NATIONAL HEALTH INSURANCE FUND AND COMMUNITY HEALTH FUND LINKAGE TO ACCREDITED DRUG DISPENSING OUTLETS

REPORT SUMMARY

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Introduction.

Improved accessibility, equity and quality of health care with special emphasis on the most vulnerable are the main goals of the ongoing Health Sector Reforms. Numerous evaluations and discussions have underlined the need for improved strategies to realize the goals above. The rural and peri-urban areas have specifically been observed to be deficient in critical inputs for quality health care. These inputs include pharmaceutics and diagnostics. Recent experiences by beneficiaries of the National Health Insurance Fund (NHIF) and the Community Health Fund (CHF) have underlined the negative impact shortages of pharmaceutics can have in the functioning of complementary financing options and quality of health care services.

In an attempt to address the deficiencies above, an assessment co-sponsored by the Ministry of Health Tanzania, and Management Sciences for Health (MSH) had as one of its conclusions that there was a need to improve access to affordable quality drugs and pharmaceutical services in retail drugs outlets in the areas of the most vulnerable i.e. rural and peri-urban areas where there are few or no registered pharmacies. A just completed SEAM study compliments this conclusion well by observing that the suggested outlets could optimally contribute to improved pharmaceutical supplies if they are linked to NHIF and CHF. This study was a follow up of these conclusions.

Objective of the Study

The main objective of this study was to examine the NHIF and CHF and how they are functioning and if a way could be found on how they can work with the drug outlets ie. Accredited Drug Dispensing Outlets (ADDOS in the rural and peri- urban areas to improve availability of drugs to rural communities.

METHODOLOGY

A triangulation of methods was used in collecting and generating information. These methods included: Focus group discussions, In-depth interviews and visits to health care facilities belonging to the government and the voluntary sector. Review of reports from the study regions related to NHIF, CHF, the indent system and the Mackay House in Dodoma was done. Focused Group discussions were both homogenous and mixed these were conducted with owners of DLDBs, clients of NHIF, CHF and non clients of both systems. Other groups involved included Health Management teams at Municipalities and Districts visited in Ruvuma, Dodoma, Morogoro and Coast Regions. Standard approaches to design sampling, implementation and analysis were used specifically in Ruvuma Region the main focus of this study. In Dodoma, Morogoro and Coast Regions, purposive sampling was applied. It sought to contact the Health Sector leadership, the Mackay House accredited pharmacy staff, and clients found at service providing units or deep in the rural areas. The latter specifically targeted

teachers and extension workers who form more than 75% of the funds clients in the regions.

In-depth interviews were conducted with political and government leaders who play key roles in local agendas, health and social sectors. Those interviewed included regional Medical Officers, Regional Pharmacists, Districts Medical Officers, District Nursing Officers, Medical Officers incharge of the NHIF and CHF funds, the Medical Directors of Peramiho Hospital, and the Songea Archidiocese Medical Director Shorter, Informational interviews were conducted with Regional Commissioners of Ruvuma and Dodoma, Regional Administrative Secretaries of Ruvuma and Dodoma, District Executive Directors of studied districts, and heads of all the visited health care units. All interviews were guided by open-ended questions and allowed for exploration of elicited responses.

Sample Selection

Ruvuma Region was the main region of this study because this is where a pilot program of Accredited Drug Dispensing Outlets (ADDOs) will be established. Mackay House Pharmacy in Dodoma region was chosen because it is the only pharmacy accredited by the NHIF. It was included in the study to facilitate derivation of lessons on how accredited status functioned with NHIF, and what are possible lessons for ADDOS in the future. In an attempt to deepen understanding of the current state of NHIF and CHF, related questions were raised in Dodoma, Morogoro and Coast regions. This study was conducted in Ruvuma (the main study Region) from 13th to 24th December, 2002. Morogoro and Dodoma regions were visited between 5th to 12th January 2003. Coast Region (Kisarawe and Bagamoyo) were visited 21st and 22nd January, 2003.

Altogether, 19 focused group discussions were held in this study. Their distribution is as follows: 10 in Ruvuma Region (Songea Rural 3, Songea Urban 3, Mbinga 2 and Namtumbo 2), 5 in Dodoma (Dodoma Rural 1, and Coast Region 3 (Kisarawe 2 and Bagamoyo 1). The focused group discussions were held with of NHIF & CHF clients, health care providers from health care units-public and voluntary, health management committees and Duka la Dawa Baridi owners. The groups were mixed or homogenous. In this case homogenous means participants were of one profession only e.g. Teachers. Mixed means different professional backgrounds were brought together.

Altogether forty three indepth interviews were conducted in the four regions. Twenty five of these came from Ruvuma Region while the remaining were conducted in Dodoma, Morogoro and Coast. A total of eighteen informational interviews were conducted. Eleven from Ruvuma Region and seven from the remaining regions.

Indepth interviews were conducted with the Regional Medical Officer of Ruvuma, the Medical Director of Peramiho Hospital, the Director health Services Archiodiocese of Songea. The Ruvuma Regional Pharmacist, later the acting RMO, Ruvuma, and DMOS in Mbinga an acting DMO was interviewed because the substantive one was away in Morogoro. The District executive Directors (DEDS) were also interviewed except Namtumbo DED who was out in the villages. To fill this gap in Namtumbo a Senior Officer was interviewed instead. Medical officers in charge of the NHIF and CHF clients at all care provider units were interviewed at length. So also were District education Officers.

Informational interviews were held with 17 individuals who were not technicians or day to day operatives in the health care sector. Due to their position however, they were involved in making decisions, or were briefed from time to time on what was going on in the social sector in relation to NHCF and CHF. In this group, interview, were conducted with the Regional Commissioners of Ruvuma and Dodoma, their respective Regional Administrative Secretaries, District Commissioners, ward councilors in Ruvuma and Dodoma.

Selection of participants for focused group discussions was guided by the objectives of the study itself. Some of the terms of reference demanded a thorough understanding of NHIF and CHF funds in order to be able to recommend whether and how ADDOS could be linked to these funds. Individuals for focused group discussions therefore were: -

(i) Those who are clients of the funds. These will have experienced the fund. They will have known its weakness and strengths.

(ii) Owners of DLDBs who know how these shops function, what is needed to facilitate better performance, and what has been their experience so far with demands of NHIF & CHF clients as far as drugs are concerned. They are also best located to give views on how they could be linked to the funds.

(iii) Both health sector and political administrative Leaders at district and regional levels. These individuals are in decision-making and are involved in policy-making processes. Their positions expose them to discussion for and reports related to the funds. They are, so to speak, better informed.

(iv) Workers in the health facilities where clients receive services experience the funds in operation daily. They know the shortfalls and can potentially contribute ideas on how ADDO'S could be linked to the funds. Those who have been appointed to coordinate NHIF or CHF are particularly useful.

In the selection, furthermore, it was purposively ensured that clients from remote rural and peri-urban areas were included. This was the case because drug availability is particularly problematic in remote rural areas. For the purpose of this research a remote area was defined in terms of distance in kilometers from the district headquarters 50 kms and beyond from the district headquarters was counted as remote in the sense that a person whose prescription can not be filled at their unit, can not cover this distance on foot to get drugs elsewhere.

Each focused group was planned to have 9 participants. A range of five to ten was allowed. In some instances 11 participants showed up and in some 5 attended. Clients groups and leadership groups had an average were most confirmatory with an average of 7. For the others particularly the DLDB owners the average was 5. This figure was found to be satisfactory.

Selection of leaders at districts and regional levels was not a problem because the intention was to interview all the top Regional and District leadership. The intensity of the interviews, however, differed. The political leaders were given only informational interviews. Those leaders with more technical roles in relation to health care or health care financing were given indepth interviews.

For focused group discussions held at the outpatients department involving clients of the funds, simple random selection was used. This was made easier by the fact that at the regional hospital clients of the fund report at an office which has been set-aside for them only. Space for the discussions was provided by the regional hospital.

Health facilities to be visited beyond the district headquarters were chosen by simple random selection out of a list of facilities provided by the district authorities Distance was considered. As said above the cut of point was 50kms from the district offices. At the health facility all health care staff was involved in discussions.

In the rural areas focused group discussions were held with clients of the fund. The majority of these were teachers. In some areas there were a few extension workers of the Ministry of Agriculture at a ward level. In constituting these groups, the school nearest the facility being visited was requested to allow its teachers to participate. In instances where a school had a large number of teachers, simple random selection was used to get the required number. Likewise, all DLDB owners with business in the area being visited were requested to participate in individual interviews and group discussions.

An attempt was made to get views of outsiders (non-NHlF and non- CHF members) on how the funds (NHIF & CHF) work and so their potential of

linking with ADDOS. To do this, exit interviews were conducted at the regional hospital and all health care facilities visited. The interviews were obtained by use of a random number table. Village leaders where the visiting health care providing units were located were also interviewed to elicit their opinions on how the funds were functioning.

NHIF officials at the head office in Dar es Salaam were finally interviewed. These interviews were useful in understanding NHIF deeper. They also helped to crosscheck information provided by clients and regional/district authorities. The CHF coordinator in the ministry of Health when CHF was being introduced in Ruvuma region was also interviewed on several occasions to deepen understanding on CHF growth and functioning in the area. The Head health Sector Reforms and the Chief Pharmacist were also contacted.

Data Collection

The terms of reference for this study guided preparation of focus groups and interview instruments. The principal investigator and one field assistant worked together in conducting the focused group discussions and taking notes. In most of the individual interviews both the principal investigator and field assistant took notes. These notes were later compared for comprehensiveness. Since the investigators are bilingual like all the interviewees, it was easy to use both or one language as the situation determined.

The work of the team was greatly facilitated by the presence of Mr. Shirima currently with MSH. His presence enabled the team to interview all the leaders we needed to meet at both district and regional levels, at short notice. His previous senior position (PS) in several government ministries including the Ministry of Health was a major factor. Mr. Yona Hebron from the Pharmacy Board competently gave background to the project whenever questions a rose.

Besides substantial amounts of notes taken during the interviews, the team was given all the reports they requested from the voluntary sector, regional, district and ward level authorities. These reports specifically targeted NHIF, CHF pharmaceutics, and DLDBS.

Every evening the team held a discussion on the days work. At these sessions notes were compared. Any areas, which required further clarification, were identified and listed as priority issues to be taken up the following day. At these sessions also whatever was recorded in Kiswahili was translated into English.

FINDINGS OF THE STUDY

The National Health Insurance Fund (NHIF)

The Fund became operational on 1st October 2001.Salary based deductions for beneficiaries begun on 1st July 2001. Accredited health care provider units are both from the public and voluntary sectors. Performance of the two sectors in relation to the NHIF differs greatly. The Public Sector has performed poorly and has given the fund mixed rating. The voluntary sector on the other hand has performed well,and rates the fund favorably. Below is a summary comparing the two sectors.

A summary of NHIF Functioning in Ruvuma Region: Public and Voluntary Sector Views Compared

Operational Factor	**Sector**	
	Voluntary	**Public**
Time taken to settle claims submitted to NHIF	Good and reasonable. Settled within a month or two.	Time is too long. It takes up to 7 months
Amount reimbursed by NHIF compared to what was claimed by provider facility	90 – 98% of claimed amount	30 – 50% of claimed amount
Labor input in filling the Claim forms	Fair amount of lobour needed, could be reduced	Too much lobour. It takes too long. There is no motivation
Managing NHIF patients (staff time it takes between entry into doctor room and exit)	- Moderate, -Local innovation has reduced negative impact on our other Patients, - On average longer	-A lot of time -No time to see other patients who are paying cash. -Filling the forms is too demanding
Compliance of NHIF patients at OPD (i.e. listens to unit staff and follows advice)	Quite compliant and respectful	-Arrogant - Don't listen - Demand certain drugs and laboratory investigation
Compliance of NHIF patients in inpatients minimal demands beyond what is given	- Good - Satisfied with what we provide	- Poor - Demands higher grades - Demands attention of better qualified staff
Patients assessment of how	Rated as excellent	- rated as poor and

the provider facility has handled them		needing improvement
Patients satisfaction with drugs and other item supplied	satisfied	not satisfied
Provider units accepted all NHIF Allowable members including under fives	All accepted and charged	-under fives not accepted through the fund - Asthma and Diabetes not accepted through the fund - Maternal care not accepted on the card.
Level of participation as an accredited Body in NHIF	Full participation and charges all clients and allowed services	Partial. Not sending claims on all claimable items -Don't send claims for all under fives treated
Peripheral units e.g. Health Centers and dispensaries, submitting claims for NHIF patients treated.	All of them send claims	Dispensaries and Health centers not sending claims OR Only partly, some groups are treated free.
Feed back from NHIF offices in Dar on various items received on time	Yes Feedback is received and on time	No. There are delays in receiving feedback. At times no feedback
Visited by NHIF official or received a phone call	Yes. Several times	No. Not even once
Unit has visited or called NHIF in Dar to seek clarification	Yes. Several times	Only on certain occasions
Respective accredited units leadership carried out seminars to inform peripheral units of NHIF processes	Yes. All the time as changes are announced	No such seminars

CHF in Ruvuma.

It is evident from the fieldwork that the performance of CHF differs across the districts in the region. Mbinga has the best performance. CHF is better organized there, it covers both inpatient and outpatient services. It is better managed in the sense that collections are used to improve the quality of health care as table above has shown. Other factors include higher contributions per household. Whereas in Songea Rural the contribution per household is Tshs 7,000/= per year covering outpatient care only, in Mbinga it is 20,000 for outpatient and inpatient. In 2001/2002 it was TShs.30, 000 for both OPD and IPD services. During the fieldwork we were told that counselors had agreed to reduce it to 20,000 TShs. In Mbinga the Council has full decision-making power over the fund. It has put into use contributions as they are made. In Songea Rural they opened a fixed Deposit Account. Their use of contributions is not as good as it the case of Mbinga.

Other factors that deserve attention are how contributions are made in the districts. In Mbinga contributions are made by deductions from crop sales. This means the fund has a wide base and it is sustainable given the support it enjoys among councilors and the communities. In the other districts contributions mainly came from civil servants salary deductions. Since these have now joined NHIF, the base of contributions is eroding rather fast. The council in Mbinga has remained impressively active as far as the fund is concerned. CHF is a regular item on their meeting agendas. What the fund has done is physically verifiable. This has acted as a motivation to the communities to allow deductions from their crop sales.

It is logical to argue that if a fund is to link up with ADDO, it should be stable and sustainable. In Ruvuma region unless deliberate efforts are taken, CHF will most likely continue to decline in Songea Urban and Songea Rural. This will not be the case in Mbinga.

Mackay House Pharmacy

This is the only pharmacy in the country accredited by NHIF to date. Overall the pharmacy has performed well as an accredited unit. The following were reported as factors:

(i) Adherence to price guidelines as provided by NHIF.
(ii) Availability of equivalents in generic presentation.
(iii) Submission of well-prepared claims and on time.
(iv) Regular contacts by phones or visits to iron out occasional operational problems.
(v) Willingness to negotiate to overcome bottlenecks

(vi) Their ability to manage operational costs. Wholesale procurement has contributed significantly to this.

Selected Problems experienced by the Pharmacy as reported by the Pharmacy Manager.

- When they begun, reimbursements took a longer time to be effected.
- "The paper work takes a long time. It is necessary to fill all the summary sheets. It takes about 10 hours every month to complete all the forms".
- Brands versus Generics. "Some patients want particular brands from certain companies. We according to the contract must give generics. This has often been a source of disagreements and loss of clients."
- When this contract begun due to higher turnover of stock we had more out of stock rates. Any beginner in this area may encounter this.
- When doctors/prescribers did not adhere to EDL the rate of attrition increased. Many clients had to buy through out of pocket from here or elsewhere.

- They had to tie down the time of one of their staff to fill the forms. For smaller retail pharmacies this may be a real problem.
- Although we don't experience delays in payments anymore, for pharmacies which have fever clients and small operational capital DELAYS in claims reimbursement is a major threat to the units.
- Reimbursements are effected at MSD Price plus a 25% margin. A comparatively thin margin. We normally sell to other clients at MSD price plus 40 to 50% margin. To 'fill the loss' we therefore must have a larger number of clients from NHIF. Larger numbers however mean more paper work. It is somehow complex.
- Occasionally you don't get paid all of what you claimed. Eg. In October 2002, we claimed Tshs 542,000 submitted in early November 2002, but we got paid Tshs 508,000 paid at the end of December 2002. Although the situation has been rectified for others it may be an operational bottleneck.
- We have not been able to eliminate the out of stock problem because of the limited sources of wholesale. Some of the wholesalers are prohibitively expensive. Some NHIF clients therefore do go out to buy from own money.

Mackay House Pharmacy Lessons and implications on ADDOs

The idea of ADDOs has been received favourably as the section below will show. The issue at this moment is what are the implications on ADDO arising

from lessons and experiences of Mackay Pharmacy. The following are plausible observations.

(i) For ADDOs linkage with NHIF is a source of reliable income. This will
be the case provided: (a) payments are made on time by NHlF or alternative arrangements as will be suggested later in this work. (b) that the ADDO operators are trained to process their claims accurately and submit them on time. (c) that prescribers are reminded to prescribe generic and not brand names (d) that as they deal with NHlF clients ADDOs are simultaneously selling to other clients at market prices.

(ii) Given the fact that ADDOs are managed by two to three persons or even lesser particularly in the rural areas, innovative thinking must go into reducing the paper work without reducing efficiency of claim processing. The fund is already thinking about reducing the paper work but this may take some time to be completed.

(iii) Given the fact that ADDO's will be located in the rural areas or per urban areas where telephones (available to Mackay!) area luxury, there must be the possibilities of paying them TERMS CASH as close as possible to their area of operation.

Potentially negative effects of NHlF contracted retail links could probably be masked at Mackay by the other clients and larger volumes of turnover. For a smaller retailer like an ADDO that wider clientele is not there. To protect it from the possible negative effects it needs to be protected by credit support and payments at the district level. The district could use funds available locally and them claim to be reimbursed from NHlF.

RECOMMENDATIONS.

As the main report shows numerous scenarios were considered in order to draw up concrete recommendations. Out of ten possible scenarios the following recommendations have been drawn.

NHIF and ADDOS

Critical Factors:

(i) Given the nature of transactions envisaged at the ADDO level, ADDOs will not be able to extend credit.

(ii) Given the cost to be incurred by ADDOs in procurement of drugs and ultimately dispensing them, it is envisaged that NHIF will consider reimbursing

the ADDOs at a favorable margin. Such a margin should be above the current MSD + 25% rate.

(iii) Given the need for rapid turnaround of invested capital and its small volumes it is important that delays in reimbursements are minimized as much as possible. Favorable delays should be a within 30days of claims submission. To effect this, establishment of local NHIF agents to process and settle claims should be Seriously considered.

In view of these factors the following recommendation is given to link NHIF and ADDOs.

Recommendation

ADDOs will dispense to NHIF beneficiaries allowable drugs as prescribed by accepted prescribers. ADDOs will retain original prescription papers and submit them to the closest NHIF agent for verification and settlement of claims. Favorable claim settlement period to be within 30 days.

CHFs and ADDOs

Favorable factors

(i) Possibility to make expenditure decisions locally.
(ii) Availability of Financial Resources at respective areas .

Recommendation

Respective CHF Committee meets and decides which drugs need to be purchased from source other than MSD. Health care providers units dispense medicines to eligible communities members including NHIF beneficiaries. For the NHIF beneficiaries the provider unit thereafter claims reimbursement from the NHIF.