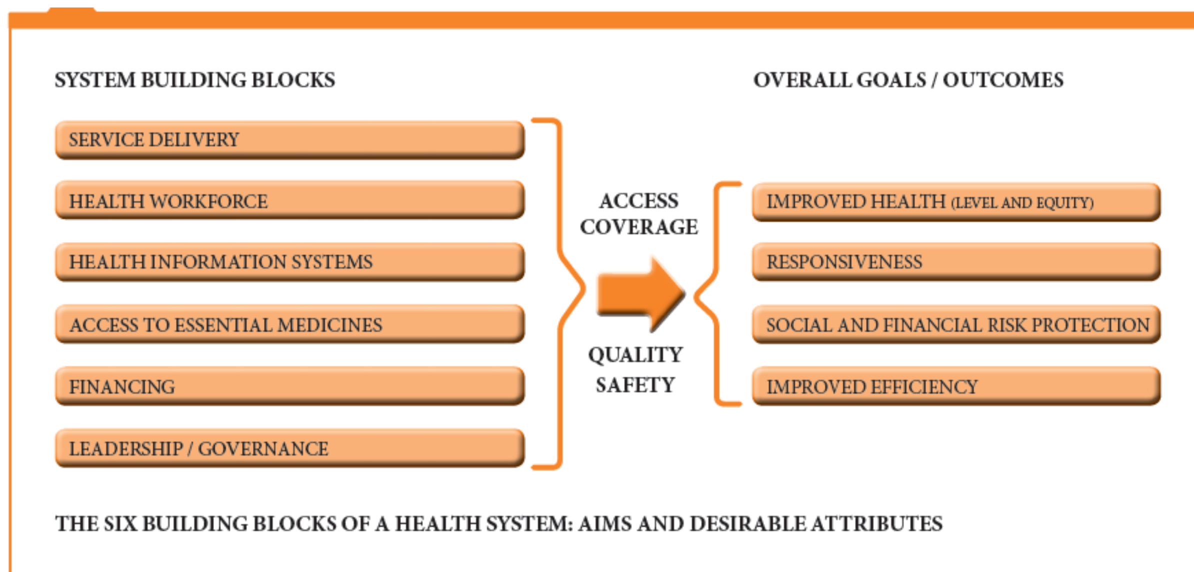


Figure 1. The World Health Organisation Health Systems Framework

Carefully designed and implemented health financing policies are essential to address social protection issues. For example, proper health insurance arrangements can incentivize care coordination and improved quality of care while sufficiently and timely disbursement of funds to providers can increase both the competent staffing with skills mix and availability of adequate medicines and health commodities to treat patients(5).

Health insurance mechanism is one of the possible organizational mechanisms for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community insurance, and others(6). Within this context, there has been considerable variation in how insurance mechanism systems have developed across countries. Revenues are typically from membership contributions, employer contributions, government subsidies and interest payments on any accumulated funds (7).

In the insurance mechanism, the relationship between insurer, health service provider and clients are mostly designed in four systems, namely. Private insurance where consumer buys health care services directly from providers (6). Second system that is common in developed countries where clients pay directly insurer and get reimbursed for spending on health care, there is no contractual relationship between insurer and service provider. In third and fourth system, the insurer enters into contract with service providers to provide services to clients and, in turn, they claim for reimbursement for the services offered. Service provider is responsible to ensure that clients get quality service as stipulated in the contract(8). Insurer is responsible to paying claims submitted by service providers once there are approved following the agreed set of criteria. Multitude of ways of paying providers claiming for service provided can be observed from unrestricted fee for service to selective contracting at negotiated rates(9).

In sub-Saharan Africa, evidence of health care claims process management mostly emanates from Ghana and Kenya where the common mechanism used to pay providers who claims for reimbursement is Fee for Service and Capitation (9). In Kenya, studies focusing on providers' implementation of the claims processing management explored experiences of private health care providers with NHIF payment methods and reported that the mechanisms were good revenue sources(10). However, claims rejections, delayed reimbursements, inadequate capitation rates and support from NHIF do negatively impact providers' facility operations and their participation in the scheme. In Ghana, the claims review report analysed a total of 421,574 medical claims in the years 2011 to 2013 with a cost of USD 2.6 million. The proportion of claims settled beyond 90 days increased rapidly from 26% to 90% over the same period whereas the rejection proportion increasing from 0.9% to 3.6% (11).

In Tanzania, the National Health Insurance Fund (NHIF) was established in 1999 as mandatory Social Health Insurance Scheme for public servants. From 2001, several amendments have been done to expand membership coverage to ensure that every Tanzanian can join NHIF(12). The NHIF enters into service contracts with both public and private facilities and the accreditation is done by levels (13).Service providers are supposed to provide service to all NHIF beneficiary and claim for cost of service. The NHIF internal policy requires claims to be processed within 60 days of their receipt. However, there is variation between claims submitted and claims paid. This is due to concerns of claims rejections, noncompliance of claims processing procedures and missing of key information while submitting the claims forms in both levels of facilities. If a claim is rejected, the facility absorbs the loss from the cost of service which later impact the operations of facilities (14).

The claims process management involves two main components, namely the provider and scheme parts. The process starts from the point when the client enters the facility to access the service through the submission of claims by the service provider to the scheme and ends either with the claim being rejected or approved for reimbursement(15). The processes may be fraught with diverse challenges at the stages of claims submission, vetting, reimbursement and the general working environment of officials. the claims process in different funds has name specific timelines for both submitting claims and receiving reimbursement. A well- managed claims process should be compliant with the set guideline and procedures for management and reimbursement of claims. Failure to comply with the processing or false claims may results to the claims rejections (9).

1.2 Problem Statement

In Tanzania and other developing countries, Social Health Insurance is relatively a new industry. An electronic claims (E-claims) system was established by NHIF in 2012 to speeding up the processing of claims with the purpose of eliminating complaints of delayed payments as among objectives of the system (16). A study conducted in India showed that Gujarat region where a direct fee for service is operated, the claims process implementation has faced challenges such as delayed reimbursement and a high rejection rate for health insurance claims (15). Health care providers' experiences with the implementation of the claims process management in sub-Saharan Africa emanate from west Africa (7). In Ghana, the study conducted in Brong-Ahafo Region reported issues such as noncompliance to claiming process, fraud and code mismatch as a result of poor implementation of NHIS claims; and all these negatively impact the claims processes (17).

Claims processing management is among the challenges that face health service providers in Tanzania. The Controller and Auditor General 2016/2017 reported that TZS 343 Tanzanian million shillings (TZS) were lost by providers due to claims rejection, which implies an infficient claims process management. The CAG 2019/2020 reports that poor filling in of patients and client's information in the claims forms has resulted in the loss of 4.48 billion TZS due to claims rejections. Lee, Tarimo and Dutta reveal, among other challenges facing services providers in claims process management, a mismatch between what is claimed and what is reimbursed to facility which affects the providers ability to render sustainable quality services to NHIF beneficiaries (reference).

The implementation of the claims process management implementation is said to be crippling the operational survival of health facilities at different levels because of delays and rejections of claim payment by the insurer. However, little is known about the concerns raised by service providers on the implementation of claims process management especially at regional referral hospitals in Tanzania. It is against this backdrop that this study sought to assess the implementation of claims processes of the National Insurance Health Scheme in the regional referral hospitals which are electronically processed (e-claims) and submitted to the fund nd factors affecting it as an attempt to fill that gap of knowledge.

1.3 Conceptual framework of the evaluation

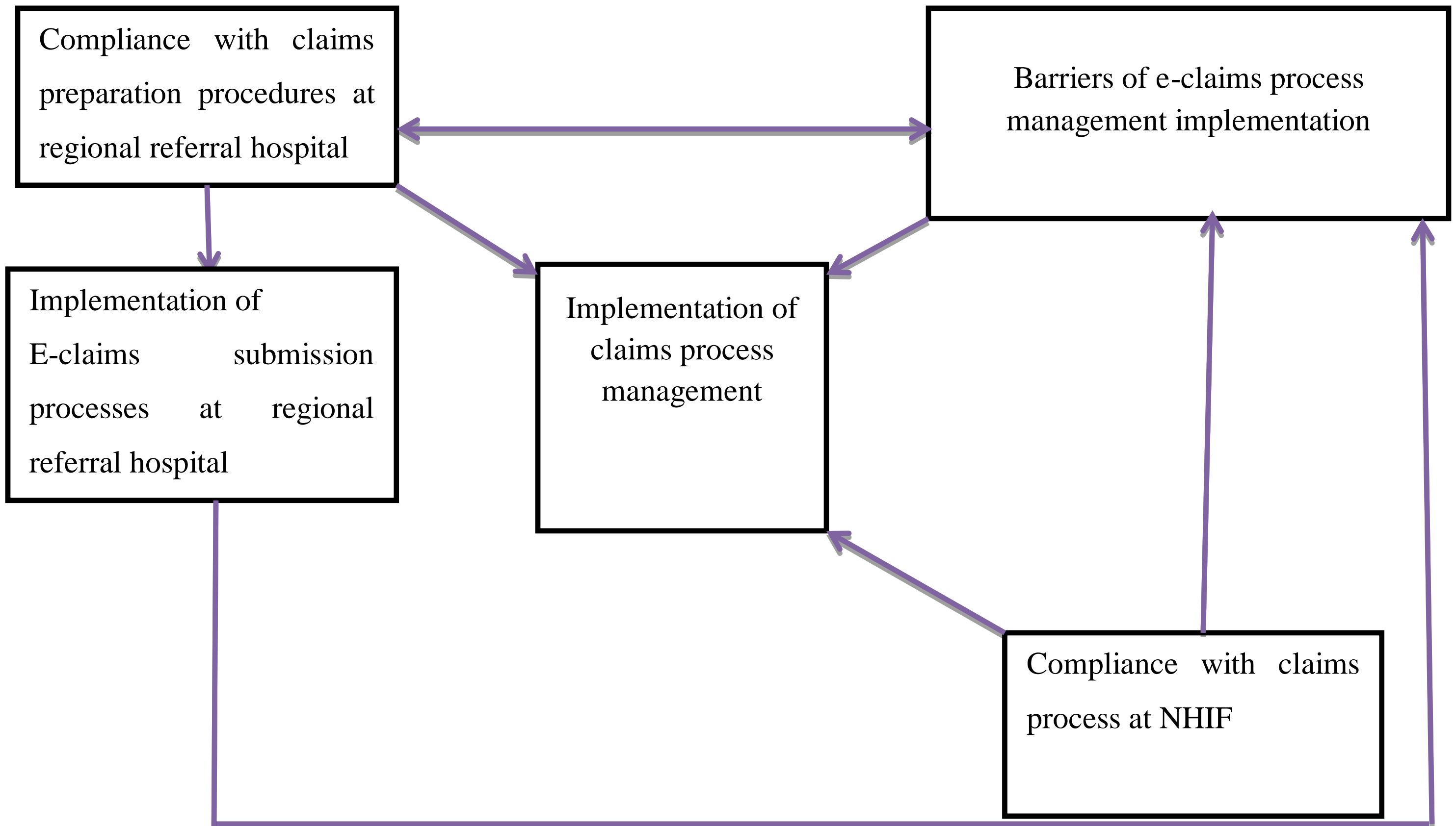
The conceptual framework in Figure 2 below shows a number of factors and their potential interactions that may influence the claims management. The framework portrays a comprehensive view of the role of health providers working together with insurer (NHIF) to ensure an effective and efficient claims process management.

In particular, the framework includes how NHIF claims process procedures are compiled at Temeke regional referral hospital, focusing on the following key issues:

- Implementation of e-claims submission processes are implemented at Temeke regional referral.
- NHIF Temeke regional office compliance with claims assessment process.
- Service providers' level of awareness on implementing claims process management.
- Barriers to implementation of claims process management both at Temeke regional referral hospital and NHIF Temeke regional office.

In order to have an efficient claims management, it was necessary to analyse the claims process management at health facilities to establish providers' compliance with the claim's preparations and submission procedures while, on the other hand, what is done by insurer to ensure an effective assessment of the claims. The implementation barriers were assessed from both the provider and insurer sides.

Figure 2. Conceptual Framework for the Implementation of NHIF Service Provider Payment Mechanism a Regional Referral Hospital



Source: Researchers own construct

1.4 The Rationale of the Study

Regional referral hospitals (RRHs) play a major role in providing curative and diagnostic services, and have a substantial influence on the performance of the entire health system in the country. This study aimed to evaluate the implementation of NHIF claims process management at Temeke regional referral hospital. In Tanzania, there is limited information on the implementation of NHIF claims process management, especially at the regional referral hospital level. Therefore, the findings from this study inform policymakers on the effective implementation of NHIF claims process management through highlighting the factors affecting the implementation. The study results offer a problem-solving approach for policymakers and health managers to improve the implementation of NHIF claims process management to ensure the sustainable provision of quality health services. The study findings contribute to advancing the understanding of the performance of the roles and responsibilities of both parties in the NHIF scheme, including recommending relevant solutions for policymakers and health service providers. The study findings add knowledge to the health insurance body of knowledge. Furthermore, the findings from this study provide the basis for future studies on the related topic.

1.5 Research Questions

1.5.1 Main Study Question

How is NHIF claims management at Regional Referral Hospitals implemented?

1.5.2 Specific Evaluation Questions

1. How is service provider complying with claims preparations procedures at regional referral hospital?
2. How is NHIF e-claims submission processes implemented at regional referral hospital?
3. How is NHIF complying with e-claims assessment process?
4. What are the barriers of e-claims process management implementation?

1.6 Research Objective

1.6.1 Main Objective

To assess implementation of NHIF claims management at Regional Referral Hospital

1.6.2 Specific Objectives.

1. To examine service providers compliance with claims preparations procedures at regional referral hospital
2. To evaluate implementation of NHIF e-claims submission processes at regional referral hospital
3. To examine NHIF compliance with e-claims assessment process
4. To identify barriers of e-claims process management implementation

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The implementation of the NHIF in Tanzania, like any other similar insurance schemes, has been described on the basis and principles of social unity and risks sharing. The NHIF scheme has a prearranged package of benefits while contributions to the scheme are gathered in a specific account, self-regulating from the Government budget(13).

Health insurance claims process management is the organization, billing, filing, updating and processing of medical claims related to patient diagnoses, treatments and medications (7). The NHIF currently operates an all fee-for-service payment mechanism and determines its reimbursement rate based on market surveys on the price of health services and commodities (18). This section is organized in the following sub-sections.

2.2 The concept of National Health Insurance

The national health care is a wide concept that has been applied in numerous ways. The common denominator for all such programs on the national health care is some forms of the government actions that aim at increasing population access to health care as extensively as possible(19). Most countries implement health care through legislation, regulation and taxation. Some health care programs are paid for out of tax revenues whereas, in some cases, the government involvement includes directly handling of the health care system. Globally, many countries use mixed public and private systems to deliver health services to communities(20).

2.3 Health Financing System in Tanzania

In Tanzania, up to 1990s the provision of health services was free to all citizens and was financed by the government (14). The government adopted the health sector reform strategy in 1995, particularly on health care financing which was the first step in introducing user fees in public hospitals(13). Several other alternatives of funding option were explored of which the government introduced two new major ones in line with the principle of social security in the

health sector. Firstly, the (NHIF) as a compulsory health insurance scheme for formal sector employees, and secondly, the voluntary Community Health Fund (CHF) which aimed to cover the informal sector. In addition to the government programs, there are several private health insurance initiatives(13).

The NHIF was established by the Act number 8 of 1999 of the parliament. The establishment of this fund was the outcome of 1990-1992 study on long term options for financing health services in Tanzania. This scheme became operational on 1st July 2001 by members and their respective employers making contributions to the scheme and beneficiaries having access to medical services from 1st October 2001. The contribution is made by both employees and their employers making a total of 6% which is deducted directly from employees' payroll. Currently, there has been expansion of coverage to accommodate individuals and organizations that are out of the public scope (21).

The Community Health Fund (CHF) was introduced in Tanzania as part of the Ministry of Health's endeavour to make health care affordable and available to the rural population and the informal sector(22). The scheme started in 1996 in Igunga district, acting as a pilot district, and was later expanded to other districts. The scheme was identified as a possible mechanism for granting access to basic health care services to populations in the rural areas and the informal sector in the country. As such, its primary aim was not to raise additional funds but to improve access to health care for the poor and vulnerable groups. As of March 2018, the CHF coverage was 13,325,718 representing 25 percent of the population (11). There is a counterpart scheme called *"Tiba kwa Kadi"* (TIKA) which mainly targets the informal sector individuals in urban areas. The CHF and TIKA are both regulated under the CHF Act 2001 and managed at the district level (23).

On the other hand, there has been the government commitment to expand the insurance coverage in the country. The improved CHF (iCHF) was launched which is a voluntary, district-owned health insurance scheme, built on a strong partnership between the NHIF, the district councils (local government), public healthcare facilities and the Swiss Agency for

Development and Cooperation (SDC). The iCHF scheme was launched in Dodoma region in 2011 and later in 2015 was rolled out in Shinyanga and Morogoro region. The aim of the iCHF is to improve community health by strengthening both the demand and the supply sides of the health system and increasing access to quality health care for people in the informal sector, mostly rural and low-income groups (23).

The National Social Security Fund (NSSF) introduced a special package for Social Health Insurance Benefit (SHIB) in 2007 as part of the NSSF benefits. All members of NSSF have access to medical care through SHIB after undergoing registration process with only one facility of their choice. The scheme accredits both public and private health providers. The benefit is part of their 20% contribution to the NSSF(24). There are several domestic and international private companies that offer private health coverage for both company and individual plans. Strategis company was one of the first registered private health insurance firms in Tanzania, hand the space has grown to include companies such as AAR, Jubilee Insurance, Resolution Health and Metropolitan Insurance (10).

2.3.2 Operationalization of NHIF in Tanzania

NHIF does not provide health care services to the beneficiaries directly since it does not own health facilities; it therefore facilitates access to health services through a network of accredited health facilities (18). Currently, there is a network of accredited health facilities throughout the country and these facilities are classified as government, faith-based organizations, non-governmental organisation (NGO) and private health facilities. The accredited health facilities are required to provide quality services to NHIF beneficiaries because the success of NHIF depends much on how health care providers treat NHIF beneficiaries. Retirees who were contributing members of the NHIF, together with their legal spouses, are entitled to access health services for the rest of their lives without any monthly contributions. NHIF accredits service providers who enter into service agreement or contract to provide services to their beneficiaries. A fee-for-service is the mechanism used to pay providers under the NHIF service agreement (11).

2.3.3 Claims Management Process

A claim is defined as a request for payment or reimbursement for one type of service, on one date, by one provider, for one beneficiary. To make a claim, systems are put in place starting from when a client first accesses healthcare through the submission of a formal claim to the insurance company till the point when the service provider is reimbursed in full or with deductions or the claim rejected. A well-managed claims process is in compliance with the procedures, guidelines and the timeframes spelt out in the law governing the fund, which is expected to result in prompt submissions and processing of claims and rejection of false claims (25).

In Tanzania, the NHIF claiming process starts with the service provider have submitted to the Fund genuine claims on a monthly basis, the claim forms should be submitted within thirty days of the succeeding month. Claim forms have to be submitted in an orderly manner by arranging and assigning folio numbers serially. The service provider has to ensure that beneficiaries sign NHIF Claim Form 2A&B acknowledging receipt of health care services after receiving the services and not otherwise. All claim forms are filled by attending registered medical practitioners and not otherwise. The service provider has to submit claims electronically and is required to deploy the e-claims system provided by the Fund or through the hospital management information system. The claims are submitted both on hard copy and electronically (18).

2.3.4 Use of electronic claims system

In the United States, claims can be electronically submitted or paper forms used in standard formats. Health services codes are more commonly used by physicians to bill for their services(26). Although electronic submission of claims introduces a level of efficiency into the claims process it is not without its challenges. The claims are sorted out and either entered into a computer or rejected for such reasons as missing diagnoses, dates, and signatures. Once computerized, the claim is reviewed by a claims examiner who has limited knowledge of medical terminology and coding. If the claims are uncontested, payment is authorized. If the

claims are queried, the claims examiner takes one of three actions: (i) return claim for more information, (ii) refer for higher technical review or (iii) file claim for later review (15)

In Tanzania, the NHIF introduced an e-claims processing in January 2012 due to the challenges of prolonged claims delays, errors during claims processing and sky-high expenditures on invalid members. The objectives were to speed up processing hospital bills and to verify NHIF valid beneficiaries. The NHIF had high expectations of eliminating complaints from health facilities regarding delayed payments, saving massive expenditures incurred on invalid members and curbing fraudulent practices in health facilities (16).

The following subsections provide a review which is aligned to the core domains of this study following the areas covered by the respective objectives. At the end of each objective, this review provides a gap that was filled by this study.

2.4.1 Service provider's compliance with claims preparation procedures

Claims preparation procedures and compliance are at the core of any provider payment mechanism (PPM). Payment rates, claims processing and management act as the starting point for negotiations between health care provider and purchasers (20). The reviewed literature on compliance with claims processing management suggests that the preference is on PPM that had a higher compliance with claims processing and a short period of reimbursement after claims submission to the fund (27).

In Nigeria, health care providers' experience with claims management process revealed challenges in providing healthcare services with negative experiences such as delays in claims processing at the fund, claims rejection and changes of payment and claims processing policies that are not in support of the providers (28). Furthermore, mechanisms to resolve problems with claims management such as under payments, rejections of claims, delays in reimbursement and changes in purchasing polices providers are not involving service providers (29).

NHIF in Tanzania has an electronic system for claims processing and management (e-claims system). The claims from providers are submitted both in hard copies and soft copies. The compliance with claims process management has not been studied in Tanzania as compared to Kenya, Ghana and Uganda. An evaluation report by Lee, Tarimo and Dutta reveals, among other challenges facing services providers in claims process management, a mismatch between what is claimed and what is reimbursed to facility according to the service agreement contract. On time for submission of claims that is 30 days after claims submission and the actual time when claims are reimbursed back to facility. On the other side of the implementation, a poor compliance to claiming process on the provider side has been reported as a challenge that inhibits smooth claims management(30). The noncompliance to claiming process affects the providers ability to render sustainable quality services to NHIF beneficiaries.

Although NHIF has been running since 2001, there is little documentation on service providers' compliance with claims preparation procedures at the facility level. This study objectively evaluated service providers' compliance with claims preparations procedures at the facility level

2.4.2 Implementation of Claims Submission Processes

A claim is a detailed invoice that service providers send to the health insurer, which shows exactly what services have been rendered to a patient(s) at the point of healthcare service delivery (31). The claim submission process is one of the key steps in the medical billing process. It determines the amount of reimbursement for the healthcare provider after the insurance company clears the dues(32). In state-owned health insurance systems, for example, the South Korean and Japanese systems, there are established independent claims review institutions for overseeing claims review and reimbursement and ensuring compliance for both provider and purchaser (12).

Many developing countries, particularly in sub-Saharan Africa, are at different stages of implementing social health insurance schemes aimed at providing access to healthcare for all citizens. Evidence, however, demonstrates that sustainability of this model of healthcare

financing depends on efficient and compliance to claims submission processes and management system to respond early to reimbursement and being able to detect errors, abuse, and fraud (28). Besides, an efficient claims review process is an important aspect of quality of care since it contributes to early settlement of claims thereby incentivizing healthcare providers to deliver sustainable quality care service to the insured (34).

Kenya NHIF providers are paid on a fee-for-service basis, with packages defined for each of the covered procedures and interventions. Claims submission and processing is cashless through an electronic system, allowing hospitals and insurers to submit claims and payments through an online system(36). The process for reporting and paying claims is designed to be simple, cashless and user-centred from the provider and beneficiary perspectives. Despite the efforts of making the claiming process and management easy and digitalized, studies reveals that the preparations and submissions of claims still face major challenges such as delays of reimbursement and claims rejection while the providers are left to face the consequences after providing services to NHIF beneficiaries (7).

In Tanzania, the NHIF claims submission system is electronically. After preparations of claims, healthcare providers submit claims both on paper form and soft copy through the electronic portal to the NHIF regional office, where the facility is found, for review and payment. The "fulfilment" stage is the first point of receipt of the paper claims, where the claims are checked for compliance in terms of the number of patients and reimbursement amount with what is stated in the cover letter and the summary sheet that accompanied the claims (37). The eligibility of the provider to provide services to the NHIF beneficiaries is also verified at this stage. Claims with problems are exclusively marked; the claims officer either writes a report of its initial review and sends it together with the claims to the quality assurance officers for a complete review or returns the problematic claims to the health services providers for correction and resubmission. The second stage of the paper-based claims review process is the "vetting" stage, where checks are conducted on the various sections such as quality assurance and accounting before paying the service provider (4).

Studies show a number of persisting challenges to the claim's submission process. The evaluation of NHIF performance report revealed that the major challenges are challenges delays in reimbursement due to late preparations and submission of claims to NHIF by health facilities, but they are often due to late release of funds by NHIF. Similarly, review of NHIF annual performance reports for the financial years 2015/2016 to 2017/2018 shows delays of reimbursement to service providers for more than the specified duration, which is supposed to be below 60 days (11,24). In addition, CAG 2019/2020 report reveals non-compliance to NHIF claims preparations process and submissions procedures as one of the major problems that results to claims rejections (38).

Various literatures have looked on the matter from a whole National Health Insurance perspective. For that reason, this study particularly evaluated the service provider implementation of NHIF claims submission procedures at facility level.

2.4.3 National Heath Insurance Fund adherence to claims assessment process

The National Health Insurance Scheme has provided an alternative for sustainable health care financing. The scheme over the years has realized a tremendous appreciation in the number of subscribers and widening the scheme's coverage (15). There are, however, some inherent demerits associated with the scheme, especially with the issue of claims management, which has been an unsolved bothering issue with health service providers since the inception of the universal health coverage (40).

The health insurance funds over the years have been inefficient in the vetting and payment of claims resulting from weak internal controls as well as the absence of compliance with the fund internal policy on claims management procedure. There is also the problemFurthermore, some of the funds' officers vetting claims do lack requisite knowledge and skills (NHIA Audit Report, 2012). Sakyi et al 2017 reports that due to noncompliance of internal policy on claims management procedure by NHIA the service providers are faced by shortage of cash flows (23). The National Hospital Insurance Fund Act stipulates that the processing of claims from service providers has to be completed within a 30-day period from when the claims are

submitted to the fund while providers have to submit the claims to the fund within 30 days after the completion of the month. The same timeline is stipulated for some providers under the United States' federal system of health insurance for those requiring financial assistance – Medicaid – with the slight variation of an ill-defined timeline for reimbursements in Washington State (12) In 2006, America's Health Insurance Plans (AHIP) released a report demonstrating that 98% of "clean" claims were processed within 30 days (11).

In Tanzania, NHIF claims processing procedures for the services rendered is our inconformity with both the national standard treatment guidelines and according to the service agreement's terms, conditions and rates/price. The Act, under Clause 12.1, entails the claims for any given month shall be settled within sixty (60) days of receipt of the claim forms from the service provider (16). The payment within the prescribed period is only done if claims were prepared in accordance with the service agreement and the Act. In complying with reimbursement process, the service providers are supposed to submit dully filled in claim forms 2A & 2B or any claim form approved by the Fund within thirty (30) days from the last date of service, together 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 (18).

Various studies agree that claims assessment is the bloodline towards the achievement of a functional National Health Insurance Fund. However, the extent to which NHIF is complying with claims assessment guidelines is not well established. This study objectively evaluated the NHIF compliance with the claim's assessment guidelines.

2.4.4 Barriers of e-claims process management

In improving access to quality healthcare services, the World Health Assembly in 2005 increasingly called for countries to prioritize universal health coverage (UHC). The advancement of technology has led to the development of health information systems which are cost-effective, reliable, scalable and flexible. The main goal of HIS is to improve the

efficiency of information flow within health institutions without altering tasks to healthcare practitioners(26).

Worldwide, an electronic claims processing has increasingly been deployed in many countries. In the United States, this has been a remarkable progress in the electronic claim's submission accounting for 2% of claims in 1990, 44% in 2002 and 75% in 2006. 13,11 One US based company, TMG, with over 30 years' experience in claims management reported to have a software system that "processes more than 40,000 claims a day, 365 days a year (26).

In Kenya, the NHIF introduced Electronic Fund transfer (EFT) payments to health providers and Mpesa payments for members who claim to ensure that payment is received within 21 working days. The objectives of the system were to ensure faster service delivery to the member or health provider. Delays in reimbursement contrary to what is stipulated in the act, shortage of human resources and ICT) challenges such as connectivity have been reported as the barrier towards the implementation of electronic claims by service providers in Kenya (42).

In Tanzania, NHIF introduced e-claims processing in January 2012. The objectives were to speed up processing hospital claims and to verify NHIF valid beneficiaries with expectations of eliminating complaints from health facilities regarding delayed payments, saving massive expenditures incurred on invalid members and curbing fraudulent practices in health facilities (16). The claims processing and management has evidenced issues such as claims rejection, delayed reimbursements, inadequate payment rates as negative experience on the implementation of claims management process. The implementation of claims electronic claims system has faced barriers such as administrative and technological challenges that inhibit attainment of NHIF objectives of introducing the e-claims system. Delayed reimbursement and the requirements to submit both hard copy and soft copy of the claims forms to NHIF offices are reported as barriers of e-claims implementation in Tanzania (43)

It is important that service providers implement electronic claims systems for NHIF claims processing and submission. However, little is known on what are the barriers towards the

implementation of e-claims at the facility level and NHIF regional office. This study also assessed the barriers of e-claims implementation at the facility level and the NHIF regional office.

CHAPTER THREE

3.0 MATERIALS AND METHODS

3.1 Introduction

This chapter explains the methods that were employed to conduct this study. It outliness the study area, study design and study population. It further describes sampling procedures, data collection methods, data analysis plan and concludes with the ethical considerations related with the study.

3.2 Study Design

A qualitative case study design was used in this study. This design was selected because it provides a room for underpinning process to adequately capture the relationship between intervention and context during the implementation. This was fundamental to holistically explaining what was implemented, understanding how and why the implementation worked or not and informing the transferability of the intervention into routine practice for continuous quality improvement (23).

3.3 Description of the Study area

The study was conducted in Temeke regional referral hospital in Temeke Municipality. The municipality consists of 124 health facilities, 24 public facilities and 96 are private facilities. A total of 52 facilities are accredited to provide services to NHIF beneficiaries and they include Temeke Regional Referral Hospital where the study was conducted. As of the end of 2020, a total of 49588 beneficiaries received health services in 24 public facilities (44).

3.4 Study population

The study target population comprised Temeke Regional Referral Hospital (RRH) executive management team, health care providers working at RRH NHIF department and NHIF staff in Temeke Region.

3.5 Sampling technique and sampling procedure

A purposive sampling was used for getting participants of the study who were implementing the NHIF e-claims process management. By virtue of their knowledge and experience, the following participants were purposefully involved in in-depth interviews (23) and a total of thirteen officers (13) was yielded for the study:

- Temeke RRH executive committee: medical officer in charge, hospital health secretary, matron, hospital accountant.
- Heads of selected Temeke RRH departments and units: head of NHIF department, head of inpatient department (Doctor in Charge and Nurse in Charge), head of specialized clinics, head of claims processing management and quality assurance units, and In Charge of registration unity.
- NHIF Temeke Region office: head of claims management, head of quality assurance, officer responsible for Temeke RRH claims and reimbursement, and accountant responsible for Temeke RRH.

3.6 Data collection methods and tools

3.6.1 Data collection methods

Data collection was conducted using qualitative methods to obtain primary data The interview questions were framed around four themes originating from the study objectives. The data collecting techniques was in-depth interview (IDI) with key informants (23).

3.6.2 Data collection tools

The interview guide was used comprising factual questions about the implementation of NHIF claims management processes both on NHIF and providers perspectives. The interview guide was developed in English and translated by the author into Swahili to ensure that participants understand the content. In order to maintain content, it was translated back to English.

Two research assistants were recruited to assist the researcher in data collection. Their background education was diploma in health-related education and this was an advantage for

quality data collection because of high understanding of the purpose of the research. The researcher conducted a two-day training for the research assistants to ensure that they have shared understanding of the purpose, objectives of the study, study area and study population, data collection procedures and tools, the importance of confidentiality, the ethical consideration and timeframe (45). This training was followed by a one-day pre-testing of data collection tools at a different health facility, which was not a study site, in order to validate and finalise the tools.

3.6.3 Data Collection Procedure

The principal investigator met with the key informants in their respective working areas, made an appointment with them and agreed on a particular time to meet for the interview depending on their convenience. Before starting the IDI, respondents were informed about the study details and given assurance about ethical principles, such as confidentiality and for further reference and the interview was recorded to save time and for later review. This gave respondents some idea of what to expect from the interview (46)

3.7 Trustworthiness and Reliability

To ensure trustworthiness, a triangulation technique of asking the same question to more than one respondent so as to see the consistency of the answers was used. To ensure consistency and reliability of the answers, data collection tools were developed by researcher based on the study questions that reflect objectives of the study.

3.8 Data management and analysis

3.8.1 Data management

All recorded scripts and field notes from in-depth interviews were checked on daily basis to ensure their quality, correctness, completeness and consistency. Recorded scripts were stored in a separate external hard disk for verbatim transcription process. This is done to ensure that all information from the interview were recorded and documented effectively. High level confidentiality was maintained to ensure that data collected are safely stored, which included

submitting all the tape recorder and field notes to the principal investigator at the end of every working day and data was accessed by only those directly involved in the study. Interviews that was audio-recorded was transcribed in verbatim to pave way for analysis. One to two interviews were transcribed at the end of every working day and that ensured the quality assurance of the data and correctness of information collected from the respondents (46).

3.8.2 Data analysis plan

The recorded interviews were transcribed verbatim by people with experience in transcribing qualitative interviews. Based on the objectives of the study, four themes emerged from the data, a codebook was prepared to guide data coding and analysis. The recorded interviews were transcribed simultaneously with data collection. The transcribing team read these transcripts and offered feedback to main researcher and data collectors. This was to ensure that thematic saturation was monitored and that data was collected to cover all themes. The data was coded using NVivo 12 software for thematic framework analysis (47).

Thematic analysis was based on the main six steps as follows:

- i Reading content: Analysis began with data reading and re-reading of transcripts so that content becomes familiar and evolving issues noted.
- ii Coding: A list of codes was created based on identified themes and assigned to specific sections of text.
- iii Displaying: After transcripts have been coded, inventory was taken regarding what is related to the given code. To ensure inter-coder reliability, the same transcript was coded by two different people.
- iv Reduction: Matrices with categories of data was used to display data so as to help the reader easily understand the dimensions of categories; also this helped in interpretation.
- v Interpretation: After the text has been read, coded and refined and themes extracted, the next step was to identify and give meaning to the analysis.
- vi Producing the report: The analyzed data was transformed into interpretable pieces of writing by using vivid and compelling extract examples that relate to the themes, research question and literature.

3.9 Ethical considerations

Ethical clearance was sought and obtained from the Institutional Review Board (IRB) of the Muhimbili University of Health and Allied Sciences (MUHAS) with approval number IRB#: MUHAS-REC-06-2021-670. The research permit was also sought and obtained from the Office of Hospital Director Temeke regional referral hospital and from Director General National Health Insurance.

Possible limitations of Study

This study was exposed to a risk of bias since health care workers working at health insurance department were selected by a purposive sampling. This might cause bias as information were only obtained from health care workers who were willing to participate. Those not willing to participate may have been holding important information that could inform a success or barrier of successful implementation of NHIF claims process management. To mitigate this the researcher provided adequate information about the research and its significance in the health sector and how the provider's participation would impact the study. An adequate time for deciding on participation was given to the providers and only those willing to participate were involved in the study.

CHAPTER FOUR

4.0. FINDINGS

This section presents the findings on the implementation of the National Health Insurance Fund claims process management in Temeke regional referral hospital. The information was collected from health care workers working in different sections of NHIF department at the regional referral hospital, management of regional referral hospital and officials working at NHIF Temeke regional office. A total of 13 respondents participated in the study.

The results are presented in four main themes aligned with the specific objectives and are detailed in the following order:

Table 1: Thematic analysis process

<table>
<tr><th>CODE</th><th>SUBTHEME</th><th>THEME</th></tr>
<tr><td>Claims</td><td rowspan="4">Claims preparation</td><td rowspan="9">Claims preparations processes</td></tr>
<tr><td>Preparations</td></tr>
<tr><td>Trainings</td></tr>
<tr><td>Procedures</td></tr>
<tr><td>MoHCDGEC regulations</td><td rowspan="2">Compliance with processes</td></tr>
<tr><td>NHIF regulations</td></tr>
<tr><td>Quality assurance</td><td rowspan="3">Claims Quality assurance and fraud control</td></tr>
<tr><td>Fraud</td></tr>
<tr><td>Control</td></tr>
<tr><td>Procedures</td><td rowspan="2">Claims submissions procedures</td><td rowspan="4">Implementation of e-claims submission procedures</td></tr>
<tr><td>Adherence</td></tr>
<tr><td>Trainings</td><td rowspan="2">e-claims at facility</td></tr>
<tr><td>System installation</td></tr>
<tr><td>Claims submission</td><td rowspan="3">Vetting processes</td><td rowspan="12">NHIF compliance with claims assessment process</td></tr>
<tr><td>Vetting</td></tr>
<tr><td>Procedures</td></tr>
<tr><td>Non-medical</td><td rowspan="2">Quality assurance</td></tr>
<tr><td>Medical</td></tr>
<tr><td>Internal Manuals</td><td rowspan="4">Compliance with vetting process</td></tr>
<tr><td>Ministry regulations</td></tr>
<tr><td>Service agreement</td></tr>
<tr><td>Benefit package</td></tr>
<tr><td>Claims preparation</td><td rowspan="3">Service providers compliance</td></tr>
<tr><td>Claims submission</td></tr>
<tr><td>Fraud control</td></tr>
<tr><td>Human resources</td><td rowspan="3">Barriers at facility level</td><td rowspan="4">Barriers of e-claims process management implementation</td></tr>
<tr><td>Technical capacity</td></tr>
<tr><td>Connectivity</td></tr>
<tr><td>Systems setup</td><td>Barriers from insurer side</td></tr>
</table>

4.1. Demographic characteristics of respondent

The study involves findings from 13 key informants including 9 health facility key respondents (1 male and 8 females) and with 4 NHIF key respondents (2 males and 2 females) participants. The mean age of all study participants was 40 years. Overall, respondent's education level ranges between bachelor degree to master degrees. The cadres of ourt he respondents include nurses, medical doctors, pharmacist, accountants and business analyst.

4.2. Service provider's compliance with claims preparations procedures

Claims preparations at providers' levels starts when the clients visit the facility. Patients are required to provide their cards for verifications and authorization for treatment. If the system approvals the card, the patient's personal details are filled in both in the system and in provided forms. After receiving treatments, the forms with signature of a doctor and patients are submitted back to required departments for further processing of claims. After collation of forms from all departments, the forms are submitted to NHIF for vetting according to their procedures.

NHIF claims manual entails claims preparation procedures that start upon verification of patient's health insurance card status at the registration point in the facility. Afterward, patient is issued an authorization number which is valid for 24 hours. The authorization number expires when the patient is issued a form 2C prior confirmation that medicines prescribed to the patient are out of stock. After completion of service delivery both patient and health provider are required to sign the claim forms in accordance to NHIF requirements as a proof that service was provided to the patient. Therefore, forms are submitted to the pharmacy department for verification of medicines and prices as per NHIF price list. After that, forms are submitted to the quality assurance department for verification of compliance to the Ministry of Health regulations and NHIF manuals on claims preparations. Lastly, the quality assurance department submits the forms to e-claims section for entry in the system.

The information on the service provider compliance with claims preparations procedures was collected through in-depth interview. The respondents were asked on how claims are prepared and how do they comply with preparation procedures. The analysis of the collected information generated three subthemes which are substantiated as follows below:

4.2.1 Claims preparations procedures

NHIF claims manual entails claims preparation procedures to start with patient's registration and health insurance card status verification at the registration point in the facility when he/she is issued a NHIF forms after identity are verified and authorization numbers for 24 hours is provided. The client then goes through all the service points ending at the pharmacy from where the filling of the claims form starts. The claims form then goes to claims officers who complete the claims forms after checking compliance with approved NHIF benefit package, price list and the National Standard Treatment Guidelines (STG). The information is then keyed into e-claims system. Through interviews our respondents from facility (Temeke RRH) working at health insurance department and hospital management team revealed that they are aware of the procedures. Moreover, they reported that claims preparation procedures are initiated once the client visit the facility at registration section in either health insurance department or special clinic department. At this point registration section is responsible to verify cards and give authorization number to clients that last for 24 hours. During treatment process doctors are responsible to key in information as per NHIF requirements such as disease code, tests, treatment plan together with patients and doctor's signatures at the end of consultation as a proof that patients received treatment. Upon completion of consultation claims form are submitted at pharmacy for verifications of medicine and fill inn price of medicines as per NHIF price list. The claim forms then go to verification section who complete the forms after checking for compliance with NHIF requirements and Ministry requirement. From quality assurance, forms are submitted at e-claims for entry in the electronic claims system. This was justified by an informant who said:

> *"Health providers are aware of the claims preparation procedures. There is guideline for claims preparation that we frequently use during on job training to remind them on the procedures. Preparation of NHIF claims starts when clients arrive at registry either*

*here or special clinic area…….. Forms will be left at pharmacy department for verification of medicine and prices as per NHIF price list. From pharmacy forms will be taken to verification sections for quality assurance……..After quality assurance forms are submitted to e-claims section for entry in the system and that's complete claims preparations" (*Respondents no 005 from the facility).

4.2.2 Compliance with claims preparation procedures

The NHIF manuals and service agreement contract require facilities to comply with NHIF claims preparation procedures throughout the process. Specifically, NHIF manual requires all claims forms to be filled properly in every section in compliance with NHIF guidelines and manuals. Our findings from hospital management team shows health workers understand that compliance to claims preparation procedures is the responsibility of every section within the department. However, our findings shows that human error and negligence are partly attributed to failure to comply with proper filling of the forms. This is caused by failure in filling some information in claims forms such as disease code and signature, mismatch of information such patient's treatment plan and dosage or age. In sum, this amount to improper filling of the , and thus amounting to noncompliance to NHIF claims preparation procedures. One of the participants from Hospital Management said:

"*Compliance to claims preparation procedures is the responsibility of the whole department. In preparation of claims the biggest challenge that aim seeing is the whole process is compliance; this is due to human error and sometimes negligence. There is missing of codes, missing of signatures, mismatch of information such as disease code and treatments plan or treatment plan and the patients age and times wrong authorization numbers if this happens in a form it will be rejected because we did not comply to how NHIF wants their forms to be filled to qualify for payment*" (Respondent 005 from facility).

With respect to compliance with claims preparation procedures, health providers are required to adhere to guidelines provided by the Ministry of Health of Health, Community Development, Gender, Elderly and Children and NHIF They include the Standard Treatment Guidelines, NHIF price list and NHIF benefit package. Evidence from our respondents showed that there is lack of compliance of procedures of claims preparation that has been presented in

form of missing of information such as disease code and signatures, mismatch of information. The missing information may include patients age and treatment plan. Our respondents complained of poor adherence to guideline due to number of guidelines and manuals, incomplete feelings of information in claims forms from doctors, negligence in feeling of forms. Furthermore, our respondents reported that there is unjustifiable medical test and treatment plan contrary to NHIF manuals and STG. Evidence reported by our respondents prove that there is noncompliance to claims preparation procedures as required by NHIF and Ministry of Health. One of the respondents explained the following:

> *"Our biggest challenge is complying with claims preparation procedures. There are number of guidelines and manuals that need adherence to……. Sometimes doctors are not signing the claims forms or patients forgets to sign the forms, sometimes due to noncompliance to the STG you find treatment and dosage or age do not match. Or medicine prices written on claim forms are different from price list provided by NHIF. ……There are times doctors writes tests or treatment plan that are not justified while both benefit package and price manuals require a doctor to write justifications for any tests that is written in claim forms"* (Respondent 006 from Facility).

4.2.3 Claims quality assurance and fraud control at service provider level

NHIF require facilities to verify claims as quality assurance procedure before uploading to e-claims and submission to NHIF. Our study findings show that health providers at health insurance department works in line with NHIF requirements to ensure the process of quality assurance is adhered. Our findings shows that that pharmacy department after filling medicine price the forms are submitted to verification section for consistence checking by the quality assurance team. The team systematically verify all the attachments and if responsible doctors have signed the forms to avoid countersigning of the forms by other doctors or staff. Moreover, the team also works towards identifying any unintentional fraud by verifying the matching of information in the claim forms such as date of treatment, signatures and treatment provision as per NHIF benefit package. The quality assurance is done to reduce claims rejection due to noncompliance to claims preparation or negligence. Despite this important initiative, the major concern of nonadherence practices has not been resolved. The study results show that facilities

do not adhere to NHIF requirement and rocedures of verifying claims before uploading to e-claims and submission to NHIF. One of our study respondents said:

> "*Pharmacy department after filling the medicine price they will submit claims forms to us for quality assurance………Quality assurance also check the if forms have all the attachments and the responsible doctor has signed the forms to avoid counter signing of the forms. Verification team also works towards identifying any unintentional fraud like making sure that the date for treatments and signature match......We are doing this as the method to reduce claims rejection as a result of noncompliance to claims preparation or negligence" …………….* (Respondent 003 from facility).

The service agreement between NHIF and facility prohibits the provider from committing fraud. NHIF has categorize fraud in two category intentional fraud and non-intentional fraud. Evidence from our study shows that non-intentional forgery is a common fraud committed by health providers at facility. Usually this happens when a patient is attended by health provider of a lower cadre but the claim form is signed by another health provider of higher cadre. For instance, Assistant Medical Officer (AMO) and medical specialist with the intentional of increasing a consultation fee revenue. Our study respondents explained that NHIF currently is concerned with countersigning of the claims forms which is grouped in non-intentional fraud. A study respondent confirmed that it is true that such scenario happens, though at times it is the concern of mistrust between NHIF and the facilities as currently they have enough specialists who attend the patients and signs claims forms. Working towards controlling the such incidences, the hospital management held meetings with NHIF and submitted changes in human resources availability meanwhile doctors were reminded to comply with NHIF requirements by signing the claims forms during patient's treatment process. These findings show incidences of unintentional fraud raise concerns with NHIF as a result they lose trust on health providers at the facility level. One of the respondents said:

> *"Currently the only fraud that NHIF are talking about is of counter signing which they are calling it non-intentional forgery. This happens when a patient is treated let's say with AMO but the signature is of a medical specialist. Sometimes it's true that happens*

but in most cases, it is not the case but NHIF they do not want to trust us...... The only way to control that is reminding the medical doctors to comply to claims preparation requirements. Meanwhile management is working towards submitting the changes in human resources……....." (Respondent 006 from Health facility).

4.3. Implementation of e-claims submission processes

The National Health Insurance Fund Act and NHIF internal manuals and regulations oblige service providers to submit claims on a monthly basis after verification in accordance to claims preparation procedures as part of service agreement contract. Our study revealed that claims are submitted monthly to NHIF regional office, after fulfilling claims preparation procedures which includes verification and uploads of claims in e-claims system until end of the month. Prior to submission, it requires re-checking of the hard copies of claims forms and filling in monthly report letter provided by NHIF; and upon submission both soft file in flash and hard copy, NHIF provides receipt acknowledging the receipt of claims forms for registration and processing. One of the health providers said:

> "*Claims submission is not done on daily basis it done monthly. After claims verification and checking the fulfilment of the claim's preparation……The hard copy forms will be re checked again; soft copy file will be carried in the flash for submission with hard copy forms. NHIF provides monthly report letter that is supposed to be filled by the service provider when submitting the claims forms to NHIF after receipt of claims NHIF normally gives receipt as evidence that your facility claims has been registered for processing"* (Respondent 007 from health facility).

As far as e-claim submission is concerned, our study findings evidenced adherence to claims submission by observing the deadline which is on 15th of every next month. The study respondents revealed that internally the health insurance department at the facility has agreed on 10th of every next month as their submission deadline with the aim of ensuring that even with unforeseen challenge such as system challenges and shortage of human resource they will still meet the deadline of NHIF. However, there are still some inconsistences in the e-claim

forms such as missing of official stamp, attachments, mismatch of the number of hard copies and soft copies in the system. Despite the prevailing challenge, it was reported by the health providers that the facility is working to address the challenges.

> *"In complying with claims submission, we do not have the challenge of meeting the deadline. Very few times we fail to meet deadline and meanly is because of e-claim system challenges. We still do have challenge of non-compliance of some other requirements such as sometimes forms will be submitted without facility stamp, or missing some of the attachment or some forms are lost so the number of forms that are submitted as hard copies do not tally the authorizations numbers given out or soft copy submitted to the electronic system. We are still working on compliance hopefully we will get there as the situation is not as it was before"* (Respondent 005 from facility).

4.3.1 Implementation of electronic claims system at facility level

NHIF introduced electronic claims system in 2015 to improve claims management from both provider side and insurer side. The service agreement contract between NHIF and service provider oblige NHIF to install e-claims system at provider site and provide training on the system usage while the provider has a responsibility of using e-claims system for claims processing at facility level. Our study findings show that e-claims system is installed in facility and health providers are capacitated on the system use. Our study found that e-claims is installed to the facility and providers are trained on how to use system to process claims at facility level as it has same form as claim form. Moreover, the system has been helpful because prior to system installation data entry officers at NHIF were responsible for claims entry in NHIF claims management system the process that delayed the payment processes. Furthermore, NHIF issue access to the system and assign responsibilities to health providers by providing system passwords example at registration they have access to card verification and authorization number provision to client. This was quoted from one of the respondents as follows:

> *"From what I know E-claims is system that NHIF installed to us and they trained us on how to use it. They told us we will use the system in processing of claims. The system has the same form as the one we use for claims. It has been helpful because before that the provider was supposed to submit the hard copy only and the NHIF claims officers will do the work of filling in all the claims forms submitted by service providers that*

> *was time consuming and it was among the reasons for payment delays. NHIF normally give us password so that we can do different work in the system and the portal. Those passwords give us different responsibility in the system. At registration they have access to give authorization numbers and very cards.* (Respondents 007 from facility).

4.4. NHIF compliance with e-claims assessment processes

Under the NHIF claims assessment process, the healthcare providers submit claims in soft and hard copy from the electronic system to the regional office for review and payment. The claims section is the first point of receipt of the paper claims and soft file in hard disk, where the claims are checked for non-medicals requirements appropriateness including the number and amount with what is stated in the cover letter and the summary sheet that accompanied the claims. The claims departments writes a recommendation report of its initial review and sends it together with the claims to the claims quality assurance department where checks are conducted on the various sections of the claims form such as medical procedures performed, diagnoses, investigations (laboratories, imaging), and medicines supplied, followed by verification and approval for a complete review and payment of claim. Inadequate information on the claim form would lead to partial or complete rejection of the claim, depending on the extent of the problem.

Respondents were asked on how the assessment process was conducted including vetting process, quality assurance and compliance with claims vetting processes. The analysis of the findings generated three themes as described below:

4.4.1 Claims vetting process at NHIF Temeke region

The NHIF claims manual and quality assurance manual entails that claims vetting process starts when they receive claims from service providers, the healthcare providers submit claims in both paper form and in flash disk from the electronic system to the regional office for review and payment. The claims section is the first point of receipt of the paper claims and soft file in hard disk, where the claims are checked for non-medicals requirements appropriateness including the number and amount with what is stated in the cover letter and the summary sheet that accompanied the claims. The claims departments writes a recommendation report of its

initial review and sends it together with the claims to the claims quality assurance department followed by verification and approval for a complete review and payment of claim. Our respondents from claims department, quality assurance department, accounts departments and regional manager office at NHIF Temeke regional office explained that claims vetting process is initiated once they receive claims from service providers both in softy copy and hard copies. The first point of claims vetting is claims department where claims are registered in NHIF claims management system, acknowledgement receipt is issued to the provider, and assessment of non-medical requirements in claims forms which are dates, sex, age, signature and authorization number and official stamp are checked. Furthermore, after completion of initial vetting claims, the department writes a recommendation to the quality assurance for further review. Inadequate information on the claim form would lead to partial or complete rejection of the claim at the claims department though the process are not completed until the claim passes through all departments. This was reported by one respondent as follows:

> *"We do receive claims both in soft copy and hard copy...... Our internal process of claims vetting starts with registration of claims in our systems of claims. Data entry is the next step. At claims department the claims are checked to assess the compliance to non-medical requirements in the claim form which are date, sex, age, authorization number, signature and official stamp. After that a claim officer will recommend claim to another stage or if any of the above requirements are not adhered to the claim will be rejected at claims department but still for verification purposes it will be through the whole vetting procedures"* (Respondent 009 from NHIF Temeke regional office).

Moreover, another respondent reported that at claims department there are regulations for claim vetting. The regulations inform among other things when the rejection should be partly or of whole claim. Upon data entry to system soft and hard copy claim is matched. All items between soft and hard copy must match. This is followed by assessment on compliance with non-medical requirements and recommendation is given for further action. Non-compliant claim forms are either amended or completely rejected as it was revealed by a respondent.

> "*In claims vetting here at claims department we have internal regulations that inform us when the claims rejection is for a whole claim form or when is for few items in the claim form which will result to adjustment of claim. When we do entry the first task is matching one claim after the other between the hard copy and soft copy. There should be a match in all items between soft copy and hard copy. After that is when the assessment of non-medical issues will follow and then after that we will give recommendation either to the next step or the claim is rejected"* (Respondent number 010 from NHIF Temeke regional Office).

4.4.2. Claims quality assurance process at NHIF regional offices

The quality assurance department at NHIF offices is as per NHIF internal quality assurance manual. Our study results show that the quality assurance team is made of people with medical background. Among responsibilities of the team is to verify what is done by their fellow doctors at the facility level. The team verification, in particular, focuses on adherence to Standard Treatment Guideline and NHIF guidelines such as disease codes, treatment plan, tests, procedures against age and sex of the patients and medicine and prices if they comply with aforementioned manuals and guidelines. Recommendations from the quality assurance team can be in line with recommendations from claims department or nullify previous recommendation afterwards claims are sent for verification. Prior to claims approval, a second verification is done by another team within the quality assurance department for re-assurance purpose is to minimize chances of errors from two previous process as described by the respondent, the claims approval follows prior to payments of claims. This was reported by one respondent as follows:

> "*Department of quality assurance is made of medical personnel………. The verification of claims at this stage is only on medical requirements of claims forms. We will check on disease code, test requested, treatment plan, procedures requested against age and sex of the patient this is to check if they comply with NHIF manuals such as price list and benefit package and Ministry regulations and guidelines……. Quality assurance and verification of claim are done by different person……...Even when the claim is*

rejected at first step still it will go through all the process. After verification the claim will go to approval stage and then accounts for payment of authorized amount to service provider" (Respondent 011 from NHIF Temeke regional office)

4.4.3 Compliance to claims vetting process at NHIF offices

The service agreement contract, the NHIF Act and internal NHIF manuals gives responsibility to NHIF as Insurer to comply with claims vetting process which has stages and their done at different department. Our study results reveal that they are aware of the requirement of compliance to manuals and guidelines during claims vetting process. The set of rules guides rejection, adjustment and deduction of claims and not individual decisions. Moreover, to ensure compliance NHIF manuals requires different officers to perform different tasks during claims vetting processes. Officers vetting claims at the first point for non-medical requirements are different from officers vetting claims for medical requirements. Furthermore, to avoid errors, the verification stage involves two steps with the aim of re-checking if there was any error committed during assessment. Prior to issuing a settlement letter of approved claims, NHIF and service provider review the reimbursement report for clarity and ensuring the reasons for claims rejections, deductions and adjustment are agreed between both parties as one study respondent said:

"Here we have rules that guide the whole process. We are using the system that has been developed following the rules that are binding the whole process. The decision of rejecting, adjusting or deducting the claim is not an individual decision but it is guided by the regulations. To ensure compliance NHIF has a rule that there will be no repletion of same officer on the same claim file. Officer who performed quality assurance will not be the one to verify the claim. Even at verification there are two stages of it and both are done by different people the purpose is to re check if the previous person who assessed the file did comply our internal regulation and Ministry requirement. Also, before issuing settlement letter normally there is discussion with service provider as to why there is rejection, deduction or adjustment. We so all these to comply with our internal manuals, service agreement contract with provider and

Ministry regulations and guideline" (Respondent 012 from NHIF Temeke regional office).

4.4.4. Service provider's compliance with claims preparation procedures and submission processes

With regards to providers' compliance with claims preparation procedures and submission processes, both service agreement contract between NHIF and facilities, NHIF Act and NHIF internal manuals oblige compliance. NHIF officers from the claims department, quality assurance and regional manager reported that service providers are aware of preparation procedures and submission processes. Furthermore, currently there is no delays in claims submission from facilities especially Temeke RRH. The challenge is noncompliance of claims preparation procedures and process such as forms are submitted with missing information, mismatch of information and mismatch of numbers between forms submitted in soft file and hard copies. Moreover, there has never been an incidence of an intentional fraud from the facility (Temeke RRH) as one respondent said:

> *"…………. There is a challenge of noncompliance to our procedures and processes but we still believe there is room for improvement, still we receive forms that do not adhere both our medical and non-medical requirements in the claim forms. Also, at times there is mismatch of forms that are submitted as hard copies and authorization numbers given to patients means there are patients that are treated and their forms are not submitted both in hard or soft copy. We have never encountered the issue of intentional fraud or forgery from Temeke but there still issue of counter signing that we are still verifying"* (Respondent 010 from NHIF Temeke regional office).

4.5. Barriers of e-claims process management implementation

The participants were asked about barriers that affect the implementation of e-claims process management in Temeke regional referral hospital. The analysis of the findings generated three sub-themes as described below:

4.5.1 Barriers of e-claims processes management at regional referral hospital

With regards to e-claim implementation barriers from the provider side, it was reported that human resources for health shortage is a challenge. Moreover, the process of claims preparation is a tedious work and time demanding since one mistake result in rejection of whole claim or deduction of a huge amount of the claim. This demands skilled human resources who are medical personnel, but due to scarcity the work is left to few medical personnel and support staff. As a result, there is possibility of increasing chances of errors, which means claim rejection or deduction. Responding on this matter, one respondent explained:

> *"If only it was possible and that only if the human resources were enough all the procedures of claims preparation would have been done will medical personnel and not supporting staff. ......For example, sometimes because the person working at e-claim not all of them are medical personnel errors in feeling in quantity of drugs at times they pick wrong quantity either because of tiredness or because they do not know the difference it makes to hospital. So again, if these two systems could have been integrated the hospital system afya care and NHIF e-claim the work could have* ***been*** *done once at least human errors will be minimized by that"* (Respondent 001 from facility).

Further, with respect to human resources challenges, our findings show the capacity building from NHIF to service providers as a crucial challenge. The service agreement between NHIF and health facilities require frequent training and supportive supervision as part of reinforcing the compliance to claim preparations. Despite this requirement, there are infrequent visits from NHIF offices was reported from the health facilities. Our findings show that, despite promises for formal trainings, there has been irregular follow ups and supportive supervision which have proven unsatisfactory as most of the responsible providers are found busy attending patients. Furthermore, our respondents from the hospital reported high rate of rejection from NHIF which they attributed with inadequate trainings. There have been numerous promises of training from NHIF side which are yet to be accomplished. One of the respondents from the health facility said:

> *"NHIF, they have promised to come for formal trainings and not these follow up visits*

and supervisions. It has been a while since they promise they will come for formal trainings………. Last time when we went claims rejections was very high and medical doctors were complaining that they need to trained on standard treatment guideline on how to adhere it while treating patients to reduce claims rejections. They promised to come so that we have meeting but I think there has been a challenge with their time but it's still in our plans even doctors here are aware of that." (Respondent 006 from facility).

With regards to the e-claims system installed in provider facilities aimed at improving timely processing of claims for submission at NHIF, the interviewed study participants added that there are system challenges other than network failure of the system. E-claims limit the corrections of the forms once you upload them on a daily basis. An attempt to make any correction are regarded as a double entry. One of the respondents said.

"Another system challenge is the fact that there is no ground for corrections of the form that have been uploaded even when the month folder is not …There are times when a patient is treated and you realize that an attachment was missing from the upload; if you do not enter that attachment, the claim will be deducted; if you attempt to upload that attachment, it will result in double entry, and the claim will be rejected; so, on both attempts, the claim will be deducted or rejected.. On our side this is real a challenge when it comes to claim preparation and submission." (Respondent 004 from facility).

4.5.2 Barriers of e-claim processes management from insurer side

The National Health Insurance Fund does periodically issue a price list of medication and health commodities for reimbursing service providers. Our study findings reveal that the NHIF price list provided to service providers originates from the Medical Store Department (MSD) list of medicines and health commodities. Yet, there is a significant difference in prices between the NHIF price list and the MSD price list because the NHIF does not follow the MSD routine of updating medicine and health commodities price lists. Given that the Ministry of

Health, Community Development, Gender, Elderly and Children issues the National Standard Treatment Guidelines (STG) to health facilities guiding the treatment of both NHIF beneficiaries and non-NHIF beneficiaries, it is expected that all the NHIF internal manuals to abide by STG. Findings of this study show that there is a concern of discrepancy at times between the STG and NHIF manual, and the MSD price list and the NHIF price list so. Sometimes, therefore, the health facilities are taking care of many clients, but with an irreconcilable and unsatisfactory minimal payment especially on medicine that does not reflect the health services rendered to NHIF clients. The consequence of the NHIF price infrequency is that actual costs incurred by providers can often be higher than NHIF reimbursement rates due to the inflation effects of medicines and health commodities. Adjusting NHIF pricing to reflect MSD medicine prices would ensure that providers are more accurately compensated for the services they provide to NHIF clients. One of the respondents said:

> *'We have a challenge of difference in guidelines and here is between what National guidelines tells us and what NHIF manuals are requiring. We have different in price of medicines from MSD and from NHIF but at the same time you have to comply with the requirements and regulations. NHIF should real look at this especially drugs price as we buy from MSD so we must adhere to their selling price"* (Respondent 005 from facility).

Further findings of this study show that there are rejections as a result of over prescription or not abiding by the benefit package. Our study respondents explained that NHIF benefit package is missing some of the ear, nose and throat (ENT) services and medicines in their medicine list. As a regional referral hospital, they were supposed to provide the various health services and that results to claim rejection by not abiding by the benefit package. Moreover, our analysis reveals the NHIF internal treatment manual is distinct from STG in a number of ways; for example, when a specialist who attended the client orders a treatment plan, a medical doctor who is not a specialist in the quality assurance department rejects it for reasons such as over prescribing or over usage of testing. One of the respondents said:

> *"There are times we have challenge of rejection because of over prescription without taking into account that the person who attended a patient is a specialist while the*

person assessing the claim is a medical doctor. The specialist who met the patients is writing a dose for a month with a justification as to why the dosage is for a month but you will receive a rejection with a reason of over prescription. STG allows that dose to be for a month while NHIF wants that dose to be for two weeks. On that there are medicines like some of the ENT medicine are left out in NHIF medicine list which is a challenge to us when taking care of NHIF beneficiary" (Respondent 003 from facility).

CHAPTER FIVE

5.0. DISCUSSION

In this section, the study findings are interpreted and discussed with comparison from what was reported by other studies done in developing and developed countries.

This study aimed at examining the implementation of national health insurance claims process management in Temeke regional referral hospital. The study examined compliance of claims preparation procedures, implementation of e-claims submission processes, NHIF compliance with claims vetting processes and barrier of e-claims processes implementation. The results of the study revealed that the implementation of NHIF claims process and submission procedures are well known by service providers at regional referral hospital. However, there are significant challenges especially on compliance of guidelines, procedures, and processes that limit the effective implementation of the claims process management.

5.1. Service provider's compliance with claims preparation procedures

Claims preparation is both manual and electronic process at the facility level. The study findings, through key informant interviews, reveal that the providers have high awareness of claims preparations procedures has in all department and hospital management team members. The electronic claims system has improved the claims preparation process from provider side and insurer side; and hence reduction of payment delays. There is no difference between the current study and the findings from other studies. According to Sodz-Tettey et al. the success of Ghana National Health Insurance Scheme despite of prevailing challenges lies on providers understanding of claims preparations processes. Claims preparations at the facilities level are largely both manually and using electronic system. Providers' knowledge has enabled timely completion of the process despite the increase of workload due to staff shortage as reported in two districts where study was conducted(41).

From the study findings, service providers are knowledgeable of the requirements of NHIF claims manuals that require claims preparations procedures to be in line with guideline and regulation throughout the processes. The challenge of noncompliance to claims preparation procedures attributed by human errors and negligence has impaired the ability of service providers to comply with procedures. On the other hand, evidence of noncompliance to claims preparations is claims rejections due to missing and mismatch of information in claims forms against guideline and regulations of claims preparation. Similar findings were reported in a study conducted in Ghana on health providers and insurance managers perspective on claims submission and reimbursement. The study results reported that the challenge of the providers was noncompliance to claims preparation procedures which resulted to challenging claims submission requirements and delaying reimbursement and cause claims deduction or rejection (32).

According to the NHIF claims manual, types of fraud by providers includes intentional fraud which included billing for services that were not provided or unintentional fraud which include a higher category health provider signing the forms to increase amount of consultancy fee from insurer. The results from this study reveals that incidences of intentional fraud or forgery from government provider side has decreased. The remaining incidence of forgery or fraud are unintentional type. In order to mitigate this type of fraud, the NHIF has number of strategies implemented at the facility level which includes installation of e-claims system for claims preparations at the facility and submission of both hard copies and soft file of claims for verification during claims vetting process. The quality assurance department at NHIF regional offices is composed of multi-disciplinary personnel for conducting comprehensive assessment of claims prior to claims reimbursement. This is different from the study conducted in Ghana on a case of claims process management in two districts whereby fraud incidences from service providers who are working in collaboration with patients or employees of NHIS is still the challenge facing NHIS. More than 3% of scheme funds is lost annually due to second type of fraud which is fraud from provider side (41).

These results implies that service providers are aware of claims preparations processes and submission procedures. Installation of electronic claims system at facility despite of prevailing challenges has improved claims preparation process. However, the prevailing challenges of noncompliance to claims preparations and submission requirements and unintentional fraud committed by service providers impair implementations of e-claims management processes.

5.2 Implementation of e-claims submission processes at regional referral hospital

An efficient claim submission processes is a key to the success claims payment. The NHIF Act and service agreement stipulate the processes and requirement to be followed during claims submission. The process includes submission of hard copy of claims forms with soft file of the same from the e-claims system after fulfilling all claims preparation procedures and claims submission deadline which is 15th of the next among requirements to comply. The study found that claims submission processes was complying with submission deadline but adherence to claims preparation procedures is challenging. It was found that currently provider adherence to claims submission deadline is achieved, whereas the prevailing challenge is noncompliance to the claims preparation processes requirements which arose from mismatch and missing of information such as disease code, doctors and patients' signature. This is supported by study done in Ghana on challenges on provider payment pechanism under National Health Insurance of Ghana. The study results reported timely submission of the claims as processes requirement, hence results of timely reimbursement to service providers. This study also revealed that the claims preparation and processing is done online hence minimizing the chances of non-compliance of claims preparation (41). Similarly, there is no difference between the current study and the findings from a study done in Kenya by Barasa et al 2018 on Kenya National Hospital Insurance Fund Reforms which found noncompliance of key requirements while submitting the claims resulted to claims rejection and this was found to affect much government facilities. The results point to evidence that providers have managed to meet claims submission deadlines with challenge of adherence to claims submission procedures. Currently, one of the reasons for reimbursement delays is non-adherence to procedures by providers resulting to longer claims vetting time as to ascertain the reimbursement (36).

The trend now seems to be for ICT uptake to improve the efficiency of the claim's management process. NHIF has electronic system and card verification portal installed in facilities. From the study findings, evidence shows e-claims system has improved the claims preparation and submission to a bigger percentage as a result there is timely submission regardless of challenges of noncompliance of regulations and guidelines. There are challenges of system, like network and technical capacity of the health care workers together with shortage of human resources, are also posing a challenge to e-claims implementation. This finding is similar to a study done on National Health Insurance Claims Management in Ghana. It was found out that slow network or system break down delays both service provision and claims preparation is still a challenge while the preparation of claims is done online in Ghana (41).

The result points towards service provider capacity to meet claims submission deadline as a success towards achieving compliance of other claims submission requirements. Evidence of claims rejections as a result of human errors, negligence, missing of information and mismatch of information in claims forms proves that there is a challenge of noncompliance to claims submissions procedures. On the other hand, although ICT use has improved claims preparation process, the system challenges has affected claims preparations and service deliveries to NHIF beneficiaries.

5.3. NHIF compliance with claims assessment processes

Evidence from interviews shows that NHIF Temeke region comply with their internal claims vetting regulations as for Ministry regulation there is still discrepancy between their price list and MSID price. Compliance was vividly seen when the participants explained how they work on vetting processes and researcher had a look on their claims management system. Similar findings on compliance were reported in a study done on the claims management system of Ghana NHIS whereby the scheme during claims vetting process did comply to their agreed internal manuals and regulation that service providers were aware of the whole process. To ensure compliance in claims vetting the process is done by separate entities entitled with the mandate to vetting claims. Prior to reimbursement providers and the scheme meet for feedback meeting to ascertain the claims adjustment, deduction and rejections before approval for reimbursement as per NHIS internal regulation. (11).

The quality assurance department and verification sections at NHIF regional play a major part of vetting medical requirements in the claims forms. The purpose of the process is to ensure that service providers are paid as per service rendered to NHIF beneficiaries and save NHIF from loss of paying unjustifiable costs. From the service provider side, the NHIF verification is indispensable for quality control, but it sometimes leads to deduction and/or adjustment of the claimed payments without reconciliation with service providers. These results are different to the findings from the study on health insurance in Nigeria Health Insurance it was found out that quality assurance and verification of claims is done by a separate entity. As a result of shortage of human resources or availability of human resources without technical knowledge in medical field in those entities it has resulted to claims rejections that are not corrects and the procedures for correcting this takes longer time (10).

From NHIF officers at regional office perspective, the study found that providers are aware of the procedures and the process of claims preparation processes and submission procedures. Noncompliance to the procedures and process during implementation of claims process management is the prevailing challenge. This result is different from a study conducted in Ghana on health providers and insurance manager's perspective on claims submission and reimbursement. The study results evidenced that knowledge of claims preparation procedures and submission process were reported differently from one respondent to another and all of them reported differently from what the NHIS guideline stipulate (32).

This result is different from a study conducted in Ghana on health providers and insurance manager's perspective on claims submission and reimbursement. The study results evidenced that knowledge of claims preparation procedures and submission process were reported differently from one respondent to another and all of them reported differently from what the NHIS guideline stipulate (32).

The study also found that there are incidences of unintentional fraud committed by providers from government facilities. Counter signing of claims forms has resulted to not only claims rejection but also affect the mutual relationship between NHIF and provider. The results of this

study on incidence fraud and forgery are different from the study conducted by NHIF Kenya where government facilities are the one leading on fraud and forgery. One of the respondents of the study said minor and major surgery is where the commit fraud. They perform a minor surgery to patients and claim it as a major surgery (36).

This finding implies NHIF as insurer complies with claims assessment process. Internal strategies, manuals, guidelines and regulations are guiding the claims assessment process. Quality assurance and verifications of claims are done differently prior to claims approvals to reduce chances of human errors that could affects claims payments. Additionally, intentional fraud is not committed by government service providers. However, unintentional fraud is the prevailing challenge that has a potential to worsen mutual relationship between service providers and insurer.

5.4 Barriers of e-claims process management implementation

The findings of this study through the key informant interview show that there are barriers which hinder effective implementation of claims process management. Barriers identified were classified as barriers from provider side and insurer side. It was found that from the provider's side there is shortage of human resource as a result claims preparation procedures are carried out by support staff with inadequate training from NHIF. Evidence exists that from qualified medical personnel working at NHIF department there still a challenge of non-compliance to claims preparation process requirements which is due to human errors and negligence faults that attributed to claims deduction, adjustment of rejection. This is in line with the findings of a study done by NHIF Kenya on critical analysis of purchasing arrangement a case study reported that noncompliance to NHIF requirements especially from government facilities was the number one cause of claims rejection and it was one of the push factors that enabled the current online claims preparations and submission (49).

The study found that aspects the electronic claims' system was implemented with the number of challenges such as slow of network, system being out of service, system limited corrections functions. In mostly cases has resulted to delays in service provision, claims preparation and

submission also claims rejections due to double entry of the claim. This supports the study done in Ghana on health providers and insurance managers perspective on claims submission and reimbursement reported that in relation to how electronic claims systems works still there is a challenge of slow functioning system which can be caused by internet or other factors contributed to delays in preparations and submission of claims for processing and hence delays in reimbursements (32).

Human resources for health shortage have been reported as barrier factor effective implementation electronic claims. From the study we found out that other section of NHIF department at the facility have supportive staff working at e-claim section as a result of shortage of trained medical personnel with skill mix. This has increased errors that might be due to shortage of technical capacity when processing claims. According to recent study done in Rwanda on implementations of claims process management. The study reports evidenced the challenge of human resources for health with the technical knowledge and trained on claims preparation and submission processes shortage. This poses a burden to few available to work over time to meet deadlines and hence increases chances of errors leading to rejection or deduction of claim (11).

Our study findings found that there are barriers from insurer side that hinder effective implementation of claims process management. Evidence exists that there are number of guidelines that guide claims process management from NHIF and MoHCDGEC with discrepancy hence attributed to the challenge on non-compliance from service provider side when siding with guideline that benefits them and beneficiaries. Our finding supports the current literature reporting on analysis of cost escalation at the NHIF in Tanzania. Health providers in this study complained about how the difference between NHF price list difference with MSD price list negatively affect their operations including provision of service delivery to NHIF clients. The laps of difference of the cost incurred by service provider if is different from NHIF price list stipulation are not reimbursed (37).

The study findings also found that claims rejection for the reasons of over utilization of medicines or tests poses a barrier to service provision. Health providers are arguing the decision of insurer who did not attending the clients deciding on tests and medication that was

prescribed in line with standard treatment guideline. The continuous use of the reasons to reject claims has an adverse effect on the quality service provision to NHIF beneficiaries. This supports the study done on claims management process under Ghana NHIS where it was reported that NHIS officer's inability to verify appropriateness of treatment or diagnoses made by service provider has resulted to claims rejection with the reasons of over utilization of medicine or medical test. It was thus observed that claims vetting at the scheme entailed mainly checking drugs and medical test for compliance with approved NHIS requirements and not their appropriateness for the diagnoses made to the beneficiaries(41).

The claims management processes are highly structured with diverse barriers which pose a potential of worsening implementation of claims preparations and submission procedures. Shortage of trained medical personnel at NHIF department has attributed to overload of work to few available working with support staff. Electronic claims system has number of challenges such as slow network and system being out service. Claims rejections for the reason of over utilization of medicine, tests, procedures and discrepancy between NHIF price list and MSD price list is argued by service provider as a challenge that impair service provision to beneficiaries.

The above challenges facing the NHIF claims process management may indicate the need for an independent arbitrator body that could not only manage arising dispute settlement issues between the NHIF and service providers, but also ensures the compliance of both the service providers and NHIF with claims process management as well as monitoring the overall NHIF performance.

5.5 Study limitations and mitigation plan

Since the study include the health care workers who are engaged in implementation of claims processing and facility executive team, there was a risk of information bias from participants giving their perception of issues rather than actual facts; to mitigate this bias researcher clearly explained to them the importance and objectives of this study so that they understand and provide actual facts. This study also interviewed officers from NHIF regiona officers. To address the chances of information bias that might have affected the results of the study, researcher used used triangulation method to validate the data received from other sources.

CHAPTER SIX

6.0 CONCLUSION AND RECOMMENDATION

6.1 CONCLUSION

The NHIF claims management processes are highly structured. The implementation of claims preparation processes and submission procedures at Temeke regional referral hospital are in line with guidelines, manuals and regulations. Providers are aware of the procedures and processes of claims preparations and submission. Providers have recorded timely submission of claims. However, the major challenge from provider side is noncompliance to claims preparation process and submission procedures attributing to large proportion of claims rejections. The discrepancy between NHIF price list and MSD price list has impaired ability of providers with potential of worsening service delivery to NHIF beneficiaries.

6.2 RECOMMENDATIONS

Based on the major findings of this study, the following policy measures are recommended in order to improve the implementation of the NHIF scheme:

i. Service providers at health insurance department Temeke Hospital should develop internal strategies to ensure compliance with NHIF claims preparations processes and submission procedures to reduce claims rejections as a result of noncompliance to requirements.

ii. NHIF should improve the functions of the e-claims system and build the capacity of service providers to utilize while working towards online preparations and submissions of claims.

iii. There should be a formal meeting between NHIF and Service providers to address the concern of claims rejections for a reason of over utilization of medicine, tests or procedures as it has potential of worsening mutual relationship between these stakeholders.

iv. NHIF should consider timely review of the available benefit package and price list to address their discrepancy with MSD price list and STG.

v. There is need for an independent arbitrator body that could not only manage arising dispute settlement issues between the NHIF and service providers, but also ensures the compliance of both the service providers and NHIF with claims process management as well as monitoring the overall NHIF performance.

REFERENCES

1. Assessment of Medicine Pricing and Reimbursement Systems in Health Insurance Schemes in Selected African Countries [Internet]. World Health Organisation. 2016.
2. Jamuhuri ya Muungano wa Tanzania. Waraka namba moja wa maboresho ya mfuko waafya ya jamii (CHF-TIKA). 1, 2018. p. 17.
3. Andoh-Adjei FX, Nsiah-Boateng E, Asante FA, van der Velden K, Spaan E. Providepreference for payment method under a national health insurance scheme: A survey of health insurance-credentialed health care providers in Ghana. PLoS One. 2019;14(8):1–13.
4. United Republic of Tanzania (URT) Tanzania Health Financing Profile-2016; Ministry of Health, Community Development, Gender, Elderly and Children
5. WHOThe World Health Report HEALTH SYSTEMS FINANCING. 2010.
6. Doethinchem O, Carrin G, Evans D. Thinking of introducing social health insurance? World Heal Rep Background Papaper No 26 [Internet]. 2010 Available from: https://www.who.int/healthsystems/topics/financing/healthreport/
7. Obadha M, Chuma J, Kazungu J, Barasa E. Health care purchasing in Kenya: Experiences of health care providers with capitation and fee-for-service provider payment mechanisms. Int J Health Plann Manage. 2019;34(1):e917–33.
8. Adei D, Agyemang-Duah W, Mensah AA. Predictors of enrollment in a health protection scheme among informal sector workers in Kumasi Metropolis of Ghana. BMC Res Notes [Internet]. 2019;12(1):1–6. Available from: https://doi.org/10.1186/s13104-019-4782-2
9. Barnum H, Kutzin J, Saxenian H. Incentives and provider payment methods. Int J Health Plann Manage. 1995;10(1):23–45.
10. Carapinha JL, Ross-Degnan D, Desta AT, Wagner AK. Health insurance systems in five Sub-Saharan African countries: Medicine benefits and data for decision making. Health Policy (New York). 2011;99(3):193–202.
11. Sodzi-Tettey S, Aikins M, Awoonor-Williams JK, Agyepong IA. Challenges in provider payment under the Ghana National Health Insurance Scheme: a case study of

claims management in two districts. Ghana Med J. 2012;

12. Mbogori FK, Ombui K, Iravo MA, Tan SY, Melendez-Torres GJ, Pang T, et al. Comprehensive approach for strengthening the management of regional referral hospitals in Tanzania. J Hosp Adm [Internet]. 2017;6(5):1–65.
13. Mtei G, Makawia S, Ally M, Kuwawenaruwa A, Meheus F, Borghi J. Who pays and who benefits from health care? An assessment of equity in health care financing and benefit distribution in Tanzania. Health Policy Plan. 2012;27(SUPPL.1).
14. Mtei G, Mulligan J, Ally M, Palmer N, Mills A. An Assessment of the Health Financing System in Tanzania: Implication for Equity and Social Health Insurance. Framework. 2007;(May).
15. Effah-Yeboah F, Challenges Accredited Health Service Providers Face in Health Insurance Claims Management in the Brong-Ahafo Region Thesis Submitted To the Department of African and General Studies, Faculty of Integrated Development Stu. 2018;
16. Pascal KN. National Health Insurance Fund (NHIF) in Tanzania as a tool for improving universal coverage and accesbility to health care service: 2015
17. Kipo-Sunyehzi, Amogre Ayanore, Dzidzonu, Ayalsuma Yakubu. Ghana's Journey towards Universal Health Coverage: The Role of the National Health Insurance Scheme. Eur J Investig Heal Psychol Educ. 2019;10(1):94–109.
18. Government of Tanzania. The national health insurance fund act, 1999 arrangement of sections. 1999.
19. Cashin C, Ankhbayar B, Phuong HT, Jamsran G. Assessing health provider payment systems: A practical guide for countries working toward universal health coverage. Washington, D.C: Joint Learning Network for Universal Health Coverage;2015.
20. Langenbrunner JC, Cashin C, Dougherty SO, editors. Designing and impementation health care provider payment systems: How-to manuals. Washington, DC; 2009.
21. The united republic of Tanzania ministry of health and social welfare 2010.
22. Dutta A. Prospects for Suatainable Health Financing in Tanzania: Baseline Report. Heal Policy Proj Futur Gr , Washingt DC. 2015;(February).
23. Borghi J, Maluka S, Kuwawenaruwa A, Makawia S, Tantau J, Mtei G, et al. Promoting

universal financial protection: A case study of new management of community health insurance in Tanzania. Heal Res Policy Syst [Internet]. 2013;11(1):1.

24. Haazen D. Making Health Financing Work for Poor People in Tanzania 2012.
25. University of Cape Coast https://erl.ucc.edu.gh/jspui. 2015;(July):2009–11.
26. Haule A, Ally Dida M, Elikana Sam A. Towards Data Exchange between Health Information System and Insurance Claims Management System. Int J Inf Eng Electron Bus. 2019;11(2):28–34.
27. Blanchet NJ, Fink G, Osei-Akoto I. The effect of Ghana's National Health Insurance Scheme on health care utilisation. Ghana Med J. 2012;
28. Dutta A, Hongoro C. Scaling up National Health Insurance in Nigeria: Learning from case studies of India, Colombia and Thailand. [Internet]. Health Policy Project. 2013. 6–51 p.
29. Wright A, Cornick E, Jones H, for The Health Foundation. Towards an effective NHS payment system 2017.
30. Republic U, Office NA. United Republic of Tanzania. Population policy compendium. 2016.
31. Nsiah-Boateng E, Asenso-Boadi F, Dsane-Selby L, Andoh-Adjei FX, Otoo N, Akweongo P, et al. Reducing medical claims cost to Ghana's National Health Insurance scheme: a cross-sectional comparative assessment of the paper- and electronic-based claims reviews. BMC Health Serv Res. 2017;17(1):1–7.
32. Akweongo P, Chatio ST, Owusu R, Salari P, Tedisio F, Aikins M. How does it affect service delivery under the National Health Insurance Scheme in Ghana? Health providers and insurance managers perspective on submission and reimbursement of claims. PLoS One [Internet] 2021
33. Shin H, Park H, Lee J, Jhee WC. A scoring model to detect abusive billing patterns in health insurance claims. Expert Syst Appl. 2012;
34. Ranson MK. Reduction of catastrophic health care expenditures by a community-based health insurance scheme in Gujarat, India: Current experiences and challenges. Bull World Health Organ. 2002;80(8):613–21.
35. Mills A, Ally M, Goudge J, Gyapong J, Mtei G. Progress towards universal coverage:

The health systems of Ghana, South Africa and Tanzania. Health Policy Plan. 2012;27(SUPPL.1):4–12.

36. Munge K, Mulupi S, Barasa EW, Chuma J. A critical analysis of purchasing arrangements in Kenya: The case of the national hospital insurance fund. Int J Heal Policy Manag [Internet]. 2018;7(3):244–54. Available from: https://doi.org/10.15171/ijhpm.2017.81
37. Lee B, Tarimo K, Dutta A. Analysis of Cost Escalation at the National Health Insurance Fund in Tanzania (Health Policy Brief) 2018
38. Aryeetey GC, Nonvignon J, Amissah C, Buckle G, Aikins M. The effect of the National Health Insurance Scheme (NHIS) on health service delivery in mission facilities in Ghana: 2016;
39. Sakyi EK, Atinga RA, Adzei FA. Managerial problems of hospitals under Ghana's National Health Insurance Scheme. Clin Gov An Int J. 2012;
40. Sodzi-Tettey S, Aikins M, Awoonor-Williams JK, Agyepong IA. Challenges in provider payment under the Ghana National Health Insurance Scheme: a case study of claims management in two districts. Ghana Med J. 2012;46(4):189–99.
41. Kipaseyia JS. Factors influencing membership uptake of National Hospital Insurance Fund among the poor: a pastoralist' perspective. 2016;p.2.
42. Shazy A. Causes and effects of delayed reimbursment to accredited health facilites by National Health Insurance Fund in delivery of health service.
43. Temeke Municipal Council:Annualy National Health Insurance (NHIF)Performance report ; 2020
44. World Health Organization. WHO | Universal Health Coverage. WHO. World Health Organization; 2018. p. 2.
45. Baxter P, Susan Jack, Jack S. Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. Qual Rep Vol [Internet]. 2008;13(4):544–59. Available from: http://scholar.google.com/scholar
46. Langenbrunner JC, Cashin C, Dougherty SO, editors. Designing and impementation health care provider payment systems: How-to manuals. Washington, DC; 2019.

47. Ortega PA, Ruz GA, Figueroa CJ. A Medical Claim Fraud / Abuse Detection System based on Data Mining: A Case Study in Chile. Proc DMIN 2006. 2006;(January 2006).

APPENDIX IA: KEY INFORMANT INTERVIEW GUIDE TO HEALTH CARE PROVIDERS AT TEMEKE RRH

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES

IMPLIMENTATION OF NHIF CLAIMS PROCESS MANAGEMENT AT REGIONAL REFERRAL HOSPITAL
A CASE OF TEMEKE REGIONAL REFERRAL HOSPITAL -TEMEKE MUNICIPAL

TOOL FOR HEALTH CARE PROVIDER AT NHIF DEPARTMENT IN THE FACILITY

INSTRUCTIONS TO THE INTERVIEWER

1. Interview will be conducted in privacy
2. Introduce yourself and assign an ID number to the interviewee.
3. The interview will take approximately 30 to 45 minutes.
4. Every bit of the interview should be clearly tape recorded and notes will be taken to compliment recorded interview

INTRODUCTION

Basic Participant Information	
Time of the beginning of interview:	Age:
Date of interview:	Sex:
Region:	Highest level of Education:
District:	Education specialty:
Job Title:	Interviewer name:
Duration at work place:	Time of finishing the interview:
Duration in current position:	Participant Code:

A: Service provider's compliance with claims preparations procedures at regional referral hospital

NHIF training to Service Providers on

*procedures for claims preparation

*National Treatment Guidelines and NHIF Price list is provided

*Special permit for treatment

1. Please explain your personal experience to the implementation of NHIF claims processing and management basing on your experience in this position?

   Probe; Adherence to the guidelines, responsibilities, implementation challenges

2. How training to services providers on NHIF claims preparation procedures is provided?

   Probe- Methods, barriers, facilitators, usefulness, duration, contents, when the last 3 training and what was was it for, adequacy

3. Please describe to us how your facility prepare claims for submission

   Probe: procedures for claiming, systems, stakeholders, compatibility of the system in health facility, reporting relationships, challenges

4. Please explain how is your complying with NHIF claims preparation procedures

   Probe

   - How do they perform quality control to avoid claims rejection?
   - How do they prevent possible commission of fraud or report if they suspect any

5. Based on your experiences what are the challenges with the Claims preparation procedures compliance..?

B: Implementation NHIF e-claims submission processes at regional referral hospital

Claims submission Processes

*Procedures for claims submission processes

*Last Claims submission report submitted to NHIF

6. Please explain what do you understand about e-claims system

Probe:

- How is the card verification system working, when is it used and where is it installed?
- How is the claims submission system working?

7. Please explain how NHIF claims submission processes/procedures are implemented at your facility basing on your experience in this position?

Probe; Submission processes, adherence to the guidelines, responsibilities and submission deadlines, key stakeholders, resources

D. barriers of e-claims process management implementation

10. Based on your experience what are the barriers of NHIF Claims preparations at regional referral hospital?

Probe: Health facility barriers, NHIF barriers, health workers related barriers, Human resource barriers

11. What are the barriers facing implementation NHIF e-claims submission at regional referral Hospital

Probe: Health facility barriers, NHIF barriers, health workers related barriers, Human resource barriers

APPENDIX IB: INTERVIEW GUIDE TO -MEDICAL OFFICEN INCHARGE, HOSPITAL SECRETARY AND HOSPITAL ACCOUNTANT (RRHMT)

IMPLIMENTATION OF NHIF CLAIMA PROCESS MANAGEMENT A CASE OF TEMEKE REGIONAL REFERRAL HOSPITAL -TEMEKE MUNICIPAL

INSTRUCTIONS TO THE INTERVIEWER

1. Interview will be conducted in privacy
2. Introduce yourself and assign an ID number to the interviewee.
3. The interview will take approximately 30 to 45 minutes.
4. Every bit of the interview should be clearly tape recorded and notes will be taken to compliment recorded interview

INTRODUCTION

Basic Participant Information (………………)	
Time of the beginning of interview:	Age:
Date of interview:	Sex:
Region:	Highest level of Education:
District:	Education specialty:
Job Title:	Interviewer name:
Duration at work place:	Time of finishing the interview:
Duration in current position:	Participant Code:
Identification of office:	

A: Service provider's compliance with claims preparations procedures at regional referral hospital

NHIF training to Service Providers on

*Procedures for claims preparation

*National Treatment Guidelines and NHIF Price list is provided

*Special permit for treatment

1. Please explain your personal experience to the implementation of NHIF claims processing and management basing on your experience in this position?

   Probe; Adherence to the guidelines, responsibilities, implementation challenges

2. Was training to services providers on NHIF claims preparation procedures provided?
   Probe- Methods, facilitators, duration, contents, when the last 3 training and what was it for, adequacy

3. Please describe NHIF claims preparation process at your facility for submission at your facility
   Probe: procedures for claiming, systems, stakeholders, compatibility of the system in health facility, reporting relationships, challenges

4. Is your facility complying with NHIF claims preparation procedures?
   Probe
   - How do they perform quality control to avoid claims rejection?
   - How do they prevent possible commission of fraud or report if they suspect any?

5. Based on your experiences what are the challenges with the Claims preparation procedures compliance..?

B: Implementation NHIF e-claims submission processes at regional referral hospital

Claims submission Processes

*Procedures for claims submission processes

*Last Claims submission report submitted to NHIF

6. Please explain the implementation of NHIF claims submission processes basing on your experience in this position?
   Probe; Submission processes, adherence to the guidelines, responsibilities and submission deadlines

7. Please explain the reporting procedures with respect to claims submission processes? (Request to see the last report)

   Probe. Procedures, guidelines, last submission of your facility claims report, last report to receive

8. Please explain what do you understand about e-claims system

   Probe:

   - How is the card verification system working, when is it used and where is it installed?
   - How is the claims submission system working?

D. barriers of e-claims process management implementation

9. Based on your experience what are the barriers of NHIF Claims preparations at regional referral hospital?

Probe: Health facility barriers, NHIF barriers, health workers related barriers, Human resource barriers

10. What are the barriers facing implementation NHIF e-claims submission at regional referral Hospital?

Probe: Health facility barriers, NHIF barriers, health workers related barriers, Human resource barriers

APPENDIX IC: KEY INFORMANT INTERVIEW GUIDE TO NHIF STAFF (TEMEKE REGIONAL OFFICE)

INSTRUCTIONS TO THE INTERVIEWER

1. Interview will be conducted in privacy
2. Introduce yourself and assign an ID number to the interviewee.
3. The interview will take approximately 30 to 45 minutes.
4. Every bit of the interview should be clearly tape recorded and notes will be taken to compliment recorded interview

INTRODUCTION

Basic Participant Information (………………)	
Time of the beginning of interview:	Age:
Date of interview:	Sex:
Region:	Highest level of Education:
District:	Education specialty:
Job Title:	Interviewer name:
Duration at work place:	Time of finishing the interview:
Duration in current position:	Participant Code:
Identification of office::	

NHIF STAFF

D. NHIF compliance with e-claims assessment guidelines

*Adherence to e-claims assessment process

1. Please describe the NHIF claims vetting process from when you receive claims from service providers

   Probe:

   - procedures for vetting, systems, stakeholders,
   - compatibility of the e-claims system at NHIF and health facility

2. Please describe NHIF claims quality assurance process before submitting claims for approval

   Probe:

- procedures for quality assurance
- Triangulations of hardcopy submitted claims and e-claims

3. Please describe how do you comply with claims assessment guideline

Probe:

- How do they comply with vetting processes?
- How do they comply with quality assurance processes?
- Timely payment of claims (Ask when did they the last report)

4. Can you please explain how providers comply with NHIF claims preparation procedures?

Probe:

- If the training to service provider on NHIF claims preparation was conducted
- card verification system is installed in all service provision areas
- If the training to service provider on how to use the system has been conducted
- if operation working tools that will be used to fill data were provided

5. Can you please explain how providers implement NHIF e-claims submission processes?

Probe:

- If the training to service provider on NHIF claims submission was conducted
- If the training to service provider on how to use the system has been conducted

E. barriers of e-claims process management implementation

6. Based on your experience what are the barriers of NHIF Claims preparations at regional referral hospital?
....
....
...

7. What are the barriers facing implementation NHIF e-claims submission at regional referral Hospital?

   Probe:

   - Administration (human resource availability, skills and capacity)
   - ICT environment (working tools and internet connectivity)

8. Based on your experience what are the barriers of NHIF Claims \assessment process at NHIF?

9. On your opinion how those barriers can be addressed??

   (Explain)………………………………………………………………………………

KIAMBATISHI IA: MWONGOZO WA MAHOJIANO YA KINA KWA: WATOA HUDUMA YA AFYA KITENGO CHA BIMA YA AFYA HOSPITAL YA RUFAA YA MKOA WA TEMEKE

CHUO KIKUU KISHIRIKI CHA AFYA NA SAYANSI YA TIBA MUHIMBILI

UTEKELEZAJI WA USIMAMIZI WA MCHAKATO WA MADAI YA MFUKO WA TAIFA WA BIMA YA AFYA KWA HOSPITALI ZA RUFAA ZA MIKOA

MAELEKEZO KWA MHOJAJI

1. Mahojiano haya yatafanyika kwa usiri
1. Jitambulishe jina lako na mpe namba ya utambulisho mhojiwa
2. Mahojiano haya yatachukua takriban dakika thelathini (30) hadi arobaini na tano (45)
3. Kila hatua ya mahojiano haya inapaswa kurekodiwa na baadhi ya maelezo yatachukuliwa kwa maandishi ili kujazia mahojiano yaliyorekodiwa

UTANGULIZI

Taarifa za Msingi za Mshiriki	
Muda wa kuanza mahojiano	Umri
Tarehe ya mahojiano	Jinsi
Mkoa	Kiwango cha juu cha elimu
Wilaya	Education specialty: (ubobezi)
Cheo	Jina la Mhojiwa
Muda uliotumikia kazini	Muda wa kumaliza mahojiano
Muda uliotumikia katika nafasi/cheo cha sasa	Namba ya mshiriki

A: Uzingatiaji wa taratibu za uandaaji wa madai ya Bima ya Afya kwa watoa Huduma katika Hospitali ya Rufaa ya Mkoa

Mafunzo ya NHIF kwa watoa huduma ya afya kuhusu

*Taratibu za uandaaji madai

*Mwongozo wa Kitaifa wa Matibabu na orodha ya bei za huduma za NHIF inatolewa

*Kibali maalumu cha matibabu

1. Tafadhali elezea uzoefu wako binafsi wa utekelezaji wa usimamizi na uchakataji wa madai ya Mfuko wa Taifa wa Bima ya Afya (NHIF) kulingana na uzoefu wako katika nafasi hii?

   Dodosa:

   - *Uzingatiaji wa miongozo, majukumu, changamoto za utekelezaji*

2. Mafunzo kwa watoa huduma ya Afya kuhusu taratibu za maandalizi ya madai ya Mfuko wa Taifa wa Bima ya Afya yanatolewaje?

   Dodosa:

   - *Njia za mafunzo, vikwazo, wawezeshaji, umuhimu, muda wa mafunzo, maudhui, mafunzo ya mwisho 3 yalitolewa lini na yalihusu nini, utoshelevu wa mafunzo*

3. Tafadhali elezea kituo chako kinaandaaje madai ya Bima ya Afya kwa ajili ya kuwasilisha?

   Dodoso:

   - *Taratibu za kudai, mifumo ya uandaaji, wadau, kuendana kwa mfumo kwenye kituo, mahusiano ya utoaji taarifa, changamoto*

4. Tafadhali elezea mnazingatiaje taratibu za uandaaji wa madai ya bima ya Afya ya Taifa?

   Dodosa

   - *Wanafanyaje uhakiki wa ubora wa ujazaji wa fomu za madai ili kupunguza madai kukataliwa?*
   - *Wanafanyaje ili kuzuia uwezekano wa wizi au udanganyifu wa aina yoyote kutokea au kutoa taarifa pale wanapohisi kuna wizi au udanganyifu?*

5. Kutokana na uzoefu wako kuna changamoto gani za uzingatiaji wa taratibu za maandalizi ya madai?

B: Utekelezaji wa uwasilishaji wa madai kwa mfumo wa kieletroniki katika hospitali za rufaa za mikoa

*Mchakato wa uwasilishaji madai

*Taratibu za michakato ya uwasilishaji madai

*Taarifa ya mwisho ya madai iliyowasilishwa kwa Bima ya Afya ya Taifa

6. Tafadhali elezea unaelewa nini kuhusu mfumo wa kieletroniki wa uwasilishaji madai wa Bima ya Afya?

   Dodosa

   - *Je mfumo wa ukaguzi wa kadi za Bima ya Afya unafanyaje kazi? Unatumika wakati gani na umesimikwa wapi?*
   - *Je mfumo wa uwasilishaji madai unafanyaje kazi hapa kituoni?*

7. Kutokana na uzoefu wako katika nafasi hii tafadhali elezea jinsi taratibu/michakato ya uwasilishaji wa madai ya NHIF inavyofanyika katika kituo chako?

   Dodosa;

   - *Michakato ya uwasilishaji, uzingatiaji wa miongozo, majukumu na tarehe ya mwisho ya uwasilishaji, wadau muhimu, rasilimali*

D. Changamoto za utekelezaji wa usimamizi wa mchakato wa madai kwa mfumo wa kieletroniki

8. Kutokana na uzoefu wako kuna changamoto gani za uandaaji wa madai ya NHIF katika hospitali za Rufaa za Mikoa?

   Dodosa:

   - *Changamoto zinazohusiana na kituo cha kutolea huduma ya afya, changamoto zinazohusiana na NHIF, Changamoto zinazohusiana na watoa huduma ya afya, changamoto zinazohusiana na rasimali*

9. Je ni changamoto gani mnazokabiliana nazo katika utumiaji wa mfumo wa uwasilishaji madai kieletroniki katika hospitali ya rufaa ya Mkoa?

   Dodosa:

   - *Changamoto zinazohusiana na kituo, changamoto zinazohusiana na watoa huduma ya afya, changamoto zitokanazo na rasimali*

KIAMBATISHI IB: MWONGOZO WA MAHOJIANO YA KINA KWA UONGOZI WA HOSPITALI YA RUFAA YA MKOA WA TEMEKE (MGANGA MFAWIDHI WA HOSPITALI, KATIBU WA AFYA, MUHASIBU WA HOSPITALI NA MATRONI)

CHUO KIKUU KISHIRIKI CHA AFYA NA SAYANSI YA TIBA MUHIMBILI

UTEKELEZAJI WA USIMAMIZI WA MCHAKATO WA MADAI YA MFUKO WA TAIFA WA BIMA YA AFYA KWA HOSPITALI ZA RUFAA ZA MIKOA

MAELEKEZO KWA MHOJAJI

1. Mahojiano haya yatafanyika kwa usiri
2. Jitambulishe jina lako na mpe namba ya utambulisho mhojiwa
3. Mahojiano haya yatachukua takriban dakika thelathini (30) hadi arobaini na tano (45)
4. Kila hatua ya mahojiano haya inapaswa kurekodiwa na baadhi ya maelezo yatachukuliwa kwa maandishi ili kujazia mahojiano yaliyorekodiwa

UTANGULIZI

Taarifa za Msingi za Mshiriki	
Muda wa kuanza mahojiano	Umri
Tarehe ya mahojiano	Jinsi
Mkoa	Kiwango cha juu cha elimu
Wilaya	Education specialty: (Eneo la ubobezi)
Cheo	Jina la Mhojiwa
Muda uliotumikia kazini	Muda wa kumaliza mahojiano
Muda uliotimikia katika nafasi/cheo cha sasa	Namba ya mshiriki

A: Uzingatiaji wa taratibu za uandaaji wa madai ya Bima ya Afya kwa watoa Huduma katika Hospital ya Rufaa ya Mkoa

Mafunzo ya NHIF kwa watoa huduma ya afya kuhusu

*Taratibu za uandaaji madai

*Mwongozo wa Kitaifa wa Matibabu na orodha ya bei za huduma za NHIF inatolewa

*Kibali maalumu cha matibabu

1. Tafadhali elezea uzoefu wako binafsi wa utekelezaji wa usimamizi na uchakataji wa madai ya Mfuko wa Taifa wa Bima ya Afya (NHIF) kulingana na uzoefu wako katika nafasi hii

   Dodosa;

   - *Uzingatiaji wa miongozo, majukumu, changamoto za utekelezaji*

2. Je watoa huduma wa afya walipewa mafunzo ya taratibu za kuandaa madai ya Bima ya Afya?

   Dodosa:

   - *Mbinu, wawezeshaji, muda, maudhui, mafunzo ya mwisho 3 yalitolewa lini? Utoshelevu wa mafunzo hayo*

3. Tafadhali elezea mchakato wa maandalizi ya madai ya NHIF kwenye kituo chako kwa ajili ya kuwasilisha

   Dodosa:

   - *Taratibu za mfumo wa uandaaji, wadau, kuhusiana na mifumo mingine katika kituo, mahusiano ya utoaji taarifa, changamoto*

4. Tafadhali tuambie ni kwa jinsi gani mnazingatia utaratibu wa uandaaji wa madai ya bima ya Afya?

   Dodosa

   - *Je wanafanyaje udhibiti ubora wa uandaaji wa fomu za madai ili kupunguza madai kukataliwa?*
   - *Je wanazuiaje uwezekano wa wizi au udanganyifu wa aina yoyote kutokea katika ujazaji fomu au kutoa taarifa pale wanapohisi kua wizi au udanganyifu?*

5. Kutokana na uzoefu wako kuna changamoto gani za uzingatiaji wa taratibu za maandalizi ya madai?

B: Utekelezaji wa michakato ya uwasilishaji wa madai ya NHIF kwa mfumo wa kieletroniki katika hospitali za rufaa za mikoa

*Michakato ya uwasilishaji madai

*Taratibu za michakato ya uwasilishaji wa madai

*Taarifa ya mwisho ya uwasilishaji wa madai kwa Bima ya Afya ya Taifa

6. Tafadhali elezea utekelezaji wa michakato ya uwasilishaji wa madai ya NHIF kulingana na uzoefu wako katika nafasi hii?

   Dodosa

   - *Michakato ya uwasilishaji, uzingatiaji wa miongozo, majukumu na tarehe za mwisho za kuwasilisha*

7. Tafadhali elezea taratibu za utoaji taarifa kuhusiana na michakato ya uwasilishaji wa madai (Omba kuona taarifa ya mwisho ya uwasilishaji madai)

   Dodosa:

   - *Taratibu, miongozo, mawasilisho ya mwisho ya ripoti ya madai ya kituo chako, taarifa ya mwisho kupokea kutoka Bima ya Afya*

8. Tafadhali elezea unaelewa nini kuhusu mfumo wa madai wa kielekroniki?

   Dodosa;

   - *Je mfumo wa ukaguzi wa kadi unafanyaje kazi? Unatumika wakati gani na umesimikwa wapi?*
   - *Je mfumo wa uwasilishaji madai unafanyaje kazi?*

D. Changamoto za utekelezaji wa usimamizi wa mchakato wa madai kwa mfumo wa kieletroniki

9. Kutokana na uzoefu wako je kuna changamoto gani za uandaaji wa madai ya NHIF katika hospitali za Rufaa za Mikoa?

   Dodosa:

   - *Changamoto zinazohusiana na kituo, changamoto zinazohusiana na watoa huduma ya afya, changamoto zinazohusiana na rasimali*

10. Je ni changamoto gani zinazokabili utekelezaji wa mfumo wa uwasilishaji madai kieletroniki katika hospitali ya rufaa ya Mkoa?

    Dodosa:

    - *Changamoto zinazohusiana na kituo, changamoto zinazohusiana na watoa huduma ya afya, changamoto zinazohusiana na rasimali*

KIAMBATISHI IC: MWONGOZO WA MAHOJIANO YA KINA NA MAOFISA OFISI YA NHIF MKOA WA TEMEKE (MENEJA WA MKOA, AFISA UHAKIKI UBORA, MUHASIBU, OFISA MADAI)

CHUO KIKUU KISHIRIKI CHA AFYA NA SAYANSI YA TIBA MUHIMBILI

UTEKELEZAJI WA WA USIMAMIZI WA MCHAKATO MADAI YA MFUKO WA TAIFA WA BIMA YA AFYA KWA HOSPITALI ZA RUFAA ZA MIKOA

MAELEKEZO KWA MHOJAJI

1. Mahojiano haya yatafanyika kwa usiri
2. Jitambulishe jina lako na mpe namba ya utambulisho mhojiwa
3. Mahojiano haya yatachukua takriban dakika thelathini (30) hadi arobaini na tano (45)
4. Kila hatua ya mahojiano haya inapaswa kurekodiwa na baadhi ya maelezo yatachukuliwa kwa maandishi ili kujazia mahojiano yaliyorekodiwa

UTANGULIZI

Taarifa za Msingi za Mshiriki	
Muda wa kuanza mahojiano	Umri
Tarehe ya mahojiano	Jinsi
Mkoa	Kiwango cha juu cha elimu
Wilaya	Education specialty: (Eneo la ubobezi)
Cheo	Jina la Mhojiwa
Muda uliotumikia kazini	Muda wa kumaliza mahojiano
Muda uliotimikia katika nafasi/cheo cha sasa	Namba ya mshiriki

Wafanyakazi wa NHIF

C. Uzingatiaji wa NHIF wa miongozo ya tathmini ya madai kwa mfumo wa kielektroniki

*Uzingatiajia wa mchakato wa tathmini ya madai kwa njia ya kieletroniki

1. Tafadhali elezea mchakato wa uhakiki wa madai ya NHIF kuanzia pale mnapopokea madai kutoka kwa watoa huduma.

   Dodosa:

   - *Taratibu za uhakiki, mifumo, wadau,*
   - *Kuendana kwa mfumo wa madai wa NHIF kwa njia ya kielektroniki na mifumo mingine iliyopo hospitali*

2. Tafadhali elezea michakato ya uhakiki ubora wa madai ya NHIF kabla ya kuyawasilisha kwa ajili ya uidhinishaji wa malipo.

   Dodosa:

   - *Utaratibu wa uhakiki ubora*
   - *Uoanishaji wa madai yaliyowasilishwa kwenye mfumo wa kieletroniki na mfumo wa makaratasi*

3. Tafadhali elezea jinsi mnavyozingatia mwongozo wa mchakato wa tathmini ya madai

   Dodosa:

   - *Unazingatiaje mchakato mzima wa uhakiki wa madai?*
   - *Unazingatiaje mchakato wa uhakiki ubora ?*
   - *Ulipaji kwa wakati wa madai (Uliza mara ya mwisho ya kutoa ripoti ya ulipaji wa madai kwenda kwa mtoa huduma)?*

4. Je unaweza kutuelezea ni kwa namna gani watoa huduma wanazingatia mchakato wa uandaaji wa madai?

   Dodosa:

   - *Kama mafunzo kwa watoa huduma za afya kuhusu uaandaaji wa madai ya NHIF yalitolewa*
   - *Mfumo wa uhakiki wa kadi umesimikwa katika maeneo yote ya kutolea huduma*

- *Kama mafunzo kwa watoa huduma ya afya ya namna ya kutumia mfumo wa kieletroniki yalitolewa*
- *Kama vitendea kazi kwa ajili ya kujaza taarifa kama vile fomu, kompyuta, na kifurushi cha intaneti vinatolewa*

5. Tafadhali unaweza kutuambia namna watoa huduma wanavyotekeleza mchakato wa uwasilishaji wadai kwa kutumia mfumo wa kieletroniki?

   Dodosa:

   - *Kama mafunzo kwa watoa huduma kuhusu mchakato wa uwasilishaji madai ya Bima ya Afya yalitolewa*
   - *Kama mafunzo kwa watoa huduma kuhusu matumizi ya mfumo wa uwasilishaji wa madai kieletroniki yalitolewa*

E. Changamoto za Utekelezaji wa usimamizi wa mchakato madai wa kieletroniki

6. Kutokana na uzoefu wako zipi kuna changamoto gani za uandaaji wa madai ya NHIF katika hospitali ya rufaa?

7. Changamoto gani zinazokabili utekelezaji wa mfumo wa madai ya NHIF kwa njia ya kieletroniki katika Hospitali za Rufaa za Mikoa?

   Dodosa:
   - *Uendeshaji (upatikanaji wa rasilimali watu, ujuzi na uwezo)*
   - *Mazingira ya TEHAMA (vitendea kazi, mtandao w intaneti)*

8. Kutokana na uzoefu wako; unakabiliana na changamoto gani za madai ya NHIF/mchakato wa tathmini katika ofisi za Bima ya afya?

9. Kwa maoni yako changamoto hizo zinaweza kutatuliwaje? (tafadhali elezea njia zinazoweza kusaidia utatuzi kama zipo?

APPENDIX IIA: INFORMED CONSENT (ENGLISH VERSION)

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES
DEPARTMENT OF DEVELOPMENT STUDIES

CONSENT TO PARTICIPATE IN THE STUDY

Consent to participate in a research

A research on Process Evaluation of Implementation NHIF Claims Process Management a Case of Temeke Regional Referral Hospital in Temeke Municipal

Dear Madam/ sir,

You are hereby invited to participate in a study conducted by Violeth Mlay for a Masters Dissertation at Muhimbili University of Health and Allied Sciences.

Your participation in this study is entirely voluntary. You should read the information below before deciding whether or not to participate in the study. Your participation in the study will involve responding to the interview questions.

PURPOSE OF THE STUDY: The purpose of this study is to evaluate Implementation of NHIF claims process management–a case of Temeke Regional Referral Hospital in Temeke Municipal

VOLUNTARY PARTICIPATION: Participation in this study is voluntary and you have a right to refuse to consent. If you consent to participate, you have the right to withdraw from the study at any time if you wish to do so.

BENEFITS: There are no direct benefits for participating in the study. However this study will provide information on the EVALUATION PROCESS OF NHIF PROVIDER PAYMENT MECHANISM. This information will be useful for addressing the concerns of Service Providers with regards to challenges NHIF Provider Payment Mechanism

RISKS AND DISCOMFORT: There are no risks or discomforts involved in this study.

COMPENSATION FOR TIME: You will not receive any payment or other compensation

for participation in this study. There is also no cost to you to participate in the study except your time.

CONFIDENTIALITY: Your participation in this study will remain confidential and your identity will be disclosed. There will be no any link between your identity and response.

REVIEW AND APPROVAL: The review and approval of the study has been done by the Ethical committee of Muhimbili University of Health and Allied Sciences (MUHAS).

RESULTS: The results of the study will be made available to you through a planned means of research dissemination and will be compiled in a research paper for publication as part of a partial fulfillment of a master's degree.

CONSENT FORM: I confirm that I have read carefully, understood the information provided and consent to participate in the study.

CONTACT: If you ever have questions about this study, you should contact the Principal Investigator Violeth Mlay from Muhimbili University of Health and Allied Sciences, P.O. Box 6611, Dar-es-Salaam. (Tel. 0714 773617)

The research has been reviewed and approved by Ethical Research Committee of Muhimbili University of Health and Allied Sciences, MUHAS. Please if you have any question about your rights as a participant, you may contact.

Dr. Bruno Sunguya,

Chairman of the Senate Research and Publications Committee,

P.O Box 65001,

Dar es Salaam (Tel 022-21503002-54 06, 2152489)

Dr. Aman Anaeli,

MUHAS: S.L.P, 65001,

Dar-es Salaam

Agreement Part

I therefore request your participation in this study;

DO YOU AGREE? YES:……NO……. (Tick for appropriate response)

If you agree, sign below

Participant's signature…………………………….. Date………………….

Investigator's signature……………………………..Date………………….

APPENDIX II B: RIDHAA YA KUSHIRIKI KATIKA UTAFITI (TOLEO LA KISWAHILI)

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
SCHOOL OF PUBLIC HEALTH AND SOCIAL SCIENCES
DEPARTMENT OF DEVELOPMENT STUDIES

RIDHAA YA KUSHIRIKI KATIKA UTAFITI

Ridhaa ya kushiriki katika utafiti

Tathmini ya mchakato wa uandaaji na uwasilishaji wa madai kwa watoa huduma za Afya kwa wateja wa Bima ya Afya kesi ya Hospitali ya Rufaa ya Mkoa wa Temeke-Manispa ya Temeke Dar es Salaam

Mpendwa mshiriki,

Ninakukaribisha kushiriki katika utafiti unaofanywa na Violeth Mlay mwanafunzi wa shahada ya pili (udhamili) kutoka chuo kikuu cha afya na sayansi shirikishi Muhimbili.

Kushiriki kwako katika utafiti huu ni kwa hiari. Unatakiwa kusoma taarifa zote katika fomu hii na kama kuna swali kuhusu jambo lolote ambalo halikueleweka unaweza kuuliza kabla hujaamua kushiriki au kutokushiriki. Ushiriki wako katika utafiti huu utahusisha wewe kujibu maswali yaliyo kwenye mwongozo wa majadiliano.

MADHUMUNI YA UTAFITI: Dhumuni la utafiti huu nikufanya Tathmini ya mchakato wa uandaaji na uwasilishaji wa madai ya watoa huduma za Afya kwa wateja wa Bima ya Afya kesi ya Hospitali ya Rufaa ya Mkoa wa Temeke-Manispa ya Temeke Dar es Salaam

USHIRIKI: Ushiriki katika utafiti huu ni wa hiari na una haki ya kukataa kushiriki . Kama umekubali kushiriki, unauhuru wa kujiondoa kwenye ushiriki katika utafiti muda wowote utakaoona unahitaji kufanya hivyo.

FAIDA: Hamna faida ya moja kwa moja kwa wewe kushiriki katika utafiti huu. Ila matokeo ya utafiti huu yatasaidia kutoa Tathmini ya mchakato wa Malipo kwa watoa huduma za Afya kwa wateja wa Bima ya Afya. Taarifa za utafiti huu zitakuwa na manufaa kwa watekelezaji wa mfuko wa bima ya afya na watoa huduma katika kupanga upya na kufanya maboresho ya utekelezaji wa Mfumo wa Malipo kwa Watoa Huduma za Afya kwa Wateja wao..

MADHARA NA USUMBUFU: Hakuna madhara yoyote na usumbufu wowote unaohusika katika utafiti huu.

MALIPO KWAAJILI YA MUDA: Hakutakuwa na malipo yoyote kutokana na ushiriki wako katika utafiti huu. Pia hakuna gharama zozote za wewe kushiriki katika utafiti huu isipokuwa muda wako tu.

USIRI: Ushiriki wako katika utafiti huu utabaki kuwa ni wa siri na utambulisho wako utafichuliwa. Hakutakuwa na uhusiano wowote kati ya utambulisho wako na majibu.

UHAKIKI NA RUHUSA: Uhakiki na ruhusa ya utafiti umefanywa na kamati ya maadili ya utafiti ya chuo kikuu cha afya na sayansi shirikishi Muhimbili (MUHAS).

MATOKEO: Matokeo ya utafiti huu yatapatikana kupitia njia zilizopangwa za uwasilishaji wa tafiti katika chuo kikuu cha afya na sayansi shirikishi Muhimbili na zitakusanywa nakutolewa kwenye chapisho ikiwa ni sehemu ya utimilifu wa shahada ya uzamili.

FOMU YA IDHINI: Ninathibitisha kwamba nimesoma kwa makini , nimeelewa maelezo yaliyotolewa na ninaidhinisha kushiriki katika utafiti **.**

MAWASILIANO: Kama utakuwa na swali lolote juu ya huu utafiti , unaweza kuwasiliana na Mtafiti Mkuu Violeth Mlay kutoka chuo kikuu cha afya na sayansi shirikisi Muhimbili , S.L. P 65001, Dar-es-Salaam. (Namba ya simu. 0714 773617)

Utafiti umehakikiwa na kuidhinishwa na Kamati ya Maadili ya Utafiti chuo kikuu cha afya na sayansi shirikishi Muhimbili, MUHAS. Tafadhali kama unaswali lolote kuhusu haki zako kama mshiriki unaweza kuwasiliana na.

Dr. Bruno Sunguya,
Mwenyekiti wa Seneti Utafiti na Machapisho,
S.L. P 65001,
Dar es Salaam (Simu No. 022-21503002-54 06, 2152489)

Dr. Aman Anaeli,
MUHAS: S.L.P, 65001, Dar-es Salaam.
(Tel. 0713443724) ambaye ni msimamizi wa utafiti huu.

Sehemu ya makubaliano

Hivyo basi ninaomba ushiriki wako katika utafiti huu;

JE UNAKUBALI KUSHIRIKI? NDIYO:…….HAPANA……. (Weka tiki kwenye jibu sahihi)

Kama unakubali, saini hapo chini

Sahihi ya Mshiriki…………………………….. Tarehe………………….

Sahihi ya Mtafiti……………………………..Tarehe………………….

APPENDIX III : ETHICAL LETTER

UNITED REPUBLIC OF TANZANIA

MINISTRY OF EDUCATION, SCIENCE AND TECHNOLOGY

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES

OFFICE OF THE DIRECTOR - RESEARCH AND PUBLICATIONS

Ref. No.DA.282/298/01.C/ Date: 08/06/2021

MUHAS-REC-06-2021-670

Violeth S. Mlay,
MPH-Executive Track,
School of Public Health and Social Sciences
MUHAS

RE: APPROVAL FOR ETHICAL CLEARANCE FOR A STUDY TITLED: IMPLIMENTATION OF NATIONAL HEALTH INSURANCE CLAIMS MANAGEMENT PROCESS IN REGIONAL REFFERAL HOSPITAL A CASE OF TEMEKE REGIONAL REFFERAL HOSPITAL TEMEKE MUNICIPALITY

Reference is made to the above heading.

I am pleased to inform you that the Chairman has on behalf of the University Senate, approved ethical clearance of the above-mentioned study, on recommendations of the Senate Research and Publications Committee meeting accordance with MUHAS research policy and Tanzania regulations governing human and animal subjects research.

APPROVAL DATE: 08/06/2021
EXPIRATION DATE OF APPROVAL: 07/06/2022

STUDY DESCRIPTION:
Purpose:
The purpose of this qualitative case study design to evaluate Implementation of claims process management at regional referral hospital

The approved protocol and procedures for this study is attached and stamped with this letter, and can be found in the link provided: https://irb.muhas.ac.tz/storage/Certificates/Certificate%20-%20757.pdf and in the MUHAS archives.

The PI is required to:

1. Submit bi-annual progress reports and final report upon completion of the study.
2. Report to the IRB any unanticipated problem involving risks to subjects or others including adverse events where applicable.
3. Apply for renewal of approval of ethical clearance one (1) month prior its expiration if the study is not completed at the end of this ethical approval. You may not continue with any research activity beyond the expiration date without the approval of the IRB. Failure to receive approval for continuation before the expiration date will result in automatic termination of the approval for this study on the expiration date.
4. Obtain IRB amendment (s) approval for any changes to any aspect of this study before they can be implemented.
5. Data security is ultimately the responsibility of the investigator.
6. Apply for and obtain data transfer agreement (DTA) from NIMR if data will be transferred to a foreign country.
7. Apply for and obtain material transfer agreement (MTA) from NIMR, if research materials (samples) will be shipped to a foreign country,
8. Any researcher, who contravenes or fail to comply with these conditions, shall be guilty of an offence and shall be liable on conviction to a fine as per NIMR Act No. 23 of 1979, PART III section 10 (2)
9. The PI is required to ensure that the findings of the study are disseminated to relevant stake holders.
10. PI is required to be versed with necessary laws and regulatory policies that govern research in Tanzania. Some guidance is available on our website https://drp.muhas.ac.tz/.

Dr. Bruno Sunguya
Chairman, MUHAS Research and Ethics Committee

Cc: Director of Postgraduate Studies

9 United Nations Road; Upanga West; P.O. Box 65001, Dar Es Salaam: Tel. G/Line: +255-22-2150302/6; Ext. 1038; Direct Line:+255-22-2152489;Telefax:+255-22-2152489;E-mail:drp@muhas.ac.tz;Web:https://www.muhas.ac.tz

APPENDIX IV: INTRODUCTION LETTER

UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT,
GENDER, ELDERLY AND CHILDREN

NATIONAL HEALTH INSURANCE FUND

In reply please quote:

Ref. No. AE.17/324/01 **Date:** 21 June 2021

Director of Postgraduate Studies,
Muhimbili University of Health and Allied Sciences,
9 United Nations Road, Upanga West;
P.O. Box 65001,
Dar es Salaam.

Dear Sir/Madam,

RE: ACCEPTANCE TO FACILITATE VIOLETH S. MLAY TO COLLECT DATA AT NHIF

Reference is made to your letter with reference number HD/MUT/T.633/2019, dated 10th June 2021, regarding the above captioned heading.

2. We are pleased to inform you that the Fund has granted permission and is ready to assist Violeth S. Mlay to conduct academic research titled ***"Implementation of National Health Insurance Claims Management Process in Regional Referral Hospital. A case of Temeke Regional Referral Hospital in Temeke Municipality".***

3. Data that will be collected by this student should be treated with strict confidentiality and be used for the academic purpose only.

4. The student is also required to submit a copy of her final dissertation report to NHIF Head office for reference.

Yours Sincerely,

Baraka Maduhu
For: DIRECTOR GENERAL

NHIF Building Tambukareli, Jakaya Kikwete Road, P.O. Box 1437, Dodoma, Phone: +255262963888,
e-mail: info@nhif.or.tz, Website: www.nhif.or.tz

APPENDIX V: PERMISSION LETER

UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH, COMMUNITY DEVELOPMENT, GENDER, ELDERLY AND CHILDREN

Regional: DAR ES SALAAM
Address: 'Health'
Phone No: +255 -758 908110
Telefax Na:
Email: temekerh@afya.go.tz

TEMEKE REGIONAL REFERRAL HOSPITAL
P.O. BOX 45232
TEMEKE
DAR ES SALAAM.

Ref. No. TRRH/RSC/2/76.

Date: 14/6/2021

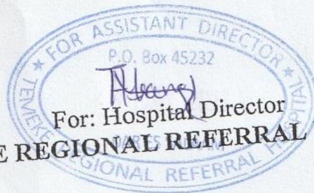
Name: VIOLETH S. MLAY
P.O.Box 60001
Institution: MUHAS.

RE: REQUEST FOR RESEARCH

Refer to the letter dated 8/6/2021 with Ref. No DA.282/298/01'C/ from MUHAS. I would like to inform you that your request for a research intends to do study titled IMPLIMENTATION of NATIONAL HEALTH INSURANCE CLAIMS MANAGEMENT PROCESS IN REGIONAL REFERRAL HOSPITAL A CASE OF TEMEKE REGIONAL REFERRAL HOSPITAL TEMEKE MUNICIPALITY is accepted Furthermore, there is no financial obligation for this request and you should report to the head of INT. MEDICINE after receiving this letter for your study.

Also you should copy with rules, laws, regulations and order of Temeke Regional referral Hospital for the period of your study.

Regards.



For: Hospital Director
TEMEKE REGIONAL REFERRAL HOSPITAL

Copy to:

1. The Head of Department
   Research (study)
   P.O. Box 60001
   INSTITUTION: MUHAS.
2. Head of INT. MEDICINE
   Temeke Regional Referral Hospital
   Kindly assist for HER Research