

**SERVICE QUALITY ASSESSMENT OF SOCIAL HEALTH INSURANCE
BENEFIT (SHIB) PROVIDED BY SOCIAL SECURITY FUNDS: A CASE OF
NSSF IN DAR ES SALAAM REGION**

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NSSF IN DAR ES SALAAM REGION**

By

Felistas Emmanuel Challe

**A Dissertation Submitted to Mzumbe University, Dar Es salaam Campus College
in Partial Fulfillment of the Requirement for the Award of the Degree of Master
of Business Administration (MBA CM) of Mzumbe University**

2013

CERTIFICATION

The undersigned certify that she has read and hereby recommends for acceptance by the Mzumbe University, a dissertation entitled: **Service Quality Assessment of Social Health Insurance Benefit (SHIB) provided by Social Security Funds: A Case of NSSF in Dar Es Salaam Region**, in partial fulfilment of the requirement of the Master of Business Administration Degree of Mzumbe University.

.....

Lusekelo Kasongwa (Major Supervisor)

Date:

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I, **Felistas Emmanuel Challe**, declare that this dissertation is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award.

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DEDICATION

This work is dedicated to my husband Joseph Mbepera, my children Monica, Christian Emmanuel and Faith Maureen and to my parents and relatives.

ABBREVIATIONS

ILO	:	International Labor Organization
LMICs	:	Low- and Middle-income Countries
NEDLIT	:	National Essential Drug List
NSSF	:	National Social Security Fund
SHI	:	Social Health Insurance
SHIB	:	Social Health Insurance Benefits
UNHCR	:	United Nations High Commission for Refugees
WHO	:	World Health Organization

ABSTRACT

The research about Assessment of Quality Service of Social Health Insurance Benefit (SHIB) provided by National Social Security Fund (NSSF) to its beneficiaries was conducted at the NSSF Dar Es Salaam Region Offices. The main objective of the study was to assess the quality of service offered by the NSSF through accredited hospitals and health centers to its customers residing in Dar es Salaam.

To perfect the study, the research was guided by Specific Research Objectives that were to assess the contribution of medical services provided under Social Health Insurance (SHIB) to its members; reliability of health services provided by SHIB; effectiveness of SHIB repayment system; and ultimately to suggest how best to improve the performance of medical services provided by the SHIB issuing system

Literature from different sources and from different authors were used for reference, and the researcher went far to see what others have done in the related field by performing the empirical review.

The study design was descriptive and 120 respondents, the sample size, from selected hospitals, the structured questionnaires. Data were analyzed using the SPSS programs, summarized and presented by using tables and figures.

From the findings it was revealed that medical services provided under Social Health Insurance (SHIB) to its members were of good quality although there are some weaknesses noted as 81.7% of all respondents enjoyed the services. Health services provided by SHIB were reliable although some improvement was required. Payment system was found to be effective and ultimately to the research paper suggested the best methods to improve the performance of medical services provided by the SHIB

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CHAPTER ONE

INTRODUCTION OR PROBLEM SETTING

1.0 Introduction

This chapter one is an introductory section which deals with the problem setting. This section gives the background information of the health insurance services in Tanzania. It states the statement of the problem, the objectives, and significances of the study, and research questions that guided this study.

1.1 Background to the Problem

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. Universal Declaration of Human Rights (1948), Article 25

Thirty years after the Declaration of Alma-Ata, an estimated 1.3 billion people worldwide still lack access to the most basic levels of health care. Although the right to social security and health is well established in international law, governments and international donors are still failing in their responsibility to guarantee these rights to millions of people. Huge disparities between rich and poor people remain evident between and within countries. All people have a right to health. In poor countries, the challenge is to finance systems that will deliver that right. After 20 years of one failed health financing mechanism – user fees, health insurance mechanisms were introduced to close health financing gaps and benefit poor people.

Although in theory social health insurance (SHI) has the most potential to achieve universal coverage, in practice this has been difficult to achieve in low-income countries. Among the main distinguishing features of SHI are the facts that membership is mandatory, and that premiums set are in proportion to income. Payment into the system is generally shared by employers, workers, and the government. SHI has the potential to create large risk pools, and to subsidize premiums for poorer members (Esmé Berkhout et al, 2008)

Health insurance schemes can be national, community or private (e.g. managed by a company for its employees). They can be mandatory or voluntary. Mandatory schemes are usually national, in which there is a legal obligation for people to pay into them and are based on the principle of social solidarity. Contributions are community-rated (i.e. based on an average expected cost of health service). These are usually called Social Health Insurance or, if covering the whole population, National Health Insurance. They are generally collected through payroll deductions (UNHCR, 2012).

There are also voluntary health insurance schemes. Voluntary or private insurance schemes may be managed on a for-profit or not-for-profit basis. Community-based health insurance schemes are usually run by community-based or non-governmental organizations, and may also be referred to as mutual health insurance, micro-insurance or community health funds. Insurance schemes often have high administrative and revenue collection costs. In most countries, national policies establish social health insurance as part of a broad social security system (Ron, 1999).

Health insurance schemes are supposed to reduce unforeseeable or unaffordable healthcare costs through calculable and regularly paid premiums. In contrast to the history of social health insurance in most developed countries, where health insurance schemes were first introduced for formal sector employees in urban areas, recently emerging health insurance schemes have taken the form of local initiatives of a rather small size that are often community-based with voluntary membership. They have either been initiated by health facilities, member-based organizations, local communities or cooperatives and can be owned and run by any of these organizations (Atim, 1998; Criel, 1998). There are several possible ways to classify these schemes, according to: kind of benefits provided, degree of risk pooling, circumstances of their creation, fund ownership and management, and distinction whether the schemes focus on coverage for high-cost, low frequency events or on low-cost, high-frequency events (Jutting, 2001).

Moving away from out-of-pocket payments for healthcare at the time of use to prepayment through health insurance is an important step towards averting financial hardships associated with paying for health services (Acharya et al., 2012). Social

health insurance is mandated for those employed in many developed countries where employment and wage rates are high; this service is extended to those unemployed through subsidy. In low and middle-income countries (LMICs) some version of SHI has been offered to those in the informal labor sector, who may well comprise the majority of the workforce (Acharya et al., 2012).

In most developing countries, this service is still facing a good number of challenges, including, especially, low coverage by the service providers and poor responses from the beneficiaries. The most excluded people are mainly the farmers and peasants in rural areas (ILO, 2006, Kuruvilla, et al. 2005).

Cost-recovery for health care via user fees was established in many developing countries usually as a response to severe constraints on government finance. However, most studies alerted decision-makers to the negative effects of user fees on the demand for care, especially that of the poorest households (ILO, 2006, Kuruvilla, et al. 2005).

. Government based Health Services Financing, which more often is significantly inadequate, is based on general tax revenues. Hence, alternative health financing systems, such as social health insurance contributions exist, to de-linking utilization from direct payment, and thereby protecting the population, especially the most vulnerable groups, from having to resort to various coping mechanisms (Carrin, 2003).

Health insurance is attracting more and more attention in low- and middle-income countries as a means for improving health care utilization and protecting households against impoverishment from out-of-pocket expenditures. The health financing mechanism was developed to counteract the detrimental effects of user fees introduced in the 1980s, which now appear to inhibit health care utilization, particularly for marginalized populations, and to sometimes lead to catastrophic health expenditures. The World Health Organization (WHO) considers health insurance a promising means for achieving universal health-care coverage.

1.2 Coverage of social security schemes and kinds of benefits provided

Various studies (see Bossert 1987, Tungaraza 1988 and Wangwe and Tibandebage 1999) on conventional social security have shown that the coverage of formal social security schemes is not comprehensive in terms of the population and risks covered.

Currently, such schemes cover only 6% of the population and about 5% of the active labour force in the country. In terms of gender, the majority of the people covered are men, since men constitute most those employed in the formal sector. In terms of risks, these schemes focus on a few benefits (Bossert 1987, Wangwe and Tibandebage 1999). They cover old age, disability, survivorship, illness, maternity, occupational accidents and diseases. Benefits are of two kinds: benefits in kind, where members are entitled to medical services from their employers and financial benefits in the case of illness and maternity. Provident funds give lump sum benefits to their members while social security schemes based on the social insurance principle provide initial lump sum payments followed by monthly benefits to their members. The same applies to non-contributory pension schemes.

The literature on the benefits available shows that conventional social security schemes have failed to protect members in distress so they may be self-respecting, self-sustaining and valuable members of society (Mangangila 1976, Mataba 1983, and Mlyansi 1991). For example, the rates of interest awarded annually to members of provident funds have invariably been negative in real terms and the lump sums paid out generally represent no more than a few month earnings.

The study done in German evidence that social health insurance provide financial protection for their members in terms of reducing their out-of-pocket expenditures, and that they improve utilization of inpatient and outpatient services. Weak evidence suggests that they have a positive impact on the quality of care. To illustrate this, schemes in Kenya, Uganda and the United Republic of Tanzania were found to improve service quality in health facilities, increase essential drug availability and shorten waiting times. (Ernest Spaan et al, 2012)

In Tanzania, The Social Health Insurance Benefit offered by NSSF was established in order to support government's efforts to increase access to healthcare services, to provide medical support to the insured person and his/her dependents and to provide relief to the employers on employees' medical expenses. It covers insured person/member spouse and up to four children, children include biological and legally adopted below 18 or 21 years if in full time education (NSSF, 2011).

Although health financing via general taxation or via social health insurance are generally recognized to be powerful methods to achieve universal coverage/access of health care with adequate financial protection for all against health care costs, yet many developing countries, especially the low-income ones like Tanzania, experience difficulties in achieving universal financial protection.

1.3 Statement of the problem

There are many benefits that National Social Security Fund (NSSF) members get through social health insurance benefit (SHIB). The NSSF provides a wide range of medical care benefits. The current benefit package offered by NSSF Health Scheme includes: registration fees, fees related to basic diagnostic tests, outpatient services which include medications as per National Essential Drug list (NEDLIT), in-patient care at fixed rates per day per level of health facility (i.e. Health Centre, District Hospital etc.), surgeries (Minor, Major and Specialized). The above benefits evolve around the need to cover members suffering from frequently recurring diseases. The package is to be reviewed from time to time for the purpose of enhancing it (NSSF Bulletin, 2011).

Despite mushrooming of health insurances providers throughout Tanzania, beneficiaries have been facing difficulties in accessing treatment through their policies and covers. Some hospitals prefer or accept insurance cards or only receive cards from selected insurance companies, sometimes patients are delayed to be given services when they use insurance cards compared to when cash is involved. Some specialized services are not prescribed for those in possession of insurance cards, just to mention a few among these challenges.

NSSF members who are registered with SHIB probably face similar challenges trying to use their health insurance schemes. There has been no study carried out to assess the service quality of SHIB and to examine whether clients are satisfied with the services they receive as SHIB members. This study will therefore assess the service quality of SHIB using a case study of NSSF in Dar Es Salaam region.

1.4 General Objective

The main objective was to assess quality service of social health insurance benefit (SHIB) provided by NSSF to its members taking the case of NSSF Dar Es Salaam Region.

Specific Objectives

- (i) To assess the contribution of medical services provided under social health insurance (SHIB) to the members.
- (ii) To assess the reliability of the health services offered by SHIB
- (iii) To study the effectiveness of SHIB repayment system
- (iv) To suggest guidelines on how to improve the performance of medical services delivered by the SHIB issuing system.

1.5 Research Questions

- (i) What is the contribution of medical services provided under social health insurance (SHIB) to the members?
- (ii) How reliable are health services offered by SHIB?
- (iii) How effective is SHIB repayment system?
- (iv) Which suggestions can be given as guidelines on how to improve the performance of medical services delivered by the SHIB issuing system?

1.6 Significance of the study

This study is very significant for health planning and administration and for the improvement of the performance of social security funds in Tanzania. This study will enable policy makers make decisions that are well informed by the existing performance of various institutions. This study is in line with the development strategies adopted by Tanzanian Government such as National Poverty Reduction Plan MKUKUTA and the Millennium Development Goals concerning the fight against diseases such as malaria, TB and HIV/AIDS by highlighting how SHIB is helping people in Tanzania to access health care. Finally, this study will help in academic cycle to help researchers to obtain basis for their work.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter provides the theories and concepts extracted from the literature and used by the researcher as references to explain the main issues regarding the service quality assessment of social health insurance benefit. It also provides tools or models to assess the quality of healthcare services as well as a definitions used in explaining service quality are given followed by the conceptual framework that provides the roadmap of the study. Service Quality has gained great importance such that service providers in the service industry use it marketing and competition weapon. The subject has as well attached researchers in a number of dimensions. In this chapter, relevant theories and.

2.1 Definitions of Key Concepts

2.1.1 Service

Service has been defined by many writers and researchers depending on the dimension and perspective of the writer. Kotler, (2001) defined service as any act or performance that one part can offer to another that is essentially intangible and does not result in the ownership of anything. Services are also defined as those separable identifiable, essentially intangible activities which provide want-satisfaction and are tied to sale of product or another service (Berry1980). Services can generally be defined as intangible experiences that cannot be tested in advance for quality or performance (Gronroos, 1990).

Service has unique characteristics that distinguish them from physical products. Such characteristics are intangibility, inseparability, variability (heterogeneity) and perish ability.

Intangibility refers to the fact that services are not physical objects. A service cannot be seen, touched, heard, smelled or tested in the same manner in which goods can be used before they are bought. For instance, when one pays an entrance fee for watching a football match in play ground or stadium, the credit that is paid for a phone call

service, the customer does not have anything in turn to own compared to when one buys a book.

Inseparability refers to the fact the customer and the service provided must interact for the service to happen. In other words, the service cannot be separated from the service provider. The client or customer is always in continuous contact with a representative (customer service employee) of the service provider. Perishability entails that services last a specific time and cannot be stored like a product for later use because they are perishable and they exist only at their production (Zeithaml, 2001).

In this study service was defined as a process consisting of a series of more or less intangible activities that normally, but not necessary always, take place in interactions between the customer and service employees and/or physical resources or good and or system of the service provider, which are provided as a solution to customer problems.

2.1.2 Quality

There are many definitions of quality used both in relation to health care and health systems, and in other spheres of activity. There is also a language of quality, with its own frequently-used terms

For the purposes of this study, a working definition by WHO characterizes quality in health care services as adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need, in a manner which maximizes resource use and avoids waste, timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need. Moreover the care which takes into account the preferences and aspirations of individual service users and the cultures of their communities and which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status and minimizes risks and harm to service users (Rafael, 2006)

2.1.3 Health

The widely agreed definition of health is that of the World Health Organization (WHO) which states that "Health is the state of complete physical, mental and social well-being and not merely the absence of disease." Health is thus considered the very

centre of persons' well being and development. It is today widely acknowledged that health is an important component of the development process in the sense that it can help or hinder national development, and that other forces of development can add to or detract from health (Kopoka, 2000).

2.1.4 Health Insurance

The Tanzania population has been exposed to free medical care for several decades. The concept of social health insurance is new to them and may not be readily understood and accepted. It is well known that the Fund is well established and has been operational for several years. And we believe that up to date the Fund has enough capacity, in terms of health manpower, to handle the demands of social health insurance scheme.

The government has put in place a number of policy initiatives and strategies to stem poverty and strengthen health care and delivery in the country. There are many health institutions in the country, both public and non-public, which can be used by the Fund to operationalize the Health Insurance Scheme. A number of health insurance schemes have been established in the past few years. These include the National Health Insurance Fund and several private insurance schemes. Experiences from these schemes we believe that would enable the Fund to run its social Health Insurance Benefit scheme (SHIB) more efficiently and effectively.

The structure of the Tanzania's National Health Insurance Fund, like other similar program elsewhere in the world, has been characterized by principles of social solidarity and risk sharing. The NSSF Health Scheme has the following features: There is cross subsidization among members of the Scheme such that the healthier assist the sick and the members earning high income subsidize those with low income etc. The scheme is financed through payroll contributors that are collected from employees by employers. The scheme is compulsory in nature in that the membership is stated in the Act establishing the Fund. [Act no. 28 of 1997]

Contributions are gathered in a specific ring fenced fund, independent from the Government budget. The scheme has a predetermined package of benefits and does not cover any thing not stipulated in the benefit package (partial coverage).

In law and economics, insurance is form of risk management primarily used to hedge against the risk of a contingent, uncertain loss. Insurance is defined as the equitable transfer of the risk of a loss, from an entity to another, in exchange for payment. An insurer is a company selling the insurance; an insured or policy holder is the person or entity buying the insurance policy. And therefore the Health policy of Tanzania refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society. An explicit health policy can achieve several things: it defines a vision for the future which in turn helps to establish targets and points of reference for the short and medium term. It outlines priorities and the expected roles of different groups; and it builds consensus and informs people. The [Strategies](#) specialize in offering affordable, appropriate group health insurance plans for the Tanzanian Industry to cover their employees and their dependants. They offer medical insurance plans ranging from the very basic to top-end executive international covers. Their products cover benefits like outpatient treatment, inpatient treatment, chronic medication, dental treatments, and spectacles for correction of eye sight.

Therefore the National social security (NSSF) in Tanzania covers the following services, 1. Outpatients: consultation with clinical/medical officers, specialists or consultants, Minor surgical procedures, dispensing of drugs in the essential drug list, referral to higher level and special hospitals. 2. In patient: accommodation, consultations with clinical/medical officers, specialist or consultants, basic and specialized investigations, minor and major surgeries, dispensing of the drug in the special list, dispensing drugs on discharge, referral to higher level and special hospital But the National social fund of Tanzania in its SHIB does not cover the following medical services: Diseases or services or services covered under maternity benefits, free services /treatments provide by the government such as immunization, tuberculosis leprosy, cancer, HIV/AIDS, epidemics, mental illnesses ,diabetes mellitus, injuries where the part is involved such as a road accident and where the vehicle is covered by insurance.

Cosmetics and cosmetic surgery, services//treatments for self-inflicted diseases/ injuries like alcohol drug and tobacco abuse, attempted suicide and criminal abortion, physiotherapy services at home, psychiatric disease except during acute illness within

seven days of care, medical examination for employment, schooling and purposes. Treatment due to disease/condition arising from participating in experimental study trials, expensive specialized investigative procedures like MRI and DNA typing, services/treatment for injuries/conditions arising from active participation in riots, demonstrations, unrest and civil strife (NSSF guide 2001). Health insurance refers to a policy that will pay specified sums for medical expenses or treatment (Woeslew, 2009). Health Insurance policies can offer many options and vary in their approaches to coverage. Two questions small business owners face when considering health insurance are “what kind of benefits should I buy?” and “How much should I pay?” Regarding the first, buy the benefits that will protect you, your employees and your families in case of emergency. Regarding the second, it depends on your age (and your employee’ ages), gender and whether families will be considered. Choosing the most suitable and cost effective selection of medical benefits can be time consuming. Gupta (2005) argued that workforce that married with children will have considerably different needs, such as maternity and dental coverage, than group of single workers. People who work outdoors or workers spend their days at a computer may prefer an optional programme for eye care, safety glasses and sunglasses.

According to NSSF Bulletin, (2005), the following are the qualities of Health Insurance Services:

- (i) Reliability: Refer to the dependability, delivering on promises, accuracy and consistency of Health Insurance services
- (ii) Responsiveness: This refers to the promptness and helpfulness of Health insurance Services
- (iii) Assurance: This refers to the competence, courtesy, credibility and security of Health Insurance Services
- (iv) Empathy: This refers to the easy access, good communication, customer understanding and personalized attention on delivery of health insurance services Tangibles: This refers to the physical evidence of Health Insurance Services.

2.1.5 Service Quality

Quality is defined as the degree to which a set of inherent characteristic fulfils requirement (ISO 9000). ISO 9000 of 1997 further defines quality as the totality of features and characteristics of product or service that bears in its ability to satisfy stated or implied needs. Generally quality can be referred to as the non-inferiority, superiority or usefulness of a service or product.

Service Quality has different meanings to different people and this has led to service quality being characterized by five approaches i.e. Product, Process, Customer, Value and Transcendent. In the customer approach context, service quality is defined as satisfying customer's requirement relying on the ability of the organization to determine customer's requirement and then meet those requirements (Muzur, 1993). Customers have needs that need to be fulfilled. The customer needs and expectations are variables that depend on different factors like age, education, level, profession, income and marital status.

Stanford (1994) argued that, if a standard level of service quality defined, and if the organization claims to be providing high quality service, customers' requirements will be exceed and the organization will have satisfied customers and creates a positive image. High quality service intends to maximize the individual customer's expectation and fulfillments extending beyond the average service attributes with regards to the reality.

The transcendental or psychological approach in defining service quality entails that service quality cannot be entirely defined but it is rather party a matter of experience. This means if three different people receive the same service, every one may have a different opinion on the quality of the service depending on how the person experiences the service.

The process or manufacturing based approach suggests that quality is associated to conformance of set requirement. Every product should meet a number of

specifications and standards and divergence from these specifications and standards would make the product be of poor quality.

Product based approach bases on the differences in quality that are a result of features and attributes of the product. This approach assumes a measurable variable for service quality. A value based approach takes care of the relationship of quality of the service or product to the cost paid for the service or the product. The product or service may be rated excellent only if the price and cost of the product related better to the product or services offered.

2.1.6 Customer Service

Customer service is the provision of service to customers before, during and after purchase. According to Turban et al, (2002), Customer service is a series of activities designed to enhance the level of customer satisfaction-that is, the feeling that a product or service has met the customer expectation. In this study, customer service will refer to any assistance, support and guidance offered by service provider (NSSF) to existing and prospective customers.

Customer satisfaction is a feeling a person experience when comparing between what one get to what one expects to get (Oliver, 1990). In the comparison process, customers especially service industry use perceived performance instead of actual performance.

Richheld (1995) defines Customer satisfaction as the state of mind that customers have about a company when their expectation have been met one exceeded over the lifetime of the product or service. Expectation is related to the mind set and customer's attitude toward the service. The achievement of the customer satisfaction leads to company loyalty and the service or product repurchase. Richhels cites that customer's attitude a service or product repurchase depends on three things:

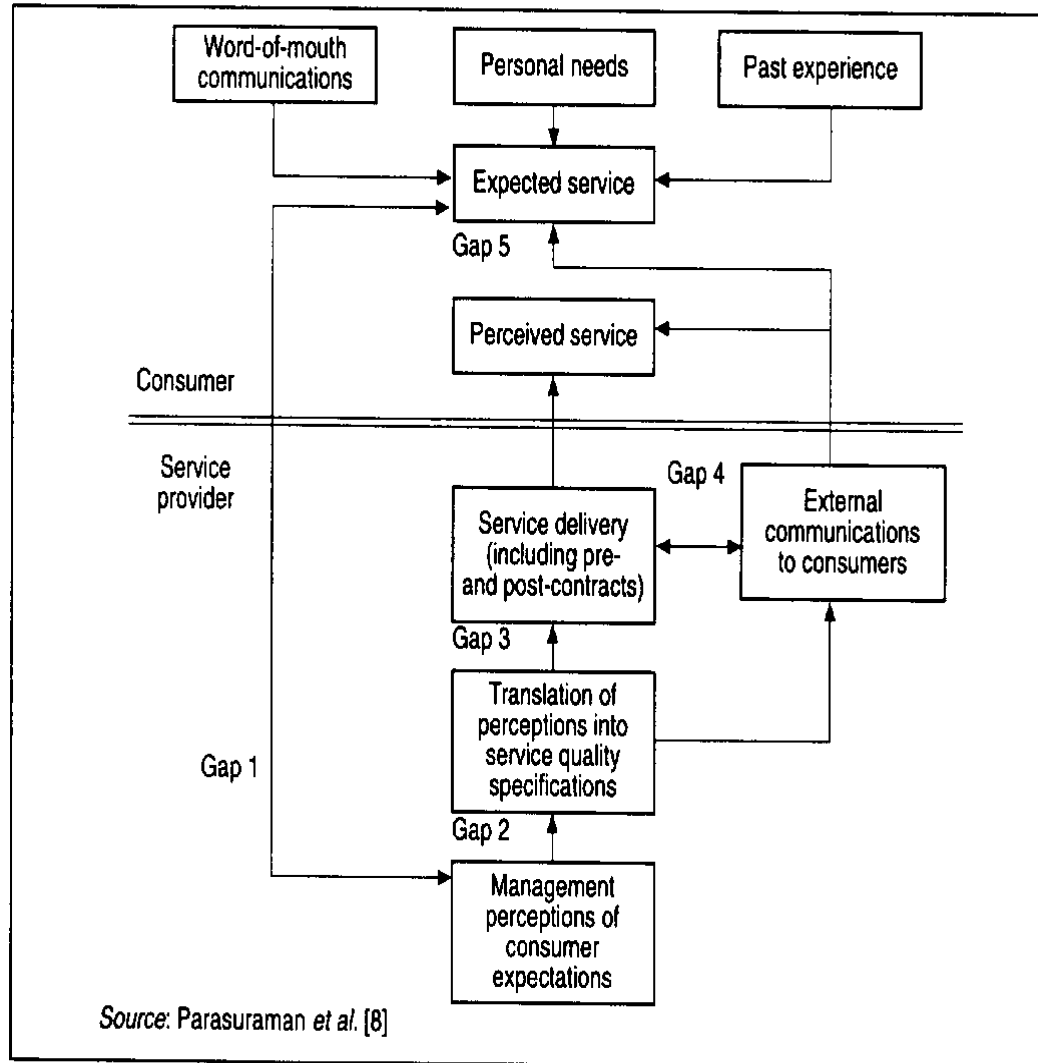
- (i) Service Acceptance: Customer is satisfied but will use the service for a better deal
- (ii) Service preference: Customer is delighted and may use service even in high price.

- (iii) Service rejection: Customer will avoid using the service at all if possible.

Satisfaction refers to any or all of the following: satisfaction with quality of a particular product or service, satisfaction with an ongoing business relationship, satisfaction with the price and performance of a product or service and satisfaction because a product or service met or exceeded the customer's expectation.

2.6 Conceptual Framework Service Quality Model

Figure 2.1: Service Quality Model (Parasuraman et al., 1985; Curry, 1999; Luk and Layton, 2002)



The model as it stands assume perfect knowledge of patients and only explore the dynamics of internal organization Gap2 and Gap 3 .I believe these dynamics are taken for granted in most of total quality management literature and it worth to explore them because they have first order affect in practical managerial setting.

There are seven major gaps in the service quality concept, which are shown in Figure 1. The model is an extension of Parasuraman *et al.* (1985). According to the following explanation (ASI Quality Systems, 1992; Curry, 1999; Luk and Layton, 2002), the three important gaps, which are more associated with the external customers, are Gap1, Gap5 and Gap6; since they have a direct relationship with customers.

- (i) Gap1: Customers' expectations versus management perceptions: as a result of the lack of a marketing research orientation, inadequate upward communication and too many layers of management.
- (ii) Gap2: Management perceptions versus service specifications: as a result of inadequate commitment to service quality, a perception of unfeasibility, inadequate task standardization and an absence of goal setting.
- (iii) Gap3: Service specifications versus service delivery: as a result of role ambiguity and conflict, poor employee-job fit and poor technology-job fit, inappropriate supervisory control systems, lack of perceived control and lack of teamwork.
- (iv) Gap4: Service delivery versus external communication: as a result of inadequate horizontal communications and propensity to over-promise.
- (v) Gap5: The discrepancy between customer expectations and their perceptions of the service delivered: as a result of the influences exerted from the customer side and the shortfalls (gaps) on the part of the service provider. In this case, customer expectations are influenced by the extent of personal needs, word of mouth recommendation and past service experiences.
- (vi) Gap6: The discrepancy between customer expectations and employees' perceptions: as a result of the differences in the understanding of customer expectations by front-line service providers.
- (vii) Gap7: The discrepancy between employee's perceptions and management perceptions: as a result of the differences in the understanding of customer expectations between managers and service providers.

2.2 Empirical Literature Review

2.2.1 Medical services and social health insurance

Randolph K. Q. (2007) conducted a study titled “Health care financing in Uganda: the role of social health insurance” The results show that Ugandans surveyed support the introduction of SHI. Some are willing to contribute financially and most believe that Ugandan government should make this benefit available to all Ugandan. While there is a great deal of support for introducing SHI, several respondents noted that cost sharing, in whatever form it takes, is burdensome on people with lower incomes and has disastrous consequences of the delivery and utilization of health services among poor.

Gupta A. Mc Daniel and Harath S. (2005) conducted a study on quality management in health insurance services firms: sustaining structure of total quality service. On their findings, the conceptual model develops three constructs: Leadership, organizational structure and employee commitment which are very important in achieving total quality service objectives. The proposed model links these three constructs with business processes and total quality service. Their study provides an important conceptual framework for evaluating the relationship between customer satisfactions and sustaining structures.

Teresa Zayas- Caban (2008) in her study titled “Modeling access to health care within a community” argued that health disparities have been a growing concern the USA. Differences in access to healthcare play a role in these health disparities. This article presents a model that illustrates access to healthcare in two rural Midwestern communities. The simulation model developed helps determine if people in these communities have equal access to health care and if physician’s insurance coverage practices prevent certain people from accessing care. From the simulation it can be determined which characteristics may lead to the disparities in access of health care.

A.M. Spreeuwerts et al (2012) in her study “Success and failure in social health insurance in sub-Saharan Africa: what lessons can be learnt?” Africa has the highest burden of disease in the world. However, in 2007 more than half of the 53 African countries spent less than \$ 50 per person on health. Of the total health expenditure, 30% came from governments, 20% from donors, and 50% from private sources – of which 71% was paid by patients themselves, the so called out-of-pocket payments.

Since health payments regularly take up a disproportional share of the household resources, out-of-pocket payments are an important barrier for seeking health in Sub-Saharan Africa. So, out-of-pocket payments create inequity in access to health care. A social health insurance can be a solution to improve access to health care.

Isaac Osei-Akoto (2010) in his study on client power and access to quality Health care, find that membership of the NHIS positively influences the decision to utilize formal or modern health care services for the treatment of illness. In the model, health insurance is assumed to be observed, and hence is deemed to be exogenous. Individuals who are insured have an increased probability of utilizing formal health care services with an effect size of 27% at a 1% level of significance. Individual characteristics also found to be statistically significant include sex of the individual and the severity of illness. Household characteristics such as income (measured here as welfare), education level of the household head, presence of married couple, number of females in the household, and locality of residence all influence the chances of an individual utilizing formal health care services

2.2.2 Reliability of the health services offered by health insurance

According to Kaseje, (2006), the worsening indices of health status in Africa demand a fresh look at the way health systems are organized and, how these systems address the complex causal pathways that lie beyond the influence of the formal health sector. This recognition suggests that effective action will only be possible when the formal system providers work in partnership with other stakeholders, particularly the community, as joint problem solvers through regular, evidence-based dialogue. This approach requires decentralized, inclusive democratic structures in the health system with effective representation of the needy households to ensure that their voices are heard. All stakeholders in the proposed participatory structures require training and orientation in skills such as communication, leadership and relationship building to ensure effective joint action for health, starting with what is possible and expanding to what is needed.

According to Agency for Healthcare Research and Quality, (2008) High Reliability organizations HROs are organizations with systems in place that are exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors. A set of challenges was identified that all the organizations pursuing high reliability had in common.

Hyper complexity: HROs exist in complex environments that depend on multiteam systems that must coordinate for safety. The safety of a hospitalized patient depends on the effective coordination of physicians, nurses, pharmacists, medical technicians, technicians who maintain equipment, support staff who provide meals and maintain the physical environment, and many others.

Tight coupling: HROs consist of tightly coupled teams in which the members depend on tasks performed across their team.

Extreme hierarchical differentiation: In HROs, roles are clearly differentiated and defined. Intensive coordination efforts are needed to keep members of the teams working cohesively. During times of crisis, however, decision making is deferred to the most knowledgeable person on the team, regard less of their position in the organization.

Multiple decision makers in a complex communication network: HROs consist of many decision makers working to make important, interconnected decisions.

High degree of accountability: HROs have a high degree of accountability when an error occurs that has severe consequences. In this respect need for frequent, immediate feedback: HROs exist in industries where team members must receive frequent feedback at all times. This feedback and the opportunity to make continuous adjustments based on it are essential to anticipate and avert problems before they become crises.

Compressed time constraints: Time constraints are common to many industries, including health care. In HROs, the systems and culture allow people to identify when they lack time to reliably complete all needed tasks and obtain additional assistance.

Higher workforce mobility: Hospitals tend to have a workforce that has higher turnover and less intact teams than many other industries. This makes training more critical (and expensive) and increases the importance of standardization of equipment and procedures.

Care of patients rather than machines: Most of the industries emphasizing high reliability deal with machines and processes that are mechanical and whose design and condition are meticulously documented. At the heart of hospital care are patients, about which little is often known, and whose behavior (and whose families' behaviors) varies from others and can change over time.

Efforts by the government to provide social security protection in the country have brought about significant development. However, due to the absence of an elaborate social security policy to guide effective functioning of the industry, there are some structural, operational and policy weaknesses inherent in the social security system.

According to the findings the SHIB is not reliable to all people as only employees in the formal sector are covered by the social security schemes and are estimated to be 1.0 million. This is only about 5.4% of the whole labour force of over 16 million Tanzanians. This means the remaining 15 million labour forces, engaged in informal sector and comparatively more vulnerable are not covered by the formal social security protection.

The social security sector lacks co-ordination at national level as each Fund reports to a different Ministry with differing operational rules and procedures. As a result, contribution rates benefit structures, qualifying conditions as well as plans and priorities differ from one institution to another.

Research findings shows that despite of the deliberate measures put forward by the government to improve provision of social services to the public, considerable part of the population has either limited or no access to services. In some instances, cost sharing in the provision of social services has reduced the capacity of the people to access the services

2.2.3 Effectiveness of Health insurance repayment system

According to Kida, (2012), individuals from poorer households are struggling to cope with the existing payment structure and therefore have developed various coping strategies to access health care services. These include:

- (i) Request for salary advance: the employed poor (formal/informal) are sometimes forced to request a salary advance in order to finance health care bills.
- (ii) Request for assistance from other close relatives and friends: In some incidents, the poor are forced to request for financial assistance from their close relatives and neighbors in order to finance medical expenses.
- (iii) Use of business capital to finance care: In some cases the poor are forced to use their relatively small business capital in order to finance health care services.
- (iv) Forced to compromise expenditure on other basic needs In some cases, the poor have to spend a large part of their (small) salaries on medical bills and thus compromise expenditure on other basic needs.
- (v) Use all/part of their small family savings The few poor individuals who have some savings are sometimes forced to spend a large part of it (if not all) to finance their health care bills.
- (vi) Accumulate debt through deferment of payment In some cases, the poor develop mutual relationships with the health care providers, especially the private dispensaries, and can defer their medical bills promising to pay later. This practice is convenient especially for the poor but it ties them to debt and also reduces their flexibility of choosing the health care facilities that could be providing higher quality care.
- (viii) Abstain from/postpone treatment in some cases, the poor are forced to

Postpone and/or abstain from receiving the required health care treatment until they secure the funds.

- (viii) Prioritizing household members in receiving health care services in some cases, the poor are forced to prioritize ill household members on seeking health care services given their limited resources. This is because in some situations they cannot afford to take all the ill members at once to consult a health care provider. For example, in some situations they would prefer to take children for better quality care while the adults wait for cheaper alternatives.
- (ix) Wait and see until the case is an emergency some of the respondents revealed that when someone in their household falls ill they do not rush to consult the health care provider, but wait until the case is severe. This behavior can be dangerous especially when small children are involved as they are taken to the hospital when the condition is very severe or too late to treat.
- (x) Forced to undertake partial treatment, this study also indicates that sometimes the poor have to undertake partial treatment, as they cannot afford to pay the full cost of treatment.

2.2.4 Ways to improve the performance

According to Yale & Murphy, (2007) improving healthcare effectiveness will require changes in how each stakeholder behaves, shifting where healthcare systems invest and putting the right incentives in place:

- (i) Care of chronic disease needs to take place within and outside the traditional medical system, and a greater investment in prevention is paramount. We can't look to the medical system alone to improve chronic care its reach is too short and boundaries are the key to tapping into these opportunities;
- (i) We need to align incentives and eliminate disincentives. While the use of incentives to motivate appropriate behavior is not new, they are often too

small and too confusing to work. We believe the application of best practices needs to be scaled up enormously. Healthcare behavior change is not its core competency. A broader set of stakeholders, including schools and employers, needs to play an active role in driving effective care, particularly prevention;

- (ii) Ultimately, change needs to take place at the local level. Well-organized collaborations across traditional organizational

2.3 Theoretical Framework

Structuration Theory and Framework

The need to explore professionalism and self-awareness have been utilized by Kondrat (1999) as a new way of thinking, Structuration theory was also utilized by Fergusson (2001) who explored practice and theory used in community based organizations. Giddens (1998) paved the way and foundation in the United States and Britain on welfare reform.

Structuration

Giddens (1984) developed Structuration Theory as a way to combine agency structure into a sociological theory. This theory allowed hope for all organizations that was considered of all dimensions. Structuration theory suggests that the representation of consciousness-raising can have a broad impact on empowerment practice. The main concern of structuration is the way social structures affect our consciousness and behavior that was displayed (Marx, 1964). Structuration has been implemented to increase the impact of empowerment practices.

Giddens (1984) believed that social structure have been intended to provide restricted explanations of human agency, while theorist of organizations was inattentive to structural arrangement and development. After reviewing the limitations of both, he developed the Structuration theory to exhibit the relationship between social structures and human beings. The Structuration process of social relations is often referred to as “Social Practices”. When human agency and social structure intertwine, this will give them the opportunity to produce different interventions Giddens (1984).

Consciousness- Raising Perspective

In many organizations, they congregate jointly to discuss a way to make improvements and how they can incorporate the changes and learn from them. This process was referred to as Consciousness raising; when you have the ability to confront your oppression, the transformation process from the acted- upon object to an acting subject who can perceive the cause of reality. First, this society had Giddens asking himself, how aware are we of our daily activities that create and recreate social structures? Second, how aware are we of how social structures and social arrangements influence our consciousness and behaviors? Giddens replied to these questions, by stating that we have been made up of three types of consciousness and knowledge that organize our experience and the interpretation of everything around us. The type of knowledge includes, Mutual Knowledge, Practical Knowledge, and Discursive Knowledge. Mutual Knowledge is the highest level. This knowledge gives you the ability to retain day to day information given to members of a community. It is “the knowledge that we must possess in order to understand what we are doing and what others do to affect our social lives” (Giddens, 1987).

This knowledge allows social practices to function together. Practical Knowledge was assumed or accepted by the receiver with no regards unless it was challenged. This allows the receiver to challenge those assumptions and examine the information that has been received. This form of knowledge can be addressed in discussion “what you were allowed to verbalize or to express feelings towards conditions, especially conditions related to our own actions” (Giddens, 1984). Discursive knowledge entails, being aware of our actions and being able to describe why we chose to engage in them. This knowledge is what we know or believe, especially our own conditions that cannot be expressed discursively (Giddens, 1984).

Structuration Theory provides consciousness-raising which brings about empowerment practices (Giddens, 1984). This theory provides an understanding of organization, while it allows individuals to be knowledgeable and empowered, which will allow them to make positive changes to their social structures based on their actions. Such understandings will innately quality care practices. This addresses the

structural and health care practices of the veterans' lives as well as the behavior we display when interacting with them. The implication allows an organization to make changes that will produce positive social practices.

Applying Structuration Theory to Critical Consciousness in Health Care Practices

Applying structuration theory to critical consciousness practices in health care practices is that individuals must want to bring change to that social relationship. Giddens (1984) argued that before social practices can be transformed, they must be dispassionately examined so that all parties' performances may be understood. To bring any positive change, it has to be understood that the participants can benefit from the social practice, thus lessening any discomfort. The practice of consciousness-raising describes earlier emphasized the importance of working jointly to provide support. Many organizations may benefit from initiating change in their social practices. This makes it easier more for an individual to engage and make positive changes.

2.4 Direct Impact to community

- Increase access
- Generate resources
- Improve equity
- Improved Access for members of Schemes
- Increased utilization of the members as compared to non-members
- Reduced out-of-pocket payment for members as compared to non-member

CHAPTER THREE RESEARCH METHODOLOGY

3.0 Introduction

This section presents the research methodology that was employed in this study. It spells out the techniques and methods of sampling, data collection, processing and analysis and presentation methods.

3.1 Research Design

Research Design as “the framework or plan for a study used as a guide in collecting and analysing data” (Brown and Suter, 2012:27), this means that selected research design should guide the conduction of the research so that at the end the study grasps the required results in the systematic manner. However, research design consists of three broad categories, namely descriptive research, exploratory research, and explanatory research.

Therefore, the research may be intending in percolating new ideas into the society so that, they can be known and hence the attention is paid upon them. This kind of research design is known as exploratory research. Though, on the other side, the aim of the research might be based or focused on the need to portray existing situation in the society which has already come into the attention of the society, this is known as descriptive research, and the last is explanatory research which much focus on the causal-factor relationship by controlling other factors (De Vaus, 2001; Brown and Suter, 2012).

This study was conducted using a descriptive design. This is the type of research which focus on the portraying a situation in the society. it is much used especially in the social sciences, however, a researcher using this kind of research design go some miles ahead and try to add the dynamics which exists in the particular topic under research. Furthermore, descriptive research encompasses much government sponsored research including the population census, the collection of a wide range of social indicators and economic information such as household expenditure patterns, time use studies, employment and crime statistics and the like (De Vaus, 2001: 1). Hence the questions which are asked in the descriptive research are much based in the descriptive manner, as the description might ask more abstract questions such as “Is the level of social inequality increasing or declining?”, “How secular is society?” or “How much poverty is there in this community?” Accurate descriptions of the level of unemployment or poverty have historically played a key role in social policy reforms. By demonstrating the existence of social problems, competent description can challenge accepted assumptions about the way things are and can provoke action (Marsh, 1982; De Vaus, 2001). Hence descriptive research is basing on describing the existing state of affair

within a particular society depending on the area under study. This design ensures that data collected are analyzed and findings are reported in order to establish a better understanding of a physical or social phenomenon. This descriptive design also combined both qualitative and quantitative approaches where both qualitative and quantitative data were collected during the study.

3.2 Study Area

The study was conducted at NSSF in Dar Es Salaam region. This scheme has a responsibility of offering protection to its members against economic and social distress that otherwise would be caused by substantial loss of income as a result of old age, invalidity, death of the breadwinner, maternity and employment injury. Also the scheme offers health care to an insured person and his/her immediate family.

The NSSF also takes care of assisting reasonable burial expenses upon the death of an insured person. Members of the scheme who are used to monthly or weekly payments are assured of continued monthly payment after retirement or becoming invalid. Payment under this scheme will also consider the member's social needs depending on the contingency facing the member while working. The main functions of the NSSF are, to register employers and employees who statutorily required to be contributing to the NSSF, to collect contribution from the registered employers and employees. to invest the collected contributions (i.e. member's funds) into viable, secure and high yielding investments/projects, to pay out benefits to entitled members of the fund.

The NSSF is a comprehensive social security institution based on International Insurance Principles, providing a wide range of short term and long term benefits to Tanzanians and their families namely: Old Age Pension, Invalidity Pension, Survivors Pension, Employment Injury, Medical Care, Maternity Benefit, and Funeral Grants. The Fund's vision is to maintain its position as "a leading provider of social security in Tanzania on the basis of the internationally recognized social insurance principles". The Fund is committed to meet member's evolving social security needs and expectations through utilization of dedicated human resource and modern technology.

The Fund provides services to its members and the general public on the basis of “respect, integrity, innovativeness, promptness and reliability” (NSSF Guide 2004). The NSSF covers the following sectors Private sectors which include Companies, Non Government Organizations (NGO), Embassies employing Tanzanians, International Organizations, Organized groups in the formal and informal sector etc. Government ministries and departments employing non-personable employees, parastatal Organizations employing non-pensionable employees. Self-employed or any other employed person not covered by any other scheme. Since its establishment in 1964 to 1989, employees were contributing 5% of their wages and their respective employers were adding another 5% to make 10% of the same. From 1989 to date the contribution is 10% from employee and another 10% from the respective employer.

Despite of the increase in number and quality of benefits offered, the employees and employers are not supposed to contribute any extra amount. However NSSF has its organization structure designed to cater the day to day operation of the Fund, this organization is under the Board of Trustee. The Fund is managed by Director General who is the Chief Executive Officer of the Fund, Five Directorates, and these are; Director of Operations (DO), Director of Finance (DF), Director of Planning Investment and Project (DPIP), Director of Human Resources and Administration (DHRA) and Director of Information and Technology (DIT). However there are Seven Chief Managers (CMs), Regional Managers (RMs), Managers and head of Department at the NSSF HQ. The study targeted client people involved in SHIB. Dar Es Salaam was selected because it is a center of various activities in the country. Therefore, this study got useful data for the subject under investigation.

3.3 Population of the Study

Gay (1987) defines target population under the research study as the group of people of interest to the research to which he would like to make some generalization on the result of the findings. As far as this study is concerned, the population of the study was client and staff involved with NSSF, SHIB officers involved in Dar es Salaam.

3.4 Sample size and Sampling Procedures

3.4.1 Sample Size

A sample represents a group of respondents drawn from the population in such a way that the information obtained from it can be generalized on a population (Kothari, 1990). The sample was selected. The sample used in this study was 120 NSSF clients and staff.

3.4.2 Sampling Procedures

This research applied purposive sampling procedure. This procedure is non-probability sampling method which involves respondents found in the area of study without randomization. This method was applied because human resource management officers are readily available in the offices and are willing to give information.

3.5 Data Collection Methods

The data collection methods used was observation, in-depth interview with key informants and using self administered individual questionnaires.

- (i) Observation methods of data collection were used in order to assess the perceived performance assessment of social health insurance benefit (SHIB). Observation method is an attempt to interpret the meaning of the events for those involved so that both apparent and unapparent actions and events can be discovered (Kothari, 1990; Brown and Suter, 2012). Through observation open ended and first-hand information are yield. It involves physical settings or environments, social interactions, physical activities, nonverbal communications, planned and unplanned activities, interactions and unobtrusive indicators. (Cohen *et al*, 2000, Brown and Suter, 2012), however, using observation, in most of the time, depends with the nature of information that a researcher wants to yield from a study. In this study, observation was done by a researcher in the certain selected areas within the study. The selected areas were those ones which required the attention of the researcher beyond using interviews, focused group discussion or telephone interviews. The

observations also helped in collecting nonverbal responses from the respondents.

- (ii) Questionnaires included already prepared questions which are structured and semi-structured questions. These questionnaires had an advantage of collecting data quickly and open ended questions, gave freedom to respondents to elaborate their answers. Questionnaires enable the researcher to collect data within a short period of time and useful, especially in the studies with big samples (Kothari, 1990). The questionnaires were distributed to the respondents, and they were filled under the supervision of the researcher for clarification in case of any problem especially in English terminologies, however, the researcher did not impose her answers upon the respondents.
- (iii) Interviews with key informants were also used in order to obtain more in-depth information. Interview used open ended questions from which respondents were able to discuss issues of interests in details. Cohen *et al* (2000) defines interview as a flexible tool for data collection that enables multisensory channels to be used such as using verbal, no-verbal, spoken and herd person. Thus through interviews a researcher is able to ask questions to the respondents and hence get their answers related on the one the researched topic.

3.6 Data analysis methods

Data collected were analyzed using the Statistical Package for the Social Science (SPSS) for quantitative data while qualitative data were analyzed using content analysis methods in which emerging issues and patterns were grouped under one category using content analysis matrix and were analyzed systematically.

CHAPTER FOUR

PRESENTATION OF FINDINGS, ANALYSIS AND DISCUSSION

4.0 Introduction

This chapter presents the findings of the research from the fieldwork, which comprised interview and secondary data collection, which took place in February and June 2013. The findings were analyzed in relation to the objectives of the study. The findings were presented by the simple statistical methods like simple frequencies in percentage presented in tables, graph and pie to presents the findings that are intended to provide systematic and comprehensive assessment of quality service of social health insurance benefit (SHIB) provided by NSSF to its members taking the case of NSSF. It, therefore, provides what were revealed through questionnaires, interview, documentary sources and observation.

4.1. Demographic Data

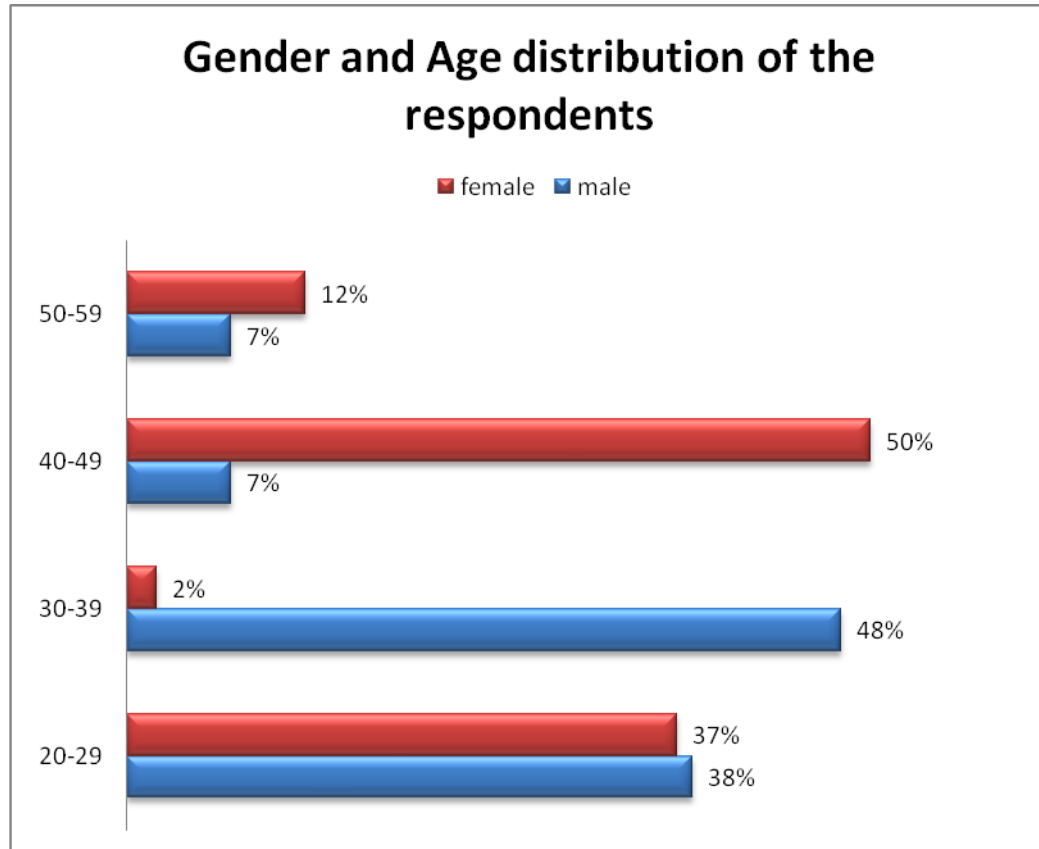
Demographic characteristics of the respondent's variables (gender, age, level of education and marital status) discussed into details.

In any study, demographic characteristics of the respondents are important because they provide information on background setting of the population where the study takes place. This section presents the demographic characteristics of the respondents including their working department, gender, age and level of education.

4.1.1 Socio-demographic characteristics of respondents

In this study respondents age and sex variable was assessed and results reveal that most of them were in middle age group, which explains that respondents were matured enough to participate into the study. The results obtained are presented in figure 4.1

Figure 4. 1: Gender and Age distribution of the Respondents.



Source: Researcher, 2013

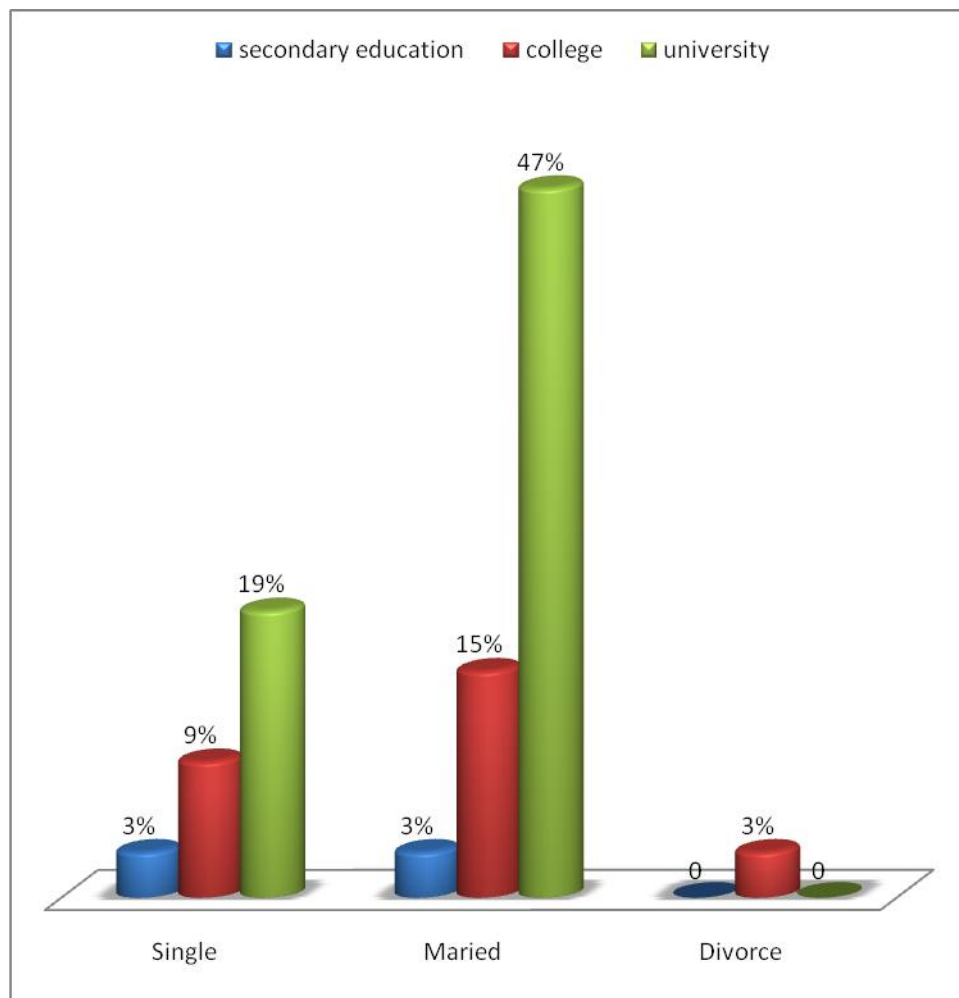
Among the patients interviewed in the study, there were more women than men (See Table 2 below). The most of respondents (50%) were age between 40 -59 and more frequency was higher among women however 48% were from age 30-39 and 38% from age 20-29 at this age the men were having more frequency than women. However, very few were from age of 50-59.

This is due to that the SHIB service covers only the insured person, their spouse and up to four children who include biological and legally adopted ones below 18 years or up to 21 years if in full time education. Also the findings reveal that young people are more informed and active in joining health insurance than elder people.

4.1.2 Educational Level of Respondents and Marital Status of Respondents

Respondents were also classified according to their level of education and their marital status.

Figure 4.2: Educational level and marital status of Respondents.



Source: Researcher, 2013

Respondents were asked to indicate their level of education because, level of education determine understanding capacity of respondents on issues of social health insurance benefit and their performances. From the research results shows that majority of the respondents had college and university education level, which implies that they are

equipped with necessary knowledge and skills on type of work they perform and that can understand well the quality of services provided by the social health insurance benefit.

The finding show that, the majority of respondents had attended university education 79 (66%) followed by collage education 33 (28 %).most of respondents were married 78 (65%), followed by single 33(31%).from the finding it shows that university graduates are more informed about different services available in the community. Furthermore married are well informed due to families' responsibilities, as they are more concerned with their health and the health of their children.

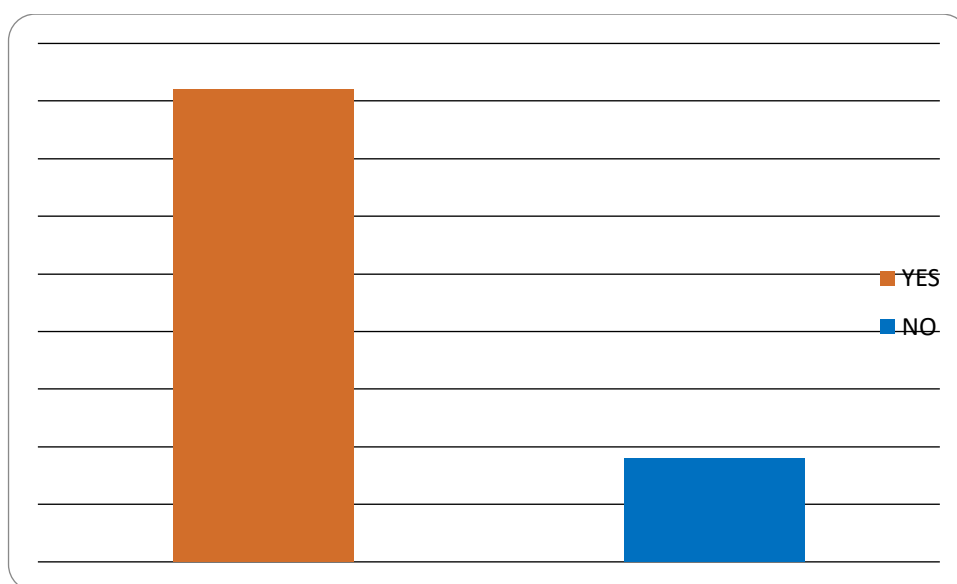
4.2 Research findings based on research questions

4.2.1 Contribution of Medical Services Provided under SHIB to the Members

This research question was assessed by requesting respondents to indicate whether they are aware of the benefits offered by the social health insurance. The respondents reported that they are aware of services offered by social health insurance although there are some diseases which are not covered with the fund. Treatment such as MRI and renal dialysis is not covered

Also Self-inflicted diseases or injuries e.g. drug abuse, tobacco, alcohol, attempted suicide, and criminal abortion and Luxurious like Cosmetic treatments with no medical indications e.g. plastic surgery

Figure 4.3: If members get benefits provided by SHIB



Source: Researcher, 2013

Figure 4.3 shows that 98 (81.7) of all respondents said yes, that they get benefits offered by SHIB while 22 (18.3%) of all respondents said no that they do not get benefits offered by SHIB.

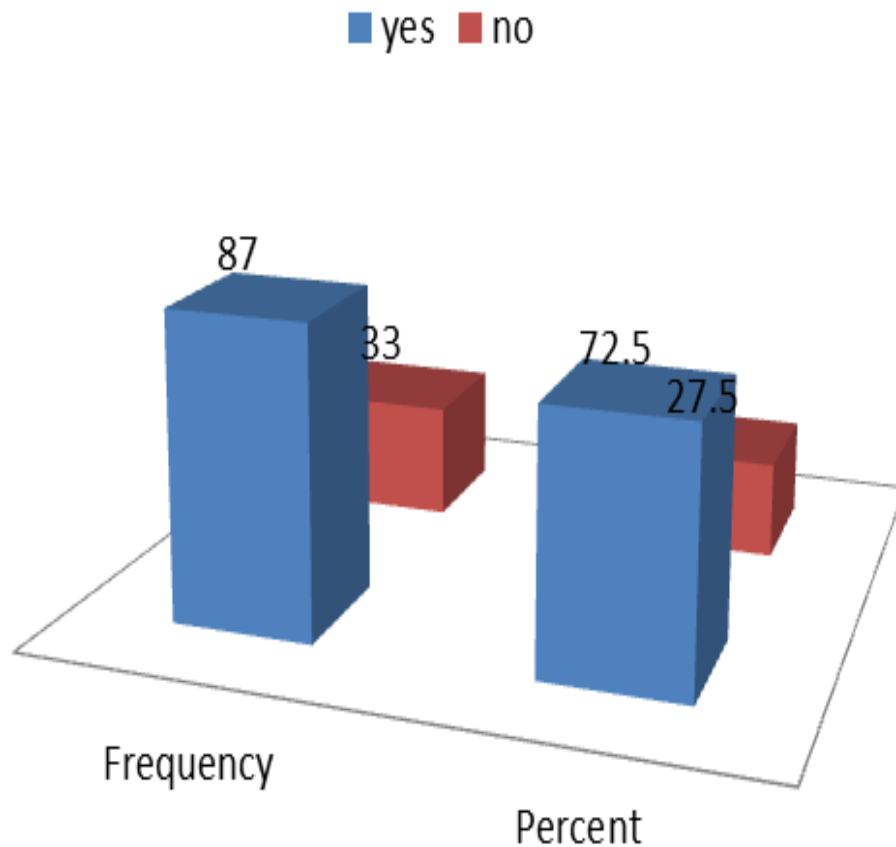
The benefits offered by SHIB include the following: registration fees, fees related to basic diagnostic tests, outpatient services which include medications as per National Essential Drug list (NEDLIT), in-patient care at fixed rates per day per level of health facility (i.e. Health Centre, District Hospital etc.), surgeries (Minor, Major and Specialized). The above benefits evolve around the need to cover members suffering from frequently recurring diseases. The package is to be reviewed from time to time for the purpose of enhancing it (NSSF Bulletin, 2011).

This proportion of people receiving benefits offered by SHIB is one indicator of quality of SHIB offered by NSSF.

4.2.2 If family members get some benefits

Respondents were asked if any of family members get some benefits from SHIB,

Figure 4.4: Benefits obtained for Family Members



Source: Researcher, 2013

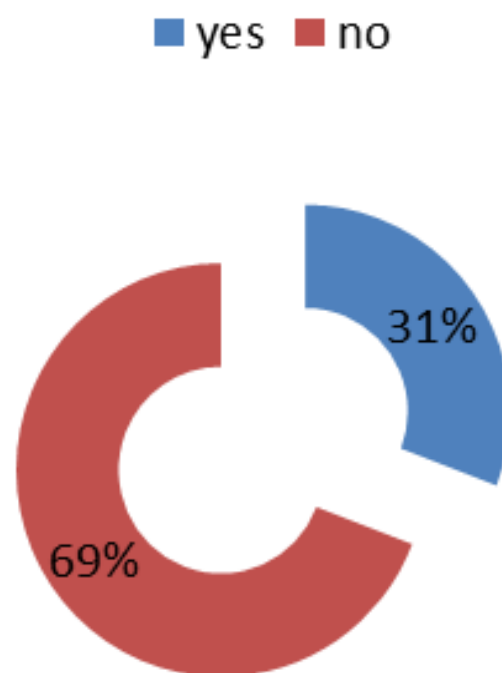
Most of respondents 87 (72.5%) of all respondents said that their family members gets some benefits from SHIB. Whereas, 33 (27.5%) of all respondents said that their dependants are not enrolled to the policy/scheme. These findings reveal that SHIB benefits are also extended to family members' primary subscriber. The reasons as to why some dependants are not enrolled to the benefits need further investigation.

4.2.3 If the respondent belong to another health insurance

The researcher asked respondents 'if they belonged to another health insurance apart from NSSF. In total, 37 (30.8%) of all respondents said yes, while the rest 83(69.2%)

of all respondents said no. The results show those respondents are satisfied with the service they get from NSSF health insurance that is most of them is not in another health insurance.

Figure 4.5: If the respondent belongs to another health insurance

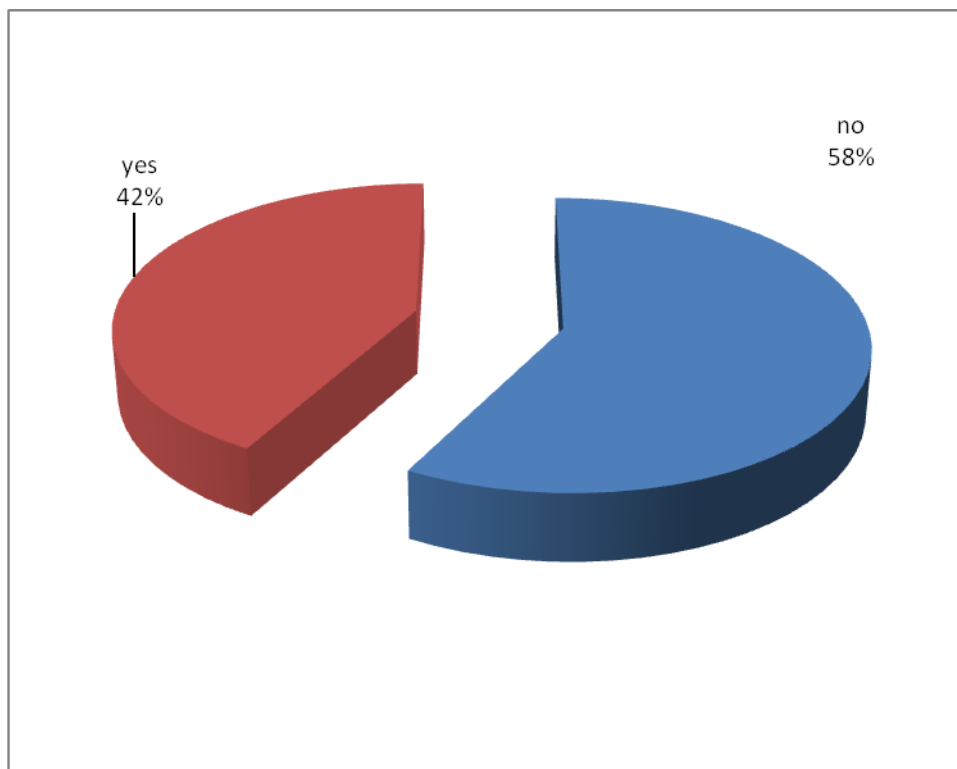


Source: Researcher, 2013

These findings show that majority of respondents 69% belong to only one health insurance which is SHIB. However, there were also other people who belong to more than one health insurance apart from NSSF's SHIB. There is a likelihood that they also subscribes to NHIF or any other private insurance, themselves or as dependants.

This multiple subscriptions mean that some respondents join SHIB due to the fact that they are already NSSF. It is also possible that these people who belong to other health insurance assume that SHIB is not enough so they keep looking for better services.

Figure 4.6: If the respondent give registration fees



Source: Researcher, 2013

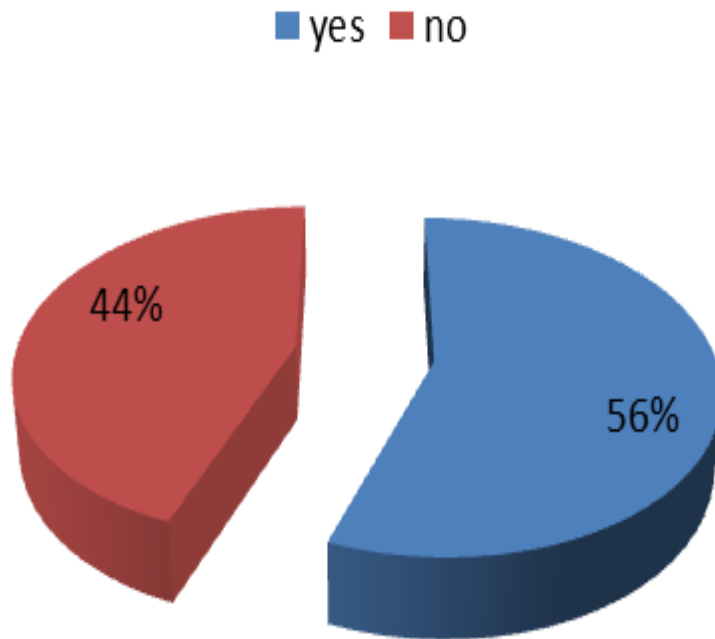
As NSSF's SHIB members, respondents were asked if they paid registration fees when every time they visited the hospital or clinic. . Most of respondents 70 (58.3%) said are not asked to pay for the registration fees, while 50 (41.7%) of all respondents said they have to pay the registration fees.

Normally SHIB members are not supposed to be asked to pay for the registration fee. Lack of awareness of this benefit among hospitals and clinics, and beneficiaries, is to blame for these uncalled for charges. There is a need to conduct education to customers to help them know their rights and privileges as members of NSSF.

4.2.4 If the respondent gets fees related to basic diagnostic tests

Respondents were asked if despite being SHIB members, they paid fees related to basic diagnostic test.

Figure 4.7: Whether respondents get fees related to basic diagnostic tests



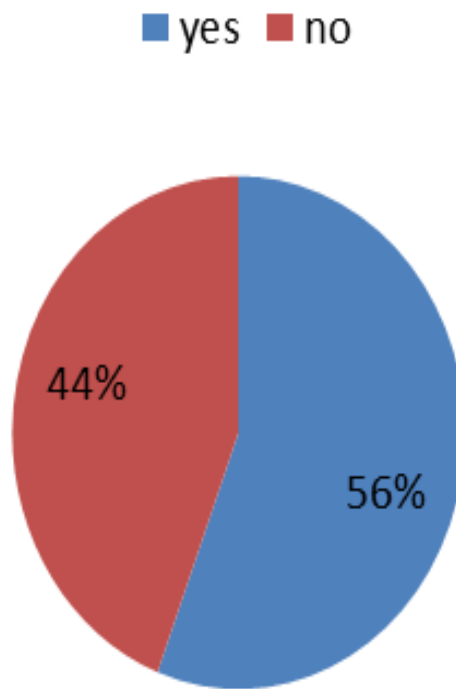
Source: Researcher, 2013

67(55.8%) of all respondents said they do pay fees related to basic diagnostic tests, while 53(44.2%) of all respondents said they do not pay any basic diagnostic fees.. Normally members are not supposed to pay fees for basic diagnostic, but due to lack of awareness some of them are charged and agreed to pay. There is a need to conduct education to customers and services providers to help them know their rights and privileges as members of NSSF.

4.2.5 If the respondent gets outpatient services

Respondents were asked if they are asked money for outpatient services despite being SHIB members. The responses given are summarized in the figure.

Figure 4.8: Whether respondent gets outpatient services



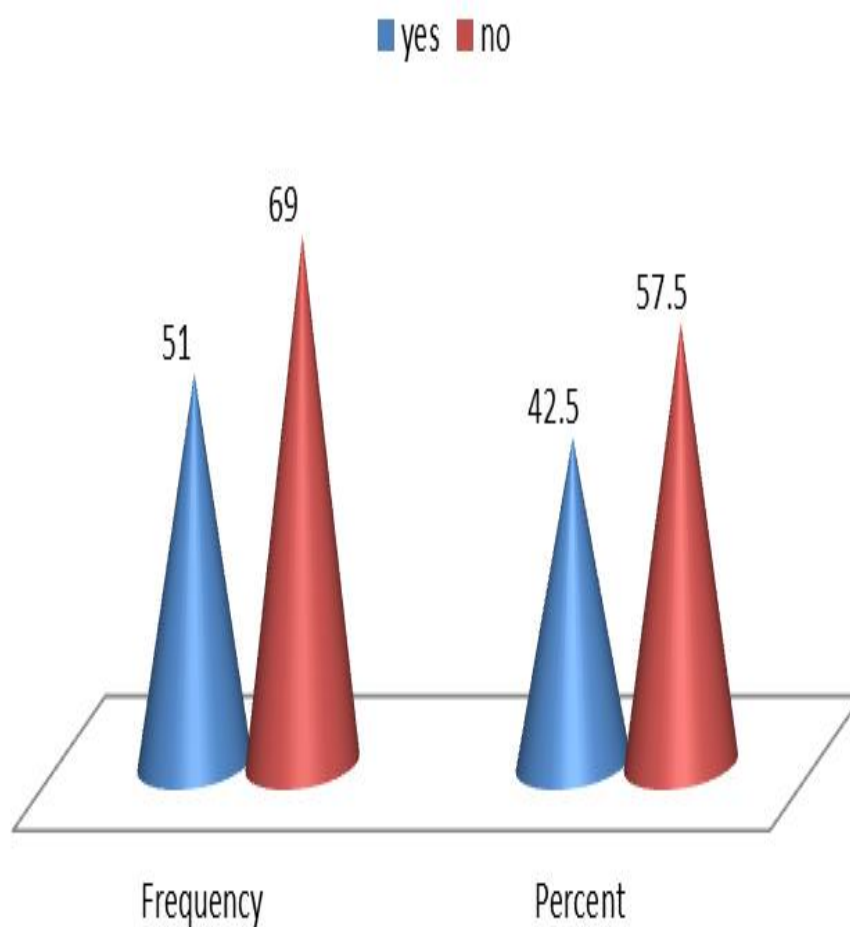
Source: Researcher, 2013

Most of respondents 67(55.8%) said they are not asked for money for outpatient services and others 53(44.2%) of all respondents said they paid for outpatient services. All SHIB members are supposed to get outpatient services free. If some respondents did not get outpatient services, this shows that some hospitals do not respect the terms with insurances, this needs to be corrected in order to allow members of SHIB to get good services.

4.2.6 If the respondent gets in-patient care

Respondents were asked if they get in-patient services, their responds is represented on figure 4.9.

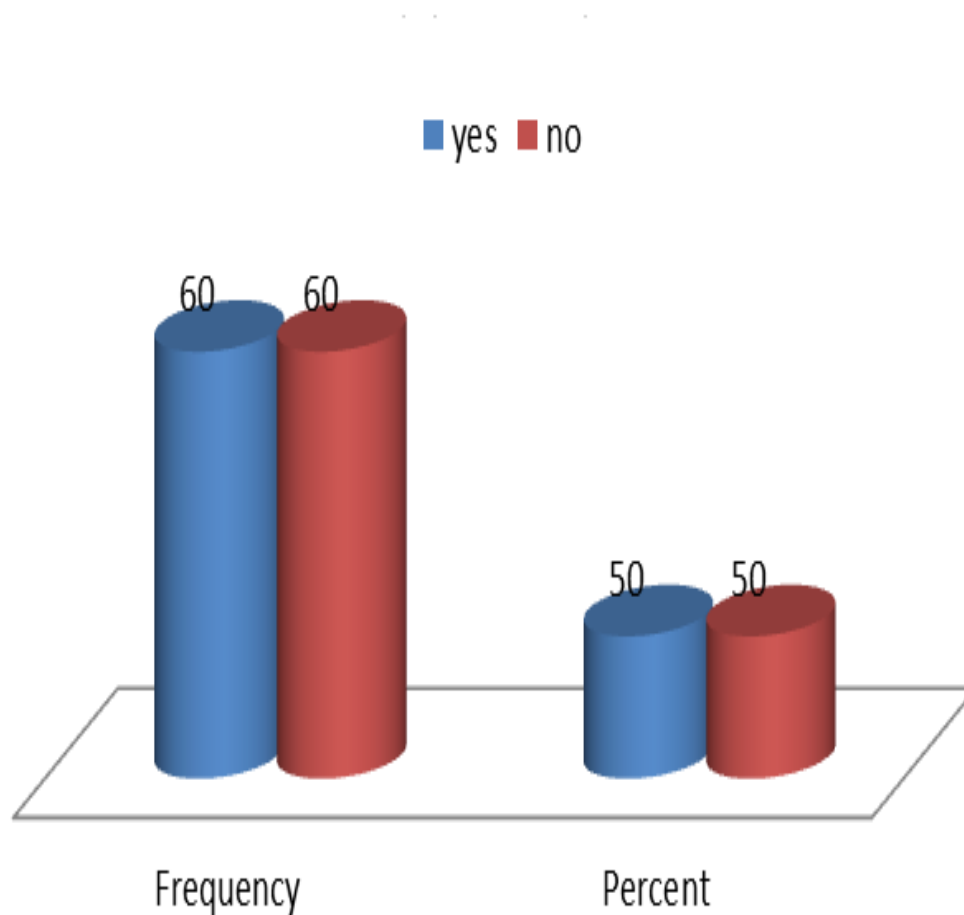
Figure 4.9: If the respondent gets in-patient care



Source: Researcher, 2013

Most of respondents 69(57.5%) said no that they do not get in-patient services and others 51(42.5%) of all respondents said yes they do get in-patient services. The findings show that members get in patient care and the findings are in line with literature NSSF Bulletin (2011) members get in-patient care fixed rates per day per level of health facility (i.e. Health Centre, District Hospital).

Figure 4.10: If the respondent gets surgeries services



Source: Researcher, 2013

The researcher of this study asked respondents if they get surgeries services, 60(50%) of all respondents said yes and the rest 60(50%) of all respondents said no. The findings show that members get surgeries services, and this is in line with NSSF Bulletin (2011) surgeries (Minor, Major and Specialized). The above benefits evolve around the need to cover members suffering from frequently recurring diseases. The package is to be reviewed from time to time for the purpose of enhancing it.

4.1 Quality of services offered by SHIB

	Frequency	Percent
very poor	3	2.5
Poor	11	9.2
Good	85	70.8
very good	5	4.2
Excellent	16	13.3
Total	120	100.0

Source: Researcher, 2013

Respondents were asked to grade the quality of services offered by SHIB. The results were as follows 3 (2.5%) of all respondents said the quality of service is very poor, 11 (9.2%) of all respondents said the quality is poor, 85(70.8%) of all respondents said the quality is good. 5 (4.2%) of all respondents when asked said the quality is very good while 16 (13.3%) of all respondents said the quality is excellent. Results from the finding shows that the quality of services offered by SHIB is appreciated by members since more than 50% of all respondents graded from good to excellent.

These findings reveal that majority of respondents graded services given by SHIB as good. This grading shows that members perceive the quality of SHIB as average. This is an indicator that they are not very much satisfied by the services given under SHIB. This situation should be addressed to make SHIB more appreciated by members. Many insurances companies are mushrooming, if SHIB does not make efforts to improve the quality of services offered, there is a likelihood that some members would be subscribes to other companies in pursuit of better quality of services

4.3 Reliability of the Health Services offered by SHIB

4.3.1 If the respondent depend on SHIB on health care

Respondents were asked if they depend on SHIB for health care, the answers given are summarized in the table.

Table 4.2: Dependency on SHIB on health care

	Frequency	Percentage
Yes	79	65.8
No	40	33.3
Don't know	1	.8
Total	120	100.0

Source: Researcher, 2013

Most of respondents 79(65.8%) of all respondents said they do depend on SHIB for health care, while 40 (33.3%) of all respondents said that they do not depend on SHIB for health services.

The findings show that most of respondents depend on SHIB for health care. However, we can see that there are about 33.3% who do not depend entirely on SHIB. This is probably due to the fact that these people are not fully satisfied with the benefits that they get from SHIB; therefore, they look for better benefits in other health insurance companies. SHIB should strive to fully satisfy the customers for them to decide to depend fully on SHIB.

4.3.2 If the respondent use personal money to pay for health care

Respondents were asked if they use personal money to pay for health care. The results obtained are summarized in the table.

Table 4.3: Usage of personal Money to pay for health care

	Frequency	Percentage
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Yes	56	46.7
No	64	53.3
Total	120	100.0

Source: Researcher, 2013

The finding show that 56 (46.7%) of all respondents said yes they use personal money to pay for health care while 64 (53.3%) of all respondents said no they do not use personal money to pay health care. The result shows that most of respondents do not use personnel money to pay for health care.

Normally, the importance of insurance is to help beneficiaries not to use out-of-pockets to pay for health services. However, from these findings, we can see that there are still people who belong to SHIB and yet they pay for services using their pocket money. This should be addressed and SHIB should be able to cover members so that they do not have to pay for their services using their pocket money.

4.3.3 If hospitals attend the respondent well under SHIB

Respondents were asked if the hospitals attend them well under SHIB, the responses given are summarized in the table.

Table 4.4: Well attendance of respondents under SHIB

	Frequency	Percent
Yes	98	81.7
No	22	18.3
Total	120	100.0

Source: Researcher, 2013

Most of respondents 98 (81.7%) said yes and 22 (18.3%) of all respondents said no, that hospitals do not attend them well under SHIB. The results show that respondents are attended well under SHIB since more than about 82 % of all respondents said yes

These findings reveal that the SHIB members get care from different hospitals. However, there are still some about 18% who report that they do not get care. This situation of not getting care shows that SHIB has not yet fully attended its objectives of helping all its members to get appropriate health care.

4.3.4 If the respondent plans to continue using SHIB

Respondents were asked if they plan to continue using SHIB, results are portrayed in the table.

Table 4.5: Plans to continue using SHIB

	Frequency	Percent
Yes	82	68.3
No	38	31.7
Total	120	100.0

Source: Researcher, 2013

Most of respondents about 68.3% said yes that they do plan to continue using SHIB while 31.7% of all respondents said no they do not plan to continue using SHIB. The results shows that members are satisfied with the service offered by NSSF that is why most of respondents 80 (68.3%) they plan to continue using SHIB.

However, it is also important to notice that about 32% do not plan to continue using SHIB as their health insurance. This is not good news for SHIB since this number is quite considerable. It is important that people should put their trust in SHIB and they should not be planning to quit. In order to achieve this stability of members, SHIB has to strive to improve the quality to meet customers' expectations.

4.3.5 If the respondent used other insurance schemes

With this question the respondents were asked if they were enjoying insurance services from other schemes, the response were as tabled below:

Table 4.6: Usage of other insurance schemes

	Frequency	Percent
Yes	30	25.0
No	90	75.0
Total	120	100.0

Source: Researcher, 2013

Most of respondents said 90 (75%) said no, that they do not use any other insurance. Other respondents 30 (25%) of all respondents said yes they use other insurance. Again this situation calls for improved quality of SHIB to help members not to look for other better services.

4.3.6 If the respondent faced any challenge with SHIB

With this question the researcher wanted to find if there were any challenge that faced the respondents, the response were as tabled below;

Table 4.7: Challenges faced beneficiaries of SHIB

	Frequency	Percent
Yes	38	31.7
No	82	68.3
Total	120	100.0

Source: Researcher, 2013

Respondents they asked if they face any challenge with SHIB, most of respondents 82(68.3%) said no they do not face any challenge with SHIB. Others 38 (31.7%) of all respondents said yes they do face challenges. The results conclude that most of members do not face challenges with SHIB. However, there are some respondents about 32% who face challenges.

In order to meet customers' expectations, quality should be improved so that these people who face challenges may feel comfortable in SHIB.

4.3.7 If the respondent failed to get treatment due to SHIB

Respondents were asked if they have ever failed to get treatment due to SHIB. The answers given are presented in the table.

Table 4.8: Failure to get treatment

	Frequency	Percent
Yes	7	5.8
No	113	94.2
Total	120	100.0

Source: Researcher, 2013

Most of respondents 113 (94.2%) said no, they do not fail to get treatment due to SHIB while other 7 (5.8%) of all respondents said yes they have ever fail to get treatment due to SHIB.

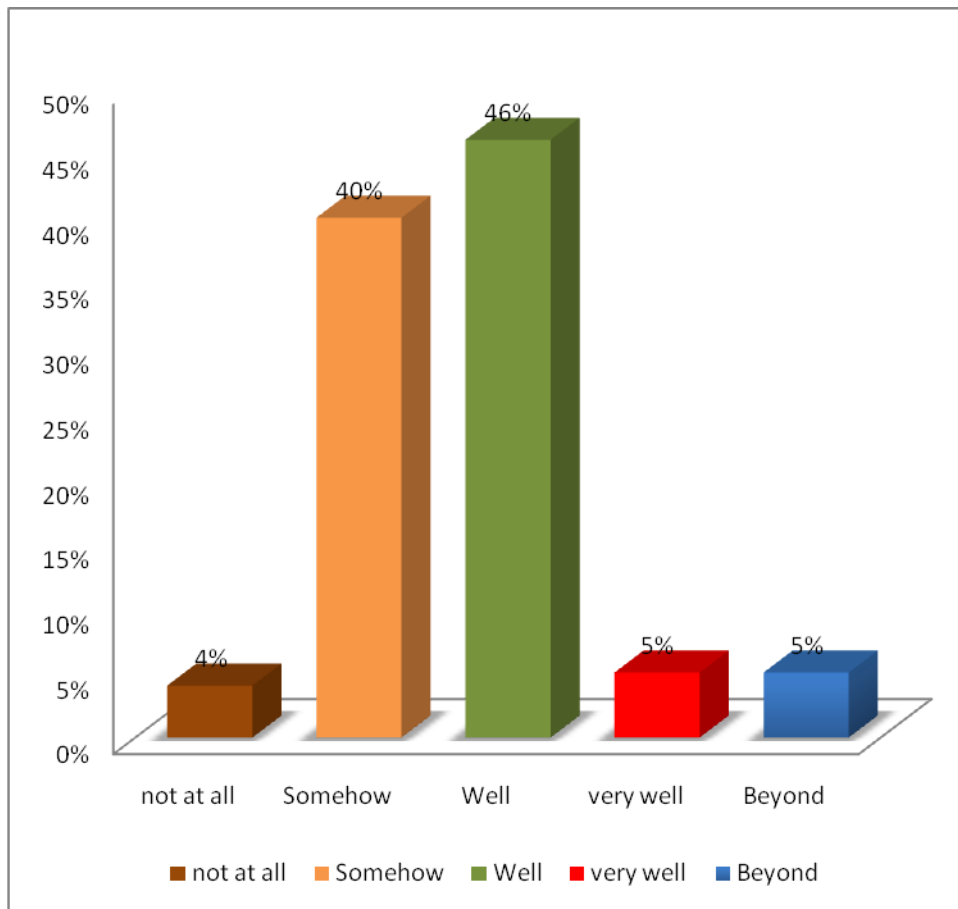
This percentage of those who do not get treatment is low only 6%. On this matter, SHIB has done well to make sure that members are given treatment.

4.4 Effectiveness of SHIB Repayment

4.4.1 If SHIB repayment meets your expectation

With this question the researcher aimed to understand if SHIB repayment met the respondents expectations, the results were as tabled below:

Figure 4.11: Re-payments to meet expectation



Source: Researcher, 2013

Respondents were asked if SHIB repayment meet their expectation, 5 (4.2%) of all respondents said not at all, 48(40%) of all respondents said somehow, 55 (45.8%) of all respondents said well, 6 (5%) of all respondents said very well and the rest 6 (5%) of all respondents said beyond.

The results show that SHIB repayment meets their expectation, since above 50% of all respondents categorize their expectation from well to beyond which mean they are satisfied with the service. However, those few who are not satisfied should also be considered in order to improve the quality of services offered.

This is in line with Richheld (1995) who defines Customer satisfaction as the state of mind that customers have about a company when their expectation have been met one exceeded over the lifetime of the product or service.

4.4.2 Problems related to membership registration

Respondents were asked if there are any problems that are related to membership registration.

Table 4.9: Problems related to registration

	Frequency	Percent
Yes	37	30.8
No	83	69.2
Total	120	100.0

Source: Researcher, 2013

Most of respondents said no 83 (69.2%) while 37 (30.8%) of all respondents said yes that they face problem related to membership registration.

The analysis of these findings show that majority of respondents did not face the problems with registration. However, since there are those who face the problems in membership registration, their concerns should be addressed in order to improve the quality of SHIB.

4.4.3 Problems related to issuing of card

Respondents were asked if they face any problems related to issuing of card, most of respondents as tabulated below:

Table 4.10: Problem related to Card issuance

	Frequency	Percent
Yes	39	32.5
No	81	67.5
Total	120	100.0

Source: Researcher, 2013

The response shows that 81 (67.5%) said no, that they do not face any problems related to issuing of card while the rest 39 (32.5%) of all respondents said yes they face problems related to issuing of card. The results show that members of NSSF do not face problems related to issuing cards.

This also is good that majority do not face problems related to issuing of cards but if there are still people facing problems, then, it is better to address their problems in order to make SHIB an excellent health insurance service provider.

4.4.4 Problems related to hospital treatment

Respondents were asked if they face any problems related to hospital treatment

Table 4.11: Problems related to hospital treatment

	Frequency	Percent
Yes	34	28.3
No	86	71.7
Total	120	100.0

Source: Researcher, 2013

Most of respondents 86 (71.7%) said no, that they do not face any problems related to hospital treatment while the rest 34 (28.3%) of all respondents said yes they face problems related to hospital treatment.

The results show that members of NSSF do not face problems related to hospital treatment. However, there were about 28% who face problems. This number can be reduced to zero with quality improvement.

4.4.5 Problems related to membership contribution

Respondents were asked if they face any problems related to membership contribution,

Table 4.12: Membership Contribution Problems

	Frequency	Percent
Yes	25	20.8
No	95	79.2
Total	120	100.0

Source: Researcher, 2013

Most of respondents 95 (79.2%) said no, that they do not face any problems related to membership contribution while the rest 25 (20.8%) of all respondents said yes they face problems related to membership contribution.

The results show that members of NSSF do not face problems related to membership contribution. However, these 21% who face problems with health insurance in SHIB should be taken care of through improvement of quality of services provided under SHIB.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.0 Introduction

This final chapter presents the summary of key findings, and gives the conclusion and recommendations achieved under this study.

5.1 Summary of findings

The first objective was to assess the contribution medical services provided under social health insurance (SHIB) to the members. Findings show that 98 (81.7) of all respondents get benefits offered by SHIB while 22 (18.3%) of all respondents do not get benefits offered by SHIB. 87 (72.5%) of all respondents have family members who get some benefits from SHIB. 33 (27.5%) of all respondents do not get any benefit. 69% belong to only one health insurance which is SHIB.

However, there were also other people who belong to more than one health insurance SHIB and another one. 70 (58.3%) of all respondents said that they pay registration fees while 50 (41.7%) of all respondents do not pay registration fee. 67(55.8%) of all respondents pay fees related to basic diagnostic tests, while 53(44.2%) of all respondents do not pay fees related to basic diagnostic tests. 67(55.8%) do get outpatient services and others 53(44.2%) of all respondents do not get outpatient services. 69 (57.5%) do not get in-patient services and others 51(42.5%) of all respondents they do get in-patient services. 3 (2.5%) of all respondents said the quality of service is very poor, 11 (9.2%) of all respondents said the quality id poor, 85(70.8%) of all respondents said the quality is good. 5 (4.2%) of all respondents when asked said the quality is very good while 16 (13.3%) of all respondents said the quality is excellent.

The second objective was to assess the reliability of the health services offered by SHIB. Most of respondents 79(65.8%) of all respondents said that they depend on SHIB for health care, while 40 (33.3%) of all respondents do not depend on SHIB for health services. The findings also show that 56 (46.7%) of all respondents use personal money to pay for health care while 64 (53.3%) of all respondents do not use personal money to pay health care. 98 (81.7%) are attended by hospitals and 22 (18.3%) of all respondents are not attended under SHIB.

Most of respondents about 68.3% do plan to continue using SHIB while 31.7% of all respondents do not plan to continue using SHIB. 90 (75%) do not use any other insurance. Other respondents 30 (25%) use other insurances. Respondents 82 (68.3%)

do not face any challenge with SHIB. Others 38 (31.7%) of all respondents face challenges. 113 (94.2%) do not fail to get treatment due to SHIB while other 7 (5.8%) of all respondents have ever fail to get treatment due to SHIB.

The third objective was to examine the effectiveness of SHIB repayment system. 5 (4.2%) of all respondents said that they were not at all satisfied, 48(40%) of all respondents said somehow, 55 (45.8%) of all respondents said they were well satisfied, 6 (5%) of all respondents said very well and the rest 6 (5%) of all respondents said that they were satisfied beyond expectation.

Most of respondents said that they did not face problem related to membership registration 83 (69.2%) while 37 (30.8%) faced problem related to membership registration. Respondents were asked if they face any problem related to issuing of card, most of respondents 81 (67.5%) do not face any problem related to issuing of card while the rest 39 (32.5%) of all respondents face problems related to issuing of card. 86 (71.7%) do not face any problem related to hospital treatment while the rest 34 (28.3%) of all respondents face problems related to hospital treatment.

Most of respondents 95 (79.2%) do not face any problem related to membership contribution while the rest 25 (20.8%) of all respondents face problems related to membership contribution.

5.2 Conclusion

This study intended to assess service quality of social health insurance benefit (SHIB) provided by social security funds using a case study of NSSF in Dar es Salaam region. In general, the quality of social health insurance benefit was assessed to be good. Members are getting benefits, they are given treatment, they are satisfied with the SHIB and they plan to continue using SHIB. However, it was also observed that there were few members who do not get all the benefits, who are not satisfied with SHIB benefits and who are not willing to continue using SHIB.

Given this situation, it can be concluded that SHIB is an important service and it has managed to improve the health of many Tanzanians who are members of NSSF. This service should be supported and should be extended to many other people by extending coverage to other people. There is also a need to address existing problems which are hindering effectiveness of SHIB. By addressing these problems, clients and their families will be able to enjoy insured services and their health will be sustained. Management of health facilities has to ensure that they monitor the attitude and conduct of their service personnel (especially auxiliary personnel) to maintain good relations with clients under SHIB.

Conventional social security programmes cover a relatively limited proportion of the population and have not reached the urban and rural poor. They do not provide adequate social protection to members, thus leaving members in poverty when faced with various contingencies. The poor rely on non-conventional social security programmes which serve them only inadequately. This is exacerbated by the erosion of traditional social security practices as a result of increasing urbanization and the process of globalization as the extended family system breaks down and as population pressure impinges on traditional use of common property.

There is a need to understand the social security needs of different categories of poor people in Tanzania, the sources and types of risks confronting the poor and the different arrangements and strategies (informal, market-based and public) for risk reduction, mitigation and coping used by individuals and the government. In order to have a real picture of the inequities in the distribution of resources and incomes in contemporary Tanzania, we must understand the extent of redistribution across generations and within a generation in both conventional and non-conventional social security schemes and programmes. Furthermore, we need to know the transactions and hidden opportunity costs involved in informal risk sharing arrangements.

5.3 Recommendations

5.3 General Recommendations

In order to improve the services offered by SHIB, this study recommends the following:

- (i) NSSF management should enter agreements with many hospitals so that insured clients can get services from various hospitals, health centers and dispensaries.
- (ii) NSSF management should give more information to SHIB beneficiaries by educating them about SHIB and the role it can play in improving their health. This can be done through public announcement, fliers, posters and the like.
- (iii) The government should extend the benefits offered by SHIB to include more specialized services; this can stimulate the increase in membership with people involved with SHIB.
- (iv) It is important that government initiate and strengthen SHIB to raise awareness to all key stakeholders including the communities

5.4 Recommendations for further studies

This study also recommends the following for further studies:

- (i) A study can be designed which will assess the quality control in SHIB to meet customer expectation.
- (ii) Also a study can be conducted to examine the competitiveness of SHIB in relation with other health insurances both public and private insurances.
- (iii) Another interesting study would be to identify factors promoting membership in SHIB and to relate them with factors promoting membership in NSSF.

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QUESTIONNAIRES

Appendix I

Questionnaire

*My name is **Felistas Challe**; I am a student in Mzumbe University, Dar es Salaam Campus, with registration number MBA / DCC / 132 / T.11, pursuing a Master degree of Business Administration (Corporate Management). I am conducting a research entitled Service Quality Assessment of Social Health Insurance Benefit (SHIB) provided by Social Security Funds: A Case Study of NSSF in Dar Es Salaam Region. The purpose of this research is to expand the body of knowledge. I am requesting your cooperation in answering the following questions and I ensure you that your responses will be kept confidential and will not be used contrary to the aim of this research. Thank you for your cooperation.*

I. Characteristics of Respondents

Categories	Variables	Tick
1. Gender	Male	
	Female	
2. Age	Below 20	
	20 – 29	
	30 – 39	
	40 – 49	
	50 – 59	
	60 Above	
3. Level of Education	Primary	
	Secondary	
	College	
	University	
4. Marital Status	Single	
	Married/Divorce	

II. Contribution of medical services provided under SHIB to the members

1. Answer by yes or No to the following questions

Questions	Tick if YES	Tick if NO
Are you An NSSF member?		
Are you a member of SHIB?		
Are you getting benefits offered by SHIB?		
Are members of your family getting same benefits?		
Do you belong to another health insurance?		

2. Did you enjoy the following benefits from SHIB

Benefits	Tick if YES	Tick If NO
Registration fees,		
Fees related to basic diagnostic tests,		
Outpatient services which include medications as per National Essential Drug list (NEDLIT),		
In-patient care at fixed rates per day per level of health facility (i.e. Health Centre, District Hospital etc.)		
surgeries (Minor, Major and Specialized)		

3. How would you rank the quality of services / benefits offered by the SHIB?

Ranking	Tick
Very poor	
Poor	
Good	
Very good	
Excellent	

III. Reliability of the health services offered by SHIB

1. Answer the following questions

Questions	Tick if YES	Tick if NO
Do you depend on SHIB for your health care?		
Do you use your personal money to pay for health care?		
Do hospitals attend you well under SHIB?		
Do you plan to stay using SHIB?		
Did you use any other insurance?		
Did you face any challenge with SHIB?		
Did you ever fail to get treatment due to SHIB		

2. Can you mention challenges that you faced under SHIB?

IV. Effectiveness of SHIB repayment

1. To what extent does SHIB repayment meets your expectation

Ranking level of meeting expectation	Tick the level applicable to your satisfaction
Does not meet your expectation at all	
Somehow it meets your expectation	
It meets your expectation well	
It meets your expectation very well	
It goes beyond your expectations	

2. Did you notice any problem with SHIB in the following areas:

Areas	Did you notice any Problem?
Membership Registration	
Issuing of Card	
Hospital Treatment	
Membership Contribution	

V. Guidelines on how to improve the performance of medical services delivered by the SHIB issuing system

1. Are there other medical services that should be included in SHIB issuing system?_____

2. Are there some measures which should be taken by NSSF to increase membership to SHIB?

3. Do you see any issue that should be addressed to improve services under SHIB?
