PERCEPTION OF HOSPITALS ON THE QUALITY OF SERVICES RENDERED BY NATIONAL HOSPITAL INSURANCE FUND

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DECLARATION

This Management Research Project is my original work and has not been submitted for a degree in any other University.

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The Management Project has been submitted for examination with my approval as the University Supervisor

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DEDICATION

To my late Dad (George I. Gitobu) thank you for everything.
And my Mum (Catherine N. Gitobu) thank you for always being there.

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Profound thanks to my committed and supportive supervisor, Mrs Margaret Ombok, for her critics and knowledge that has enriched this paper.

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ABSTRACT

Globalization has resulted in many negative effects in the developing countries. It has contributed to a decline in household income, widespread poverty, and unemployment. The objectives of the study were to determine the hospitals' expectations of quality of service offered by NHIF. Establish the hospitals' perceptions of the quality of service rendered by NHIF. Also to establish whether there are differences in hospital's expectations and perceptions on the quality of service rendered by NHIF.

The research design that was used was descriptive in nature. The population of interest included all the hospitals that offer inpatient cover within Nairobi and are accredited by NHIF. A census study was conducted because the sample frame was of only sixty-four hospitals in Nairobi but only fifty-four hospitals responded.

Primary data was collected through using structured questionnaires which were administered through the use of the drop and pick later method. Data collected was analyzed using proportions, percentages, means, standard deviations and co-efficient of variations. Graphical displays were used to amplify the comparative analysis.

Results indicate that the hospitals expectation on the ten service dimensions is quite high, compared to their perception. The hospital administrators have high expectations on the service dimensions of tangibility, understanding / knowing the customer and credibility and low expectations on courtesy and access.

Limitations of the study arose mainly due to the lack of commitment from respondents who were unwilling to respond to the questionnaire because of time and awareness. Recommendations stipulate the key areas that need improvement is that of understanding / knowing the customer through appropriate research on what the customer needs.

CHAPTER ONE
INTRODUCTION

1.1 Background

The recent past has witnessed globalization, the resultant push for liberalization and privatization, and the unprecedented competition in both private and public institutions in all sectors of the economy. There has been a growing decline in the role and size of the public sector. The threat to survival created by growing competition in both the private and public sectors, of which has introduced incentives amongst institutions to improve the market share in the service industry. The effects of the decline in public resources for health owing to the slow down in economic growth and pressures of globalization have led to the sector finding ways to bridge the gap.

In the service industry customer expectations are constantly changing as more and more consumers want value for the money that they spend. Perceptions and the expectations of the customer are taken from the delivery of the service. Services are in the position of selling millions of contacts every year and everyday. A service provider creates a moment of truth between the organization and the customer. Managing a service means having as many moments of truth as possible (Lovelock and Wright, 1999). As the consumer, the delivery of the service has to create experiences of truth, as it is instantly quite personal. In operational roles, personnel finance and marketing should work together concurrently because they are in constant contact with the customer in the systems and strategies that are there to serve the customer. Every time a service company performs for a particular customer, the customer makes an assessment of the quality of service even if unconsciously. The sum total of repeated assessments and the collective assessments by all customers establish in their minds the organizations image in terms of service quality.

NHIF as a health insurance provider has implemented changes that have enhanced efficiency in various processes that include the membership, claiming and

reimbursements procedures. Hospitals are the main service providers to NHIF and are pegged as the main service providers to the contributors who are the main beneficiaries of the NHIF service. The contributors to NHIF are mainly the majority of the Kenyans who are in the formal sector of employment and are in dire need of insurance services.

1.1.1 The Concept of Perception

Perception is the process by which an individual selects, organizes, and interprets stimuli into a meaningful and coherent picture of the world (Kanuak and Shiffman, 2003.). It is generated when a person glimpses at the face of a famous actor, sniffs a favorite food or hears the voice of a friend, recognition is instant. Within a fraction of a second after the eyes, nose, ears, tongue or skin is stimulated, one knows that the object is familiar and whether it is desirable or dangerous. Perception is the process by which we attribute meaning to incoming stimuli received through our senses. Our perception of an object is the result of the interaction of two types of factors: Stimulus factors; which are characteristics of the physical object such as size, color, weight or shape, and Individual factors; these factors not only include sensory process but also past experiences with similar items and base motivations and expectations. Perception is largely selective. Selectivity of perception serves as a filter through which potentially important or favorable experiences will be allowed to flow, while potentially unimportant or unfavorable experiences are locked out. Extensions of these are selective exposure and selective retention, (Kibera and Waruingi, 1998).

People emerge with different perceptions of the same stimulus object because of three perceptual processes: selective attention, selective distortion and selective retention. Selective attention arises due to the fact that people are exposed to a tremendous amount of daily stimuli. The consumers have a heightened awareness of stimuli that meet there needs or interests and minimal awareness of stimuli irrelevant to their needs. Selective distortion describes the tendency of people to twist information into personal meanings. Selective retention asserts that people will forget much of what they learn. They tend to retain information that supports the attitudes and beliefs for chosen alternatives (Kotler, 1988; Kibera and Waruingi, 1998).

Individuals act and react on the basis of their perceptions not on the basis of objective reality. For each individual, reality is totally a personal phenomenon, based on that person's needs, wants, values and personal experiences. Thus, to the marketer, customers' expectations are much more important than their knowledge of objective reality. It is not what actually is so, that affects their actions, their buying habits their leisure habits and because individuals make decisions and take actions based on what they perceive to be reality, it is important that marketers understand the whole notion of perception and its related concepts to more readily determine what factors influence consumers to buy (Schiffman and Kanuk, 2003). Marketers are interested in perception because it involves what customers believe to provide satisfaction effectively in the market place, marketers must understand how there marketing activities are perceived because perception greatly influence buyer behavior (Kairu, 2002).

1.1.2. The concept of service quality

Service quality is the provision of services that meet or exceed the expectations of customers (Lovelock, 1981). The aim of service quality is to make the consumption of service a memorable experience, which will generate positive communication about the service by the consumer. Providing services that consistently meet or exceed customers' expectations is key to overcoming most of the problems faced in service marketing (Lovelock, 1981). Because reliability directly addresses customer concerns about service variability and intangibility, a reputation for high quality directly reduces the purchase risk for new customers. A poor reputation makes selling the service much more difficult. High quality services are also more likely to stimulate more positive word of mouth by current customer reinforcing the firms' own advertisements by giving them more credibility and further improving the firms' reputation. Success at producing high quality service helps to build enthusiasm and high morale amongst staff members, a factor that is essential in delivering better services. In the commercial world, advocates of improving services have absolute faith in providing superior customer service quality (Zeitmal et.al., 1990).

Given the intangible nature of service, the evaluation of service quality before consumption is quite difficult as the production of service is undertaken simultaneously with consumption. This makes service providers to adopt measures that will make the service tangible and therefore add dimensions of quality. This is mostly achieved by the physical facilities and service provider personnel appearance. As the customers have to come to the service provider premises or interact with the personnel to get the service (Zeithmal et.al.1990). Researchers have studied service quality that stems from the premise that a consumers' evaluation of service quality is a function of the magnitude or direction of the gap between the customers' expectations of service and the customers' assessment of perception of service actually delivered (Schiffman and Kanuk, 2003).

1.1.3 National Hospital Insurance Fund

The concept of insurance is where the insured pays another party for protection against the financial loses he might suffer in the event of unforeseen, uncontrollable but named event. Payment is made in advance or by installments and it is generally accepted that if the specified insurance event does not occur during the life of the insurance contact no claim will be made (Campbell, 2000). In the health insurance system people pay for the cost of illness before the time of treatment, thus before illness occurs. This is done through small regular contributions known as premiums, which are made to an organization that then pays for medical care at the time when treatment is sought. In the insurance context three parties are involved: the patient (household), the provider of care (health facility) and the payer of medical bills (the insurer). A health insurance scheme can be social or private. It is social when it provides for solidarity – with the rich subsidizing for the poor, the young supporting the elderly and the healthy subsidizing for the sick- thus promoting equity and access for everyone rather than profit. A private insurance scheme is where the third party is a profit organization (CHACK Times September-December 2004 pg 6).

Medical coverage has now become more comprehensive as some insurers offer unlimited maximum benefits. Health insurance is the only practical instrument the government can use to provide across the board subsides for hospital care. Overall the Kenya Health

policy framework of 1994, stipulates the Ministry of Health's Vision of creating an enabling environment for the provision of sustainable healthcare that is acceptable, affordable and accessible to all Kenyans.

The National Hospital Insurance Fund was established in 1966 through an Act of parliament. Its operations became law, provided for under cap 255 of the laws of Kenya. NHIF become a state corporation on the 15th of February 1999 through an Act of Parliament No. 9 of 1998. The objective of its establishment was to enable a majority of Kenyans to access medical services at supplemented costs (National Hospital insurance strategic plan 2001-2006).The vision and mission of the Fund is to be a world class Social Health Insurance Scheme, and to provide accessible, affordable, sustainable and quality social health insurance through effective and efficient utilization of resources to the satisfaction of stakeholders respectively (NHIF strategic plan of 2005-2010). NHIF mandate outlined in the National Hospital Insurance Act of (1998, Cap 255) of the laws of Kenya are to, receive contributions and other payments; make payments out of the Fund to declared hospitals; set criteria for the declaration of hospitals and to accredit them; regulate contributions payable to the Fund, and the benefits and other payments to be made out of the Fund; protect interests of contributors to the Fund; advice the Government on the national policy to be followed in regard to national health insurance, and to implement all government policies relating thereto. The N.H.I.F. operations are characterized by compulsory contribution from any person who is ordinarily resident in Kenya, who has attained the age of 18 years, and whose total income is above or at Kshs 1000, whether derived from salaried or self-employment. Contributions range from Kshs 30 per month for those whose monthly income bracket of Kshs. 1000- 1499 to Kshs. 320 per month for those whose income is over Kshs 15,000 per month. NHIF provides an in-patient cover of up to Kshs.360, 000 per year for each of the members. It is possible for retrenched and retired members to continue accessing NHIF benefits under the voluntary contribution scheme. A premium of 160 a month enables a contributor; his/her spouse and dependants to benefit and one can also pay an annual premium of Kshs.1920 upfront.

The Fund currently has a total of over four hundred accredited hospitals, which are enabling Kenyans access health services. On average, private and mission hospitals charge a higher cost sharing fee on top of the NHIF reimbursement fee, than do government hospitals. The criteria used in determining the benefits rates for the hospital is based on facilities available. The National Hospital Insurance Fund (NHIF) covers 950,000 contributors and finances partial inpatient care services for its members. Healthcare services in Kenya are delivered to its population of 31.2 million people through a network of 4,500 healthcare facilities (Kenya National Health Accounts, 2001-2006).

1.2 Statement of the Problem

Kenya faces a major challenge in improving the health status of its population. Poverty contributes to the poor health status of the population, as the poor constitute more than half of the population in Kenya with women being the majority of the poor (Interim Poverty Reduction Paper, 2000-2003). This problem is further aggravated by continued high child infant and mortality levels, high birth rate and increasing re-emergence of diseases, particularly tuberculosis, HIV/AIDS of which has a prevalence of 6.7% (Household health expenditure and utilization survey report, 2003). In 1966, the Kenyan government set up National Hospital Insurance Fund (NHIF), with the key responsibility of enrolling and providing insurance coverage to a large number of Kenyans, in an affordable and sustainable manner. It is estimated that 35% of Kenyans benefit from the NHIF coverage (The 9th National Development Plan 2002-2008). The inpatient services are supplied by hospitals that are accredited by NHIF to provide care to the NHIF contributors.

These hospitals are the consumers of NHIF service as they receive service from NHIF and render a service to NHIF contributor. The expectations of hospital administrators and there perception arise form the delivery of service both at the time of sale (contracting agreement with NHIF) and after the sale (delivering the claim back to NHIF for payment) that is at all of the often transient points of contact during the relationship rather than from anything to do with the core product itself. Hospitals have complained in regards to

unpaid claims as noted in appendix 3 through a letter written by Pandya Memorial Hospital, who have not yet been paid for a period of three years (2001-2003). General complaints have also been put forth as stipulated in appendix 4 in regards to processing of information, payments, and how the client is treated when the service is being delivered at NHIF premises. NHIF also faces competition from other Health Management Organizations (HMOs) of which offer almost the same services. The biggest HMO in the Eastern and Central Africa is Africa Air Rescue (AAR), which offers both inpatient and out patient cover to both Corporate and Individual Members.

Service in this case are seen by the customer not as what is done, in terms of time to achieve a task or delivery of an item but in qualitative terms, how it is done. According to Christopher et. al. (1997), service quality is the ability of the organization to meet or exceed customer expectations. An important way in which NHIF can attract and retain its customers is by ensuring the delivery of high quality service. Especially as a government service provider where customers do not readily see important differences in the choices of service offered to them, average in this case really equates to mediocre, at least in the mind of customers. Expectations are based on the core products – the insurance policy. It is more likely those expectations will be taken from other elements, in particular the image conveyed in terms of customer expectations and their perception of the service delivered.

Studies on service quality by Njoroge (2003), focused on Kenya Power and Lighting Company Limited while that of Odawa (2004) was on the University of Nairobi's Masters in Business Administration Program and that of Mwaura (2002) focused on the Matatu Industry. The findings in these studies may not be relevant to the quality of service rendered by NHIF to the Hospitals. By understanding the perception of Hospitals NHIF will be in a position to evaluate what they regard as quality service. The study addressed the hospital perception of quality services that is rendered by NHIF, and focused on the following questions;

(i) What are the hospital's expectations on the quality of service rendered by NHIF?

(ii) What are the hospital's perceptions on the quality of service rendered by NHIF?

(iii) What are the differences between the hospital expectations and perceptions of the quality of services rendered by NHIF?

1.3 Objectives of the Study

The objectives of the study were to:

i. Determine the hospitals' expectations of quality of service offered by the NHIF.
ii. Establish the hospitals' perceptions of the quality of service rendered by NHIF.
iii. Establish whether there are differences in hospital's expectations and perceptions on the quality of service rendered by NHIF?

1.4 Significance of the Study

The study may assist in examining the expectations that the mission, private and government hospitals have on the services that are rendered by NHIF. This will provide a point of focus on the quality improvements for the organization.

The findings are expected to be useful to the government for formulation of policies and relevant regulations that may improve on health insurance industry in Kenya

Other Healthcare providers and players in the industry can use the study to understand the customer expectations and in order to improve on their services.

Generally the study may provide critical information to researchers and academia on the Health Care service industry that may assist to identify gaps that need to be filled in order to improve service quality the health sector.

CHAPTER TWO
LITERATURE REVIEW

2.1 Nature and Characteristics of Services

Services are deeds, processes and performance (Zithamal and Bitner, 1996). A service is an activity or series of activities of more or less intangible nature that normally but not necessarily, take pace in interaction between customers and service employees and or physical resources or goods and or systems of service providers, which are provided as solution to customers problems (Gronroos 1978). American marketing Association (AMA, 1996) defines services as "activities, benefits and satisfaction, which are offered for sale or provide in connection with the sale of goods." Blois (1978) defined service as an activity offered for sale that yields benefits of satisfaction without leading to physical exchange in the form of a good. This definition takes into account services like insurance, and finance. Stanton (1981) defines services as those separately identifiable, essentially intangible activities that provide want satisfaction and that are not necessarily tied to the sale of a product or other service.

Most authorities consider the service sector to include all economic activities whose output is not a physical product or construction, is generally consumed at the same time it is produced and provides an added value in forms such as convenience, amusement, timeliness, comfort or health that are essentially intangible concerns for first purchaser. (Quinn, Baruch and Paquette 1987). A good is a tangible physical object or product that can be created or transferred; it has existence overtime and thus can be created and used later. A service is intangible and perishable. It is an occurrence or process that is created and used simultaneously. While the consumer cannot retain the actual service after it is produced, the effect of service can be retained. (Sasser, Olsen and Wyckoff, 1978). The synthesis of various definitions given above and for the purpose of this study the service shall be defines as:" An activity or series of activities of more or less intangible nature offered for sale through interaction between customers and service employees that yields

benefits of satisfaction without leading to physical exchange but provide solution to customers problems".

Contemporary writers such as Gronoos (1978), Lovelock (1981), Shostack (1977), Berry (1988) and Rathmell (1974) argued that the differences between goods and services meant that the marketing tools used for goods marketing could not easily be translated to services marketing. Services have four major characteristics that greatly affect the design of marketing programs. This argument has also been put forth by Mwaura (2002) and Odawa (2004) as the characteristics of services namely, intangibility, inseparability, variability and perish-ability. Services are intangible, unlike physical products; they cannot be seen, tasted, felt, heard and smelled before they are bought. The person paying for health insurance cover will not receive any service until he or she gets injured and visits a health provider (institution) where the service is rendered, but the health institution is in constant contact with the health financier. To reduce uncertainty, buyers will look for signs or evidence of the service quality. They will draw inferences about quality from the place, people, equipment, communication material, symbols and price that they see. Therefore, the service providers task is to "manage the evidence", to "tangibilize the service". Whereas product managers are challenged to add abstract ideas, services marketers are challenged to add physical evidence and imagery to abstract offers. Service marketers must be able to transform intangible services into concrete benefits.

Services are typically produced and consumed simultaneously that is they are inseparable. If a person renders the service, then the provider is part of the service. Because the client is also present as the service is produced, provider-client interaction is a special feature of services marketing. Both provider and client affect the client outcome. Variability depends on who provides the service, when and where they are provided. Some doctors have excellent bed manners while others are very impatient with their patients. Service buyers are aware of this variability and often talk to others before selecting a service provider. Services cannot be stored they are perishable. Some doctors charge patients for missed appointments because the service value existed only at that

point. The perishability of services is not a problem when demand is steady. When demand fluctuates, service providers have problems.

2.2 Service Quality

Quality is the lifeblood that brings increased patronage, competitive advantage and long-term profitability of service-based organization. Each customer contact is referred to as a moment of truth, an opportunity to satisfy or dissatisfy the customer. According to Goerge and Shirely Ann (1995) quality is a difficult concept to define and measure, yet in marketing the quality is assuming increasing importance through out the world for a number of reasons namely; "The American Nurses Association succinctly puts it, "A profession's concern for the quality of service constitutes the hearts of its responsibility to the public". The service sector has become major growth industry during the latter part of this century and according to one estimate, it constitutes around 67% of the gross national product (GNP) of Canada. Given the rapid growth in the service industry, improving service quality is of paramount importance to all organizations. Unfortunately, because of lack of research, no reliable universal yardstick has been established for the objective measurement of service quality.

The conceptualization of service quality into a definition that captures all variables has remained elusive to many researchers. Hubbet (1995) observes that the three constructs are distinct; they are related attributes of customers' perceptions of service quality. These definitions show that service quality is not a one-occurrence act but it is a set of processes from pre-transaction to post- transaction stage. Hence it is very important that service organizations such as NHIF are aware of the customer expectations and the methods that they will use to measure them. In 1979 Crosby quoted the Japanese philosophy and refereed to quality as "zero defects-doing it right the first time". Many service organizations consider quality as being the magic word in competition as it impacts on both the future customers with many clients being more aware of quality than mere quantity (Coxe, 1990). Crosby 1996 defines quality as conformance to requirements. He defines proof of service as flawless performance or zero defects. This means 100% satisfying performance from the customer's point of view. Cost of not achieving flawless

performance is the cost of quality, which includes the cost of redoing the service, compensating for poor service, loss of customers and negative word of mouth.

Lewis and Boom (1983) described service quality as "a measure of how well the service level delivered matches customer expectations' with the deliverance of quality service meaning the conformance to customer expectations on a consistent basis." Christopher et. al. (1997) acknowledges that the satisfaction of a customer with a service can be defined by comparing perception of service received with expectations of service desired. When expectations are exceeded service is perceived to be of exceptional quality and also to be a pleasant surprise. When expectations are not met service quality is deemed unacceptable. When expectations are confirmed by perceived service, quality is satisfactory. Delivery of service quality should be based around the expectations of customers, as one of the most common causes the poor service quality by service firms revolves around not knowing what the customer's expectations are (Zeithmal et al 1990).

Parasuramann et al (1985), in developing the service quality model, defined service quality as the gap between expected service and perceived service. Service quality can be defined from five perceptions: Transcendent this is innate excellence, a mark of uncompromising standards and high achievement. It argues that people learn to recognize quality only through the experience gained from repeated exposure. The product-based approach sees quality as a precise and measurable variable. It argues that the differences in quality reflect differences in the amount of ingredients and attributes possessed by the product. This objective view fails to account for difference in the tastes, need and preferences in individual customers or even entire market segments. User based definition starts with the premise that quality lies in the eye of the beholder. These definitions equate quality with maximum satisfaction. This subjective demand oriented perspective recognizes that different customers have different wants and needs. The manufacturing based approach in contrast, is supply based, and is primarily concerned with engineering and manufacturing practices. It focuses on conformance to internally developed specifications, which are often driven by productivity and cost containment goals. Value based definition defines quality in terms of value and price by considering

the trade off between performance (conformance) and price, quality comes to be defined as "affordable excellence".

2.3 Service Quality Models

Service quality is a concept that has aroused considerable interest in public debate in research literature because of the difficulties in both defining it and measuring it with no overall consensus either (Wisinewski, 2001). There are a number of definitions on service quality, one that is commonly used defines, service quality as the extent to which a service meets customers needs or expectations (Lewis and Mitchell, 1990; Dotchin and Oakland, 1994a; Asubonteng et al., 1996; Wisniewski and Donnelly, 1996). Service quality can thus be defined as the difference between customer expectations of service and perceived service. If expectations are greater than performance, then perceived quality is less than satisfactory and hence customer dissatisfaction occurs (Parasuraman et al.1985; Lewis and Mitchell, 1990).

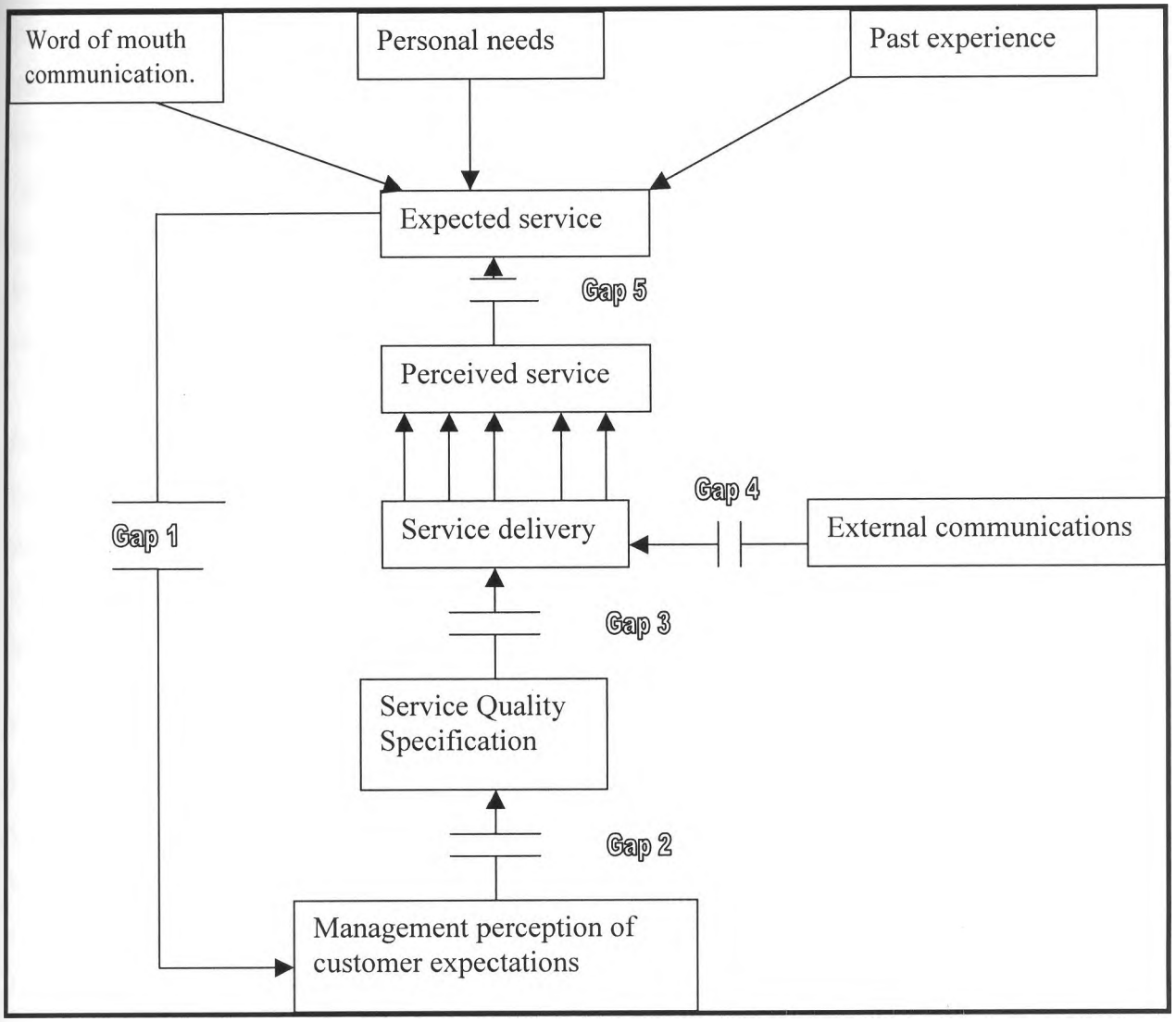
Gronroos (1982) postulated that two types of service quality exist: the technical quality, which involves what the customer is actually receiving from the service and the functional quality, which involves the manner in which the service is delivered. Sasser et al. (1978), discussed three different dimensions of service performance levels of material, facilities and personnel this implies that service quality involves more than outcome, it also includes a manner in which the service is delivered. There are several models but for this study the P-C-P model and the SERVQUAL model will be the ones that will be discussed. Palmer (1992) identified five gaps where they may be shortfalls between expectations of service level and perception of actual service delivery. In order for companies to better understand the expectations and perceptions of their customers they use the SERQUAL technique. It is applicable across the board range of service industries and can easily be modified to take account of the specific requirements of a company.

2.3.1 SERVQUAL Model

Service gap is the shortfall between expected service and actual service received. The starting premise of the model is that "received service quality (or satisfaction with

service) is a function of the difference between expected service levels and delivered (or perceived) service Parasuraman et. al (1985). The key to customer satisfaction is managing both customer expectations and actual delivered service. The product or service should meet the needs and expectations of the customer (Okatch, 2000). Customers generally have expectations of quality delivery based on word of mouth, past experience, personal needs and external communication from the service provider. Gronoos introduced the first comprehensive model of service quality. Parasuraman *et. al.* (1985) amplified the model and refined Gronroos framework. Research by Parasuraman *et. al.* (1985) has indicated that consumer's quality perceptions are influenced by a series of five gaps occurring in organizations. Figure 2:1, summarizes how perceived service can diverge from expected service, constitutes the essence of the SERVQUAL Model gaps. The SERVQUAL Model identifies five possible causes, or "gaps," that may lead to customer dissatisfaction with service.

Figure 1 SERVQUAL Model



***Source**: Parasuraman A., Zeithmal A.V. and Leonard L.B.(1985) **"A conceptual model of Service Quality and its implications for future research"** Journal of Marketing, Fall 1985, p. 44 .*

The SERVQUAL Model re-examines each of the standard personnel policies in light of the desired customer service. The model provides specific criteria concerning: the personnel and management policies that complete the linkage between customer expectations and perceived service delivery. It provides a checklist of where breaks in the chain can occur; using this checklist can provide a useful audit of service quality.

Gap 1: Not knowing what customers' expect: This shows that there can be a difference between customer expectations and management's idea or perception of customer expectations. Knowing what customers expect is the first and most critical step in delivering quality service. Organizations who suspect they may be suffering from this gap should ask if they know what our customers expect from us with respect to service. Although executives may have a broad understanding of customers' perceptions of superior quality service, they may not know about certain service features that are critical to meeting customers' desires. Some executives may not know the levels of performance customers expect.

In the health sector in Kenya most policy documents seem to be made without proper marketing research orientation within the organization, inadequate use of research findings, infrequent management interaction with customers and inadequate upward communication. Various studies such as Mugo (2002) used the gap to compare the management's perspective with customer's expectations of service quality.

Gap 2: The wrong service –quality standard: This arises when there is a discrepancy between what managers perceive that customers expect and the actual standards that they (the manager) set for service delivery. This gap may occur when management is aware of customers' expectations but may not be willing or able to put systems in place. It may require changes in fundamental organizational work processes, acquiring expensive new technology, or refocusing organizational attitudes to understand service from the customer's point of view. The causes of gap 2 are the inadequate commitment to service quality, perception of infeasibility to be committed to customer service, task standardization and goal setting.

Gap 3: The service-performance gap: Organizational policies and standards for service levels may be in place, but front line staff may not follow them. Gap 3 is a very common gap in the service industry; it is the difference between organizational service specifications and actual levels of service delivery. Organizations specializing in providing interactive, labor-intensive services in a number of locations are especially vulnerable to this gap because the customer interactions are more frequent. Opportunities

for variation in this high-volume organization are greater. Quality control employee assessment becomes complicated in organizations with multiple layers. The causes of gap 3 are role ambiguity, role conflict, and employee –job fit: fit between technology and the job, supervisory control systems, perceived control and teamwork.

Gap 4: When promises do not match delivery: Some advertisements brag the organization's exceptional service, and raise customer's expectations. The organization must be able to deliver on the promises. Customers perceive that organizations are delivering low-quality service when a gap appears between promised levels of service that is actually delivered. The causes of this gap are: advertising, personal selling or public relations over-promise or misrepresent service delivery levels. Inadequate horizontal communication within and across departments (operations, marketing and human resources) and branches. Propensity to over promise in external communications. As a result, the company's promises do not accurately reflect what customers receive in the service encounter. Commonly, a high degree of discrepancy occurs when there is increasing pressure inside the company to generate new business or when competing organizations over promise to gain new customers.

Gap 5: The discrepancy between customer expectations and their perception of service delivered: The objectives of the management in organizations that wish to maintain a competitive advantage in quality service delivery is to close the gaps in all the cases above. This result in closing ultimate gap between the customer expectations and the customer perceptions of the quality of service delivered. The quality that a customer perceives in a service is a function of the magnitude and direction of the gap between expected service and perceived service. This gap is hence influenced by the four preceding gaps. If a gap is great the task of bridging the subsequent gaps is even greater and indeed it could be said that in such circumstances quality service can only be achieved by good luck rather than good management (Mugo, 2000).

2.3 2 P-C-P Model

Research by George and Shirley –Ann (1996), came up with a P-C-P model after several criticisms of the SERQUAL Model. The P-C-P model attempts to purse the development of measurement scale for specific service industry sector. The basic premise of the P-C-P model holds that: there is a growing need to develop service specific dimensions/ attributes. The dimension of SERQUAL and other models do not adequately address some of the more critical issues associated with the assessment of individual services such as patient care, the quality of information or the quality of education received from an organization. A combined (single) scale should be used to measure the gap between expectations and perceptions, as opposed to two separate scales. Individual dimensions should have different weights attached to them to indicate the importance with which the customer holds them.

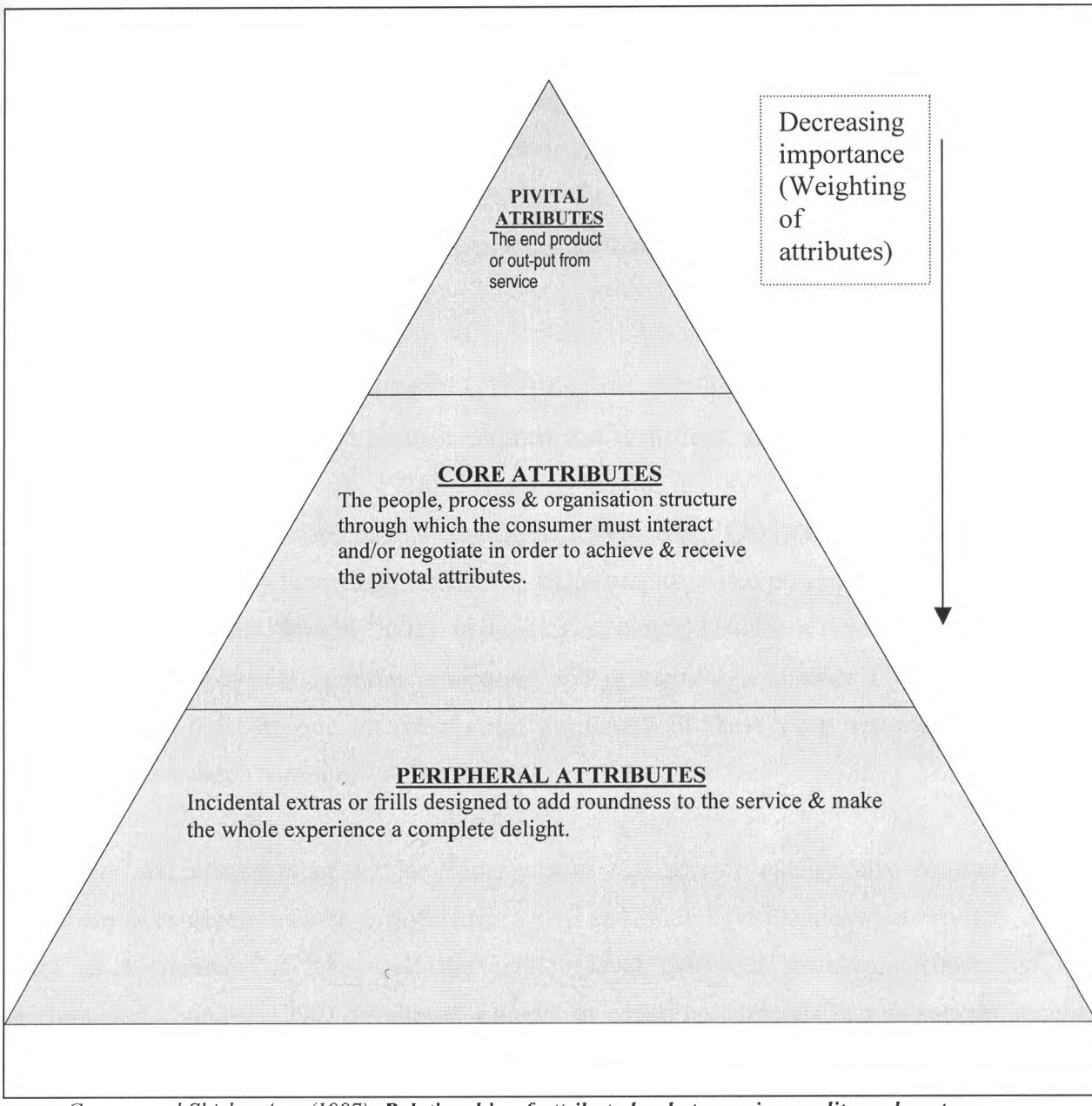
The P-C-P MODEL can best be described by examining the figure 2. According to the model, every service consists of three, albeit overlapping, areas where the vast majority of the dimensions and concept which thus far have been used to define service quality have been included. These ranked levels can loosely be defined as the inputs, processes and outputs of a service organization. This notion is somewhat similar to the systems model of an organization and hence the division of the model into three hierarchical levels-pivotal (outputs), core and peripheral (jointly representing inputs and processes).

The pivotal attributes, located at the apex of the pyramidal are considered collectively to be the single determining influence on the satisfaction levels, or otherwise, experience form the whole service encounter. Thus they are defined as the 'end product' or output from the service encounter. In other words what the customer, expects to achieve and receive, perhaps even 'take away' when the service process is duly completed. Core attributes, centered on the pivotal attributes, can best be described as the amalgamation of the people, processes and the service organizational structure through which consumers must interact and/or negotiate so that they can achieve or receive pivotal attributes. Expressed simply, during a service encounter, if the consumers come into contact with anyone or anything in the services organization, then the consumer will essentially be

considered to the core attributes. The third level of the model focuses on the peripheral attributes which can aptly be defined as the 'incidental extras' or frills designed to add a 'roundness' to the service encounter and make the whole experience for the customer a whole delight (see figure 2).

Looking at the model proposed by George et al (1996), it is also pertinent to discuss the impact that they believe each of these attributes may have on the satisfaction levels and hence, the service quality outcomes of a particular organization. They suggest that when a consumer makes an evaluation about a service encounter, he inherently attaches more weight (importance) to the achievement of the pivotal attribute(s) and so, if the service is experienced only once, and all the items embodied in the pivotal attribute(s) are achieved (i.e. the key output met all the customer's stated requirements, perhaps even exceeded them) with a lower degree of achievement of core and peripheral attributes, then the consumer can be expected to be reasonably satisfied. However, they realize that this may not always be the case; as is the service is used more frequently, the core and peripheral attributes may begin to assume greater importance. If the pivotal feature of the service is delivered to a consequently high standard, then the consumer will begin to look more rigorously and thoroughly at the other features (core and peripheral) to see if they too come up to the same high standard. In so many respects this infers a type hierarchical ordering until all the service attributes have been critically assessed. Again, it must be emphasized that irrespective of the service, the customer's satisfaction levels may depend on the output of the service, and relatively less on the personnel and the organizational structures (core and peripheral) involved. The challenge facing any service, therefore, is to the delight the customer in all the three areas (pivotal, core and peripheral attributes) so that the service becomes a hundred percent satisfactory.

Figure 2. The P-C-P Model



Source: *George and Shirley-Ann (1997)*, ***Relationship of attribute levels to service quality and customer satisfaction,*** *International Journal of Quality and Reliability management, Vol.14 No.3, 1997, pp.224.*

According to George and Shirley-Ann (1996) any service sector or individual service organization, which plans to adopt the P-C-P model, should begin by asking itself the following issues: By addressing this question the organization will be able to identify the pivotal attributes that are relevant to its service operations. Successfully understanding the role of the personnel and the organizational structures involved in the delivery of the

service will enable the organization to recognize and isolate the core and peripheral attributes. A consumer approaches a services organization with certain needs that have to be addressed, and he will interact with the organization and its personnel in a unique manner that cannot be carbon-copied by any other customer-service personnel interaction. In this respect, the service organization cannot treat its customer base as one homogenous. A consumer who is experiencing the service for the first time may inherently attach more weight to the key/pivotal attributes than would consumer who frequently uses the same services.

2.3.3 Evaluation of Service Quality

Service quality is an elusive and abstract contrast that is difficult to define and measure (Parasuraman, Zeithmal & Berry, 1998). Measuring service quality poses difficulties for service providers because of its unique characteristics (Bateson, 1995). Customers when purchasing goods employ many tangible cues to judge quality, when purchasing services, fewer tangible cues exist (Mukiri, 2001). In most cases, tangible evidence is limited to the service provider's physical facilities equipment and personnel. In absence of tangible cues, consumers must depend on other cues; the nature of these cues has not been extensively researched (Njoroge, 2003).

Researchers and managers of service firms concur that service quality involves the comparison of expectations with performance. Lewis and Booms (1983) looked at service quality as a measure of how well the service level delivered matches customer expectations. Gronroos (1998) developed a model in which he contends that customers compare the service they expect with perceptions of the service they receive in evaluating service quality; Smith and Houston (1982) claimed that satisfaction with services is related to conformation or disconfirmation of expectations, they based their research on the disconfirmation paradigm, which maintains that satisfaction is related to size and direction of disconfirmation (Churchhill and Suprenaut, 1982).

Service quality is an elusive and abstract construct that is difficult to define and measure (Parasuraman, Zeithmal and Berry, 1998). Measuring of service quality poses difficulties

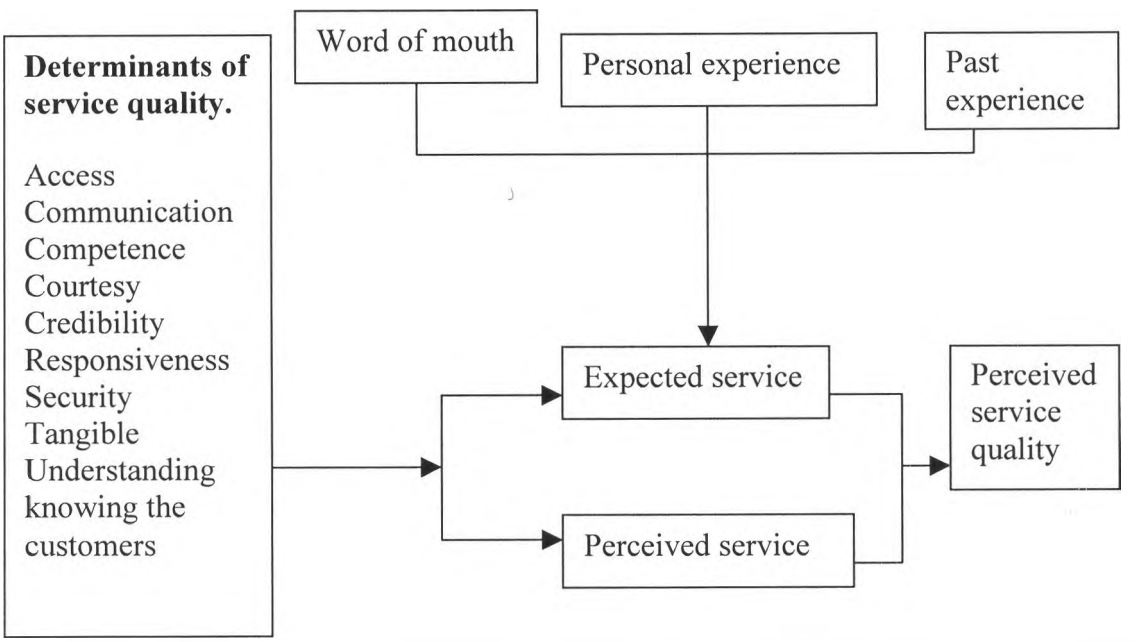
for service providers because of its unique characteristics (Bateson, 1995). Customers when purchasing goods employ many intangible cues to judge quality when purchasing services, fewer intangible cues exist (Mukiri 2001). In most cases, tangible evidence is limited to the service provider's physical facilities equipment and personnel. In absence of tangible cues, customers must depend on other cues (Kairu, 2002). The nature of these cues has not been extensively researched. To complete the definition of service quality we must emphasize that the measure of performance is essentially a measure of perceived performance. If a service provider knows how the consumer will evaluate the service then it is possible to suggest ways on how to influence these evaluations in a desired direction (Gronoos, 1982).

According to Parasuraman et. al (1998) they identified ten broad dimensions of service quality. They are; tangibles this refers to the appearance of physical facilities, equipments, and communication materials, used to provide the service and appearance of the service personnel. Reliability, it involves the ability to perform the promised service dependably and accurately. It means that the firm performs the service right the first time. In this case it will involve accuracy in billing, keeping records correctly and performing the records correctly and performing the service at the designed. Responsiveness, this is the willingness to help customers by providing prompt service. It involves the timeliness in the delivery of services thus mailing transaction slips, recording of relevant data to process payments immediately and giving prompt service. Assurance is the knowledge and courtesy of the employees and their ability to convey trust and confidence in the solutions being provided. Empathy is the caring, individualized attention the company provides its customers. Competence means possession of the required skills and acknowledges performing the service. It also involves the knowledge and skills of the contact personnel. Access includes approachability and ease of contact. It means that waiting time to receive service is not extensive, location of service facility is convenient and service is easily accessible. Courtesy entails politeness, respect, consideration and friendliness of contact personnel. It embraces clean and neat appearance of contact personnel. Communication involves keeping customers informed in a language they can understand and listening to them. In other words it means being flexible when

communicating and receiving feedback from customers. Credibility refers to trustworthiness, believability and honesty. Factors, which contribute to credibility, include organization name, reputation and personal characteristics of the contact personal. Security refers to freedom from danger, risk, and doubt. It involves physical safety and confidentiality. Understanding the customer involves making an effort to understand customers' needs. It involves learning the customers' specific requirements.

Kotler summarized the determinants of quality service into five sections as reliable, responsiveness, assurance, empathy and tangibles. The figure 3 shows the perceived service quality form the service quality dimensions' inputs.

Figure 2:3 Service Quality Dimension Inputs



Source: *Christopher, Payne and Ballantyne (1996),* ***Relationship Marketing: Bringing Quality, Customers Service and Marketing Together,*** *Lovelock (1996), service marketing, 3rd edition, Prentice Hill International, pg 563.*

2. 4 Perception of Quality

Perceived quality is defined as the customers' perception of the over all quality or superiority of a product or service with respect to its intended purpose, relative to alternative (Zeithmal, 1988). Perceived quality differs from several related concepts such as actual or objective quality which refers to extent which the product or service delivers

superior service. Product based quality, which refers to the nature and quantity or ingredients, features or service included and the manufacturing quality refers to conformance to specifications, the "Zero defect" goal.

Kibera and Waruingi(1998) point out the following perception characteristics. That customers' perception is subjective, selective, time related and summative. These summations are summed up into a complete and unified whole before a consumer can react to them. It is difficult to conceive how consumers could ever make their minds to buy if it were not for the fact that perception is summative. Perceived quality cannot be objectively determined in part because it is a perception and also because judgment about what is important to customers are involved. As Jack F Welch, chairman of and CEO of General Electric said, "The customer rates as better or worse than somebody else. It is not very scientific but it is distrusters if you score low" (Welch, 1981). Perceived quality also differs from satisfaction. A customer can be satisfied because he or she had low expectation. Perceived quality also differs from attitude (a positive attitude could be generated because a product of inferior quality is very inexpensive). Conversely, a person could have a negative attitude toward a high quality product that is over priced. Perceived quality is an intangible, overall feeling about a brand.

Consumers often judge quality of a product or service on the basis of a variety of information cues that they associate with the product. These information cues have been dichotomized into intrinsic and extrinsic cues (Olson, 1977; Olson and Jacoby, 1972). Intrinsic cues involve the physical component of products such as flavor, color and texture. Extrinsic cues, on the other hand, are product related but not part of the physical product it self. They are by definition outside the product and include price, brand name, level or advertising, amongst others.

2.4.1 Measurement of Perceived quality

In the measure of performance, it is a measure of perceived performance that counts rater than the reality of performance (Christopher et.al. 1991). To complete the definition of service quality we must emphasize that the measure of performance is essentially a

measure of perceived performance. In other words, it is the customers' perceptions of performance that counts rather than the reality of performance Christopher et.al (1997) further urges that as far as quality of service is concerned than "perceptions are reality".

Kotler (1995), reports that an individuals perceptual process simply attunes it self more closely to those elements of the environment that are important to that person. Expectations affect the same way someone will perceive an object or event. People usually see what they expect to see, and what they expect to see is usually based on familiarity on previous experiences and preconditions set.

Due to the intangible nature of service, customers opt from among virtually indistinguishable alternatives and through experiences develop an attitude towards the service. Chava et.al (1996) defines the Likert scaling as a method used to measure attitudes. To construct a likert scale researchers use the following six steps that is to compile possible scale items, administer these items to a random sample of respondents, compute a total score for each respondent, determine the discriminative power of the items, select the scale items and test reliability.

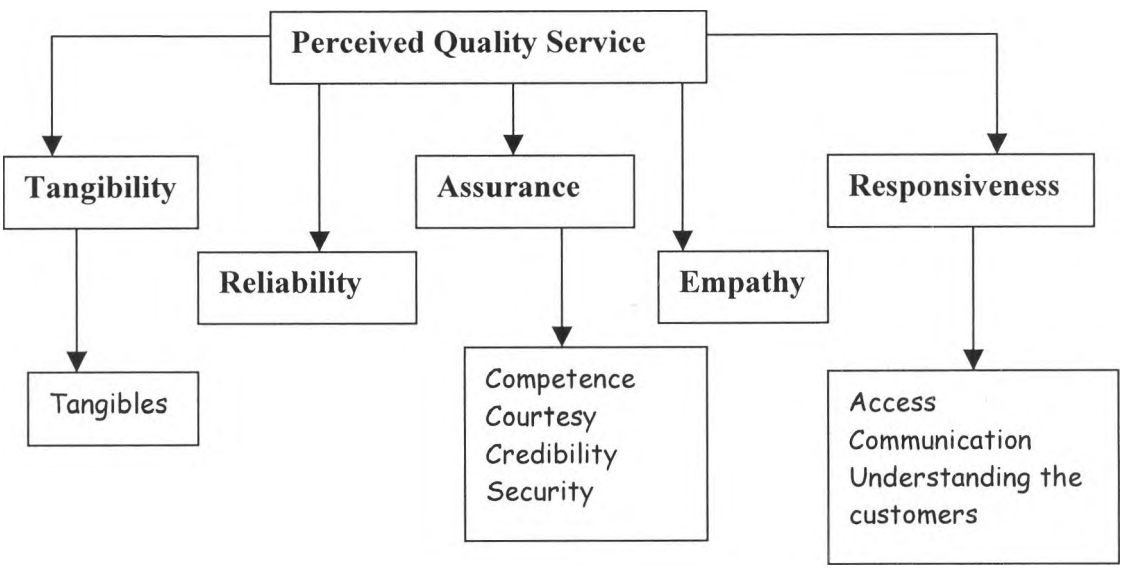
The possible scale items may express a wide range of attitudes, from extremely positive to extremely negative a fixed five – alternative expression such as "strongly agree"," agree", "neither agree or disagree" and "strongly disagree" etc.
Each item requires the respondent to check, rate and tick one of the offered five fixed alternative expressions in the five-point continuum, values of 1,2,3,4,5, or 5,4,3,2,1,as assigned. These values express the relative weights and their directions as determined by the favorableness or unfavourableness of the item. The service quality dimensions are mainly based on the behavioral considerations or the attitudes of the service vendor and eservice recipients.

2.5 Summary of the Literature Review

A broad understanding of service has been stipulated in the above chapters with key focus on the analysis of what a service is, what customers perceive as quality service and

the customers expectations of superior service quality. Customer satisfaction is the service delivery as it is the degree of fit between the customers' expectations of service quality and the quality of service as perceived by the customer. The SERQUAL scale and the P-C-P model are used to access the perception of hospital administrators on the quality of service rendered based on the following five dimensions of reliability, responsiveness, assurance, empathy and tangibility. These dimensions are further be divided into two groups: the outcome dimension- pivotal attributes, which focuses on the reliable delivery of core service and the process dimension-peripheral attributes, that focuses on how the core service is delivered that is the employees responsiveness, assurance, and empathy in handling customers and the services intangible. The literature review provides an outline on various areas of focus that hospital administrators will expect on service and what they experience in service delivery form NHIF.

Figure 2.4 Summary of the aspects of service Quality



Source: ***The Author***

CHAPTER THREE
RESEARCH METHODOLOGY

3.1 Research Design

The study was a descriptive study that aims at establishing the expectations and the perception of the hospital administrators on the service quality that is rendered by NHIF. According to Boyd, Westfall and Stasch (1990), a descriptive study aims at determining the what, when and how of a phenomenon which was the concern of the current study.

3.2 The Population

The population of focus was hospitals in Nairobi offering inpatient services and included both private and public hospitals. NHIF claims manual (2006) stipulates the accredited hospitals in Nairobi as 64 (appendix 5). Given the small number of hospitals in Nairobi a census study was conducted.

3.3 Data collection Method

Primary data was collected using structured questionnaire (see appendix 2). One respondent who is either the hospital administrator rank or their equivalent was given a questionnaire to fill in each Hospital.

The questionnaire was administered using the drop and pick later method, follow-ups was made through phone calls to ensure that the questionnaires were filled out and the researcher picked the filled questionnaires from the respondents. The questionnaire was divided into three sections. Section A aimed at gathering the demographic profile of the respondents and the hospitals under study. Section B aimed at establishing the expectation of the hospitals in regards to service rendered by NHIF. Section C aimed at establishing the perception of service rendered by NHIF. Both closed and open-end questions were used.

3.4 Operationalization of service quality

Using the criteria of judging service quality by Berry, Zeithomi, and Parasuraman(1985), the questions are relevant to these properties that were formulated to facilitate assessment by the customers. The likert scale questions will be used to measure the administrators' expectations and perceptions.

Table 3.1: Operationalization of Service Quality Dimensions

Broad Generic Dimension Of Quality.	**Expand Dimension Of Quality**	**Definition Of The Dimension**	**Relevant Issues For Administrators Of Hospitals In Regards To NHIF**	**Relevant Question**
Reliability	Reliability	Dependability of performing the service at the designated time with no delays and accurately. Availability of service when and where needed. Always keep promises.	-Timeliness of service. -Dependability of service delivery. Availability of the claiming and accreditation forms. Availability of health insurance staff. Reliability of information given.	**5(a,b,c,d, e,f,)**
Responsiveness	Responsiveness	Providing prompt service, attending to customer complaints. Understanding fast action on complaints.	Prompt response from health insurance staff on the accreditation and claiming procedures.	**5 (g,h)**
	Competence	Knowledgeable operators in service delivery, competent and skilled service staff.	Knowledge of health insurance staff on the various procedures.	**5 (i)**
	Courtesy	Service personnel being polite	Politeness, respect and	**5(u)**

		respectful and considerate to customers.	collaboration of health insurance staff to administrators.	
	Credibility	Involves trustworthiness, believability and honesty. It involves having the customers' best interest at heart.	Usefulness of health insurance staff feedback to the administrators. Fairness in evaluating and setting all procedures.	**5(v,w)**
	Security	Providing of physical and psychological sense of calm and peace to customers as they use services.	Safety of information given in health insurance forms and personal safety while visiting Offices.	**5(s,t)**
Empathy	Access	Easily accessibility of service personnel by customers.	Access to the offices, and personnel.	**5(j,k)**
	Communication	Service personnel easy and clear relay of information in a way that customers understand, without any complexity.	Clarity of all information given with all the difficult concepts being explained.	**5(i,m,n)**
	Understanding/ Knowing the customer	Involves making an effort to understand customer needs, specific requirements, providing individualised attention and concern to customers.	Support given by staff to administrators who do not understand various processes. Frequency in discussion forums.	**5(o,p)**
Tangible	Tangible	The physical appearance of service facilities like buildings, people, and dressing code.	Size and location of health insurance offices. Availability of information on the service on print and electronic media.	**5(q,r)**

3.5 Data Analysis Technique

The study being a descriptive one, descriptive statistics were utilized in the analysis of the data obtained. Data in Section A of the questionnaire was analysed by the use of frequencies tables while data of the likert scores in parts B and C of the questionnaire were analysed by use of frequency tables, mean, standard deviation and coefficient of variation for all the attributes and dimension of service quality (see appendix 6,7,8 and 9),

Mean scores on the likert scale were used to determine the weighting factor of the importance of each service quality dimension while the coefficient of variation was used to access the extent of the expectation of service rendered by a Health Management Organisation versus the perception of service rendered by NHIF. With these variables it was possible to assess, rate and rank each dimension of service quality in terms of its weighted importance in determining the expected service and perceived service.

In analysing the hospitals service expectations, mean, standard deviation and coefficient of variation for each dimension of service quality were used to rate the relative importance of each for the hospitals.

Perceived service quality was measured by comparing the mean, standard deviations and coefficient of variation of each service quality dimension in part B of the questionnaire with corresponding values from part C of the questionnaire. The differences between scores from part B and C of the questionnaire, for mean, enabled the calculation of service quality gap for the hospitals. Thereby measuring the SERVQUAL model gap 5.

Comparison of the differences between the hospitals expectations and perceptions of the quality of service rendered by NHIF was done by use of mean for expected and perceived service quality, based on all the ten quality dimensions. A graph has been used for visual presentation of findings.

CHAPTER FOUR
DATA ANALYSIS AND FINDINGS

4.1 Introduction

In this chapter, data relating to hospitals staff expectation of service, and perceived quality of service were analysed and interpreted. The analysis is done in two categories for the expected services from a health insurance company and the perceived service from NHIF.

Of the sixty-four questionnaires that where distributed only fifty-four were completed fully, gaining a return rate of 84.4%. This response rate compares favourably with other studies on perceived service quality, like the 87% response rate by Odawa (2004), 84% by Mwaura (2002) and 87% by Njoroge (2003).

4.2 Demographic Profiles of Respondents

The respondents demographic profile are analysed in terms of the type of hospitals, the job tile of the respondent and the number of years that the hospital has been accredited to NHIF.

Table 4.1 Type of hospitals

Type Of Hospital	Number	Percentage
Private	46	85.19
Government	8	14.81
Total	54	100

Out of the fifty-four respondents only 8 (14.81%) where from the government hospitals, while 46 (85.19%) where from the private hospitals. Generally there are only nine government hospitals in Nairobi and fifty-five private hospitals that are covered by NHIF inpatient scheme, making the response rate of 88.9% for government while 83.6% was for private hospitals.

Table 4.2 The Respondents Job Title.

Job Title	Number	Percentage
Supervisor	20	37.04
Manager	24	44.44
Director	10	18.52
Total	54	100%

Majority of the respondents are the middle management thus the supervisors with a response rate of 37.04% and 44.44% response from managers.

Table 4.3 The Number of year's hospitals have partnered with NHIF

Number Of Years	Number Of Hospitals	Percentage
Less than one year	4	7.41%
1-5 years	7	12.96%
6-9 years	15	27.78%
10 or more years	28	51.85%
Total	54	100%

All the hospitals that where selected have a relationship with NHIF as a health insurance service provider. Majority of hospitals 28 (51.85%) have had a relationship lasting more then ten years with NHIF. The other hospitals that have had a relationship of less than one year are only four (7.41%), while those that have 1-5 years are 7 (12.96%), and 6-9 years are15 (27.78%).

4.3 Measurements of Respondents Service Expectations

These responses from the likert scale scores and the calculated variables (i.e. mean, variance, standard deviation, coefficient of variation, and service quality gaps) are represented in the attached appendices 6, 7 and 8. The respondents' expectations of the service quality dimensions relevant issues as captured in the questionnaire were first analysed for all respondents and then a relative comparison of the expectations and the perceptions was done. A comprehensive summary of the respondents' expectations of the

ten service quality dimensions was then done. These expectations are summarized in descending order in tables 4.4, 4.5 and 4.6 for all the respondents.

The variables in tables 4.4, 4.5, and 4.6 are obtained from the respondents' score of the answers to the service quality attribute questions in the likert scale, which were entered in the score sheets in appendices 6, 7, and 8. After these entries, the mean of expectations of each service quality dimension (Me), are calculated. Similarly, the coefficient of variation (Cv), of respondents' score on the likert scale for each service quality dimension are calculated.

The mean scores are a measure of the relative importance of each service quality dimension. The mean of a service quality dimension with more than one attribute is computed by calculating the average of means of related attributes. Standard deviation is a measure of how to spread out a distribution, thus a measure of variability. It is calculated as the square root of the variance, where variance is the average squared eviction of each number of the mean. Coefficient of variation (Cv) is a measure of dispersion of a probability distribution. It is defined as the ratio of the standard deviation to the mean; it is often reported as a percentage (%).It is used to measure the agreement or disagreement of the same mean of scores by the respondents. The coefficient of variation is, equal to one, distributions with CV<1 are considered low variance, while those with CV>1 are considered high variance.

4.3.1 Service Expectations of Respondents

The respondents' service expectations were analysed by the means of variables for each service dimension (see Table 4.4). The analysis is done for all the respondents (Me) on the basis of the ten service dimensions, focusing on the relevant issues concerning availability of the health insurance services.

Table 4.4. Service quality dimension expectation relative importance for all respondents

Service Quality Dimension	Mean, Me	Standard Deviation Stde	Coefficient Of Variation, Cve
Reliability	3.74	0.49	13.10%
Responsiveness	3.97	0.52	13.31%
Competence	3.87	0.51	13.18%
Courtesy	3.5	0.46	13.16%
Credibility	4.0	0.53	13.30%
Security	3.83	0.54	14.09%
Access	3.59	0.47	13.11%
Communication	3.91	0.52	13.26%
Understanding/Knowing The Customer	4.11	0.58	14.05%
Tangible	4.22	0.57	13.61%
Average	**3.87**		**13.417**
Total	**38.74**		**134.17**

Reliability was measured in the following variables as shown appendix 6 and summarised in table 4.4 above. The ability of health insurance companies to offer reliable service is at a mean of 4.15 which is the highest mean in that category, standard deviation (Stde) is at 0.56 and Coefficient of Variation (Cve) is at 13.48%. The ability of officers to solve problems correctly is at a mean of 4.13, Stde of 0.53 and Cve of 12.9%. Provision of prompt service is at a mean of 4.06, Stde of 0.49 and Cve of 12.02%. The ability of both the staff and the website of the companies to offer reliable information are at a mean of 3.04, Stde of 0.43, and Cve of 14.30%. Staff willingness to assist administrators is at a mean of 3.13, Stde of 0.44 and Cve of 13.93%. The availability of information on packages is at a mean of 3.94, Stde of 0. 47 and Cve of 12%. On average the respondents' expectation on the reliability dimension is at 3.74.Stde of 0.49 and Cve of 13.10%.

Responsiveness form the health insurance companies to the hospitals is based on the respondents' expectation on the following variables as shown in appendix 6 and summarised in table 4.4. The prompt response on feedback of claim forms is at a mean of 3.78, Stde 0.5 and Cve of 13.12%. The address of complaints was at a mean of 4.17 Stde of 0.56 and a Cve of 13.51%. The average respondents' expectation on the responsiveness dimension is at a mean of 3.97, Stde of 0.52 and CVe of 13.31%.

Competence was based on the staffs knowledge of the health insurance polices; the mean on this area was at 3.87, Stde of 0.53 and Cve of 13.18%.

Courtesy of the health insurance service providers to the hospitals was based on the ability of the staffs' treatment to the administrators respectively and politely with a mean score of 3.5, Stde of 0.46 and a Cv of 13.16%.

Credibility of the usefulness of health insurance feedback was at a mean of 4.0, Stde of 0.53 and Cve of 13.3% and fairness in setting and evaluating the claiming procedure, had a mean of 4.018 Stde was 0.53 and Cve of 13.3%. Gaining an average mean of 4.0, Stde of 0.53 and Cve of 13.3%

Security of the respondents' information given in the health insurance policy was at a mean of 4.56, Std of 0.65 and Cve of 14.17%. The respondents' personal safety while visiting the insurances offices was at 3.11, the Stde was 0.43 and the Cve was 14.0%. Gaining an average mean of 3.83, Std of 0.54 and Cve of 14.09% on the variable.

Access, respondents had an expectation mean score of 3.63, Stde of 0.48and a Cve of 13.1% on the opening hours. The accessibility of the offices had a mean of 3.56, Std of 0.47 and a Cv of 13.12%. The overall expectation mean score for the access service quality dimension was 3.59, Stde was 0.47 and Cve 13.11%

Communication of the information given in from of feedback was at a mean score of 4.19, Stde of 0.57 and Cv of 13.54%. The clear knowledge of what is expected of you as

a hospital from the health insurance company was at a mean of 3.78, Stde of 0.49 and Cve of 13.12%. The health insurances staff communication skills mean score was at a mean of 3.78, Stde of 0.49 and a Cve of 13.11%.. On average the communication service dimension had a service quality expectation mean score of 3.91, Stde of 0.52 and Cve of 13.26%.

Understanding and knowing the customer the area was analysed using the support given by staff to administrators who do not understand various procedures, the mean was 3.96, Stde was 0.53 and the Cve was 13.26%. The frequency of health insurances and administrator's discussion forums on issues relating to hospital insurance policies, the mean was at 4.25, Stde was 0.63 and Cve was 14%. Overall mean for the understanding and knowing the customer was at 4.11, Stde was 0.58 and Cve was 14.05%.

Tangible service quality dimension for health insurances was analysed through the size and comfort of the office, which had a mean of 4.33, Stde of 0.59 and a Cve of 13.8%. Staff dressing had a mean score of 4.11, Stde of 0.55 and a Cve of 13.45%. The overall mean score for the tangible aspect was at 4.22, Stde was 0.57 and Cve was 13.61%.

As is evident in table 4.4, the service quality dimension of tangibility with a mean score (Me) of 4.22 Standard deviation of 0.57 and coefficient of variation of 13.61% tops the list of service quality dimension that are of importance to the hospitals. Followed by "understanding/knowing the customer" with a mean score of 4.11, standard deviation of 0.58 and coefficient of variation of 14.05% and thirdly "credibility" with a mean of 4.0, standard deviation of 0.53 and coefficient of variation of 13.30%. The least service dimension was that of "courtesy" with a mean score of 3.5, standard deviation of 0.46 and coefficient of variation of 13.16%.

4.4 Perceived Service Quality

The perceived service is measured by computing the means of the scores of likert scale to the answer of service quality attributes of the received service. Just like the expected service in table 4.4 above, the mean of a service quality dimension with more than one

attribute is computed by calculating the means of related attributes. Equally the standard deviation of a service quality dimension with more than one attribute is computed by calculating the square root of the sum of all variables of related attributes. The co-efficient of variation is obtained by dividing the standard deviation with the corresponding mean.

As shown in appendix 7 the perceived service quality using the ten service dimensions and the relevant issues as captured in the questionnaire are analysed. The results are shown in table 4.5.

4.4.1 Perceived service quality for respondents

The key areas for the reliability dimension with high service quality gaps were as follows. The ability of NHIF to offer reliable services to the hospitals was at a mean of 2.89 Stdp was 0.57 and Cvp of 19.87%. The ability of officers to solve problems correctly is at a mean of 3.33 Stdp of 0.57 and Cvp of 17.22%. While that of provision of prompt service is at a mean of 3.35, Stdp was 0.47 and Cvp of 13.99%. The ability of both the staff and the website of the NHIF to offer reliable information is at a mean of 2.48, Stdp of 0.46 and Cvp of 18.64%. Staff willingness to assist administrators is at a mean of 2.37, Stdp of 0.44 and Cvp of 18.64%. The availability of information on packages is at a mean of 2.37, Stdp of 0.43 and Cvp 15.19%. On average the mean of the respondents' perception on the reliability dimension is at 2.87, and a Standard Deviation of 0.49 and a Coefficient of Variation of 17.26%

Table 4.5. Service quality dimension perception relative importance for all respondents

Service quality dimension	Mean, Mp	Standard Deviation Sp	Coefficient of variation, Cp
Reliability	2.88	0.49	17.26%
Responsiveness	1.45	0.66	60.19%
Competence	2.33	0.48	20.58%

Courtesy	1.87	0.56	29.72%
Credibility	2.87	0.44	15.22%
Security	2.26	0.46	21.46%
Access	2.47	0.46	18.79%
Communication	2.72	0.45	16.62%
Understanding/knowing the customer	1.38	0.46	33.41%
Tangible	2.71	0.48	17.79%
Average	**2.29**		
Total	**22.94**		

Responsiveness from NHIF to the hospitals is based on the respondents' expectation on the prompt response on feedback of claim forms is at a mean of 2.07; Stdp was 0.52, and Cvp of 25.03%. The address of complaints was at a mean of 0.83, Stdp of 0.79 and Cvp of 95.3%. The average respondents' perception on the responsiveness dimension is at a mean of 3.97, while the Standard Deviation of 0.66 and a Coefficient of Variation of 60.19%.

Competence was based on the staffs knowledge of the health insurance polices; the mean on this area was at 2.33, Standard Deviation of 0.48 and Coefficient of Variation of 15.22%.

Courtesy of the health insurance service providers to the hospitals was based on the ability of the staffs' treatment to the administrators respectively and politely with a mean score of 1.87, Standard Deviation of 0.56 and Coefficient of Variation of 29.72%.

Credibility of the usefulness of health insurance feedback was at a mean of 2.85, Stdp of 0.43 and Cvp of 15.36%. Fairness in setting and evaluating the claiming procedure, their Means was 2.89, Stdp of 0.43 and Cvp of 15.08%. The variable gainded an average Mean of 2.87, Standard Deviation of 0.44 and Coefficient of Variation of 15.22%.

Security of the respondents' information given in the health insurance policy was at 1.81 and the respondents' personal safety while visiting the insurances offices was at 2.72 achieving an average of 2.27 on the variable of mean, Standard Deviation of 0.46 and coefficient of variation of 21.46%.

Access, respondents had a perception mean score of 2.26, Stdp of 0.45 and Cvp of 19.8% on the opening hours. Accessibility of the offices had a mean of 2.68, Stdp of 0.47 and Cvp of 17.70%. The overall perception mean score for the access service quality dimension was 2.47, Standard Deviation of 0.46 and Coefficient of Variation of 18.79%.

Communication of the information given in from of feedback was at a mean score of 2.85, Stdp was 0.49 and Cvp was 17.19%. The clear knowledge of what is expected of you as a hospital from the health insurance company was at a mean of 2.7, Stdp of 0.43 and Cvp of 16.15%. The health insurances staff communication skills mean score was at 2.62, Stdp was 0.43 and Cvp was 16.54%. On average the communication service dimension had a service quality perception mean score of 2.72, Standard Deviation of 0.46 and Coefficient of Variation of 16.62%.

Understanding and knowing the customer the variable was analysed using the support given by staff to administrators who do not understand various procedures, the mean was 1.33; Stdp was 0.43 and Cvp of 32.8%. The frequency of health insurances and administrator's discussion forums on issues relating to hospital insurance policies, the mean was at 1.42, Stdp was 0.48 and Cvp of 34%. Overall mean for the understanding and knowing the customer was at 1.38, Standard deviation was at 0.46 and Coefficient of Variation was 33%

Tangible service quality dimension for health insurances was analysed through the size and comfort of the office gaining a mean of 2.98, standard deviation of 0.48, Coefficient of variation was at 16.27%. Staff dressing variable had a mean score of 2.44, Stdp of 0.47 and Cvp of 19.30%. The overall mean score for the tangible aspect was at 2.71, Standard Deviation of 0.48 and Coefficient of Variation of 17.79%.

Through the analysis above perception of the service quality dimension showed the highest mean as that of the reliability of NHIF, with a mean score of 2.88. The lowest service quality dimension was that of understanding/knowing the customer with a mean of 1.38.

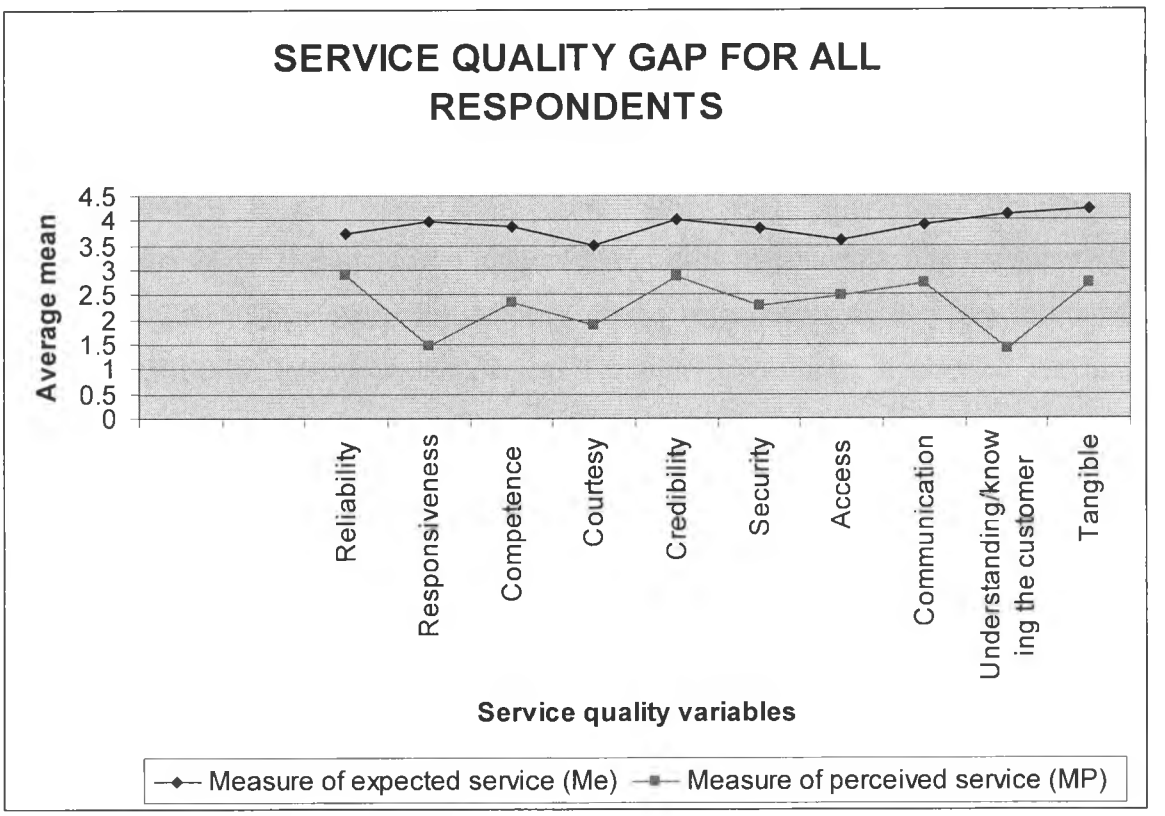
4.5 The Service Quality Gaps

The service gaps for the ten-service quality dimension are tabulated in the order of importance of each service quality dimension as shown in table 4.5. For all respondents, the perceived service quality gaps was highest "Understanding/knowing the customer" Ga=2.73 and least for "Reliability", Ga=0.83. This implies that the hospitals are most satisfied with "understanding/knowing the customer" and least dissatisfied with "Reliability".

4.6: Computed Quality Gap for all Respondents

Service quality dimension	**Measure of expected service (Me)**	**Measure of perceived service (MP)**	**Service quality gap (Ga)**	**Percentage Quality Gap** $\frac{Me-Mp}{Me} * 100$
Reliability	3.74	2.88	0.83	22.19%
Responsiveness	3.97	1.45	2.52	63.47%
Competence	3.87	2.33	1.54	39.79%
Courtesy	3.5	1.87	1.63	46.57%
Credibility	4.0	2.87	1.13	28.25%
Security	3.83	2.26	1.57	40.99%
Access	3.59	2.47	1.12	31.19%
Communication	3.91	2.72	1.19	30.43%
Understanding/knowing the customer	4.11	1.38	2.73	66.42%
Tangible	4.22	2.71	1.51	35.78%
Average	**3.87**	**2.29**	**1.42**	**36.69%**

The graphical display of service quality gaps for all service dimensions are displayed in the following page, the graph shows a high level of expected services as compared to the received service, an indication of existence of service quality gap for all dimensions of service quality.



CHAPTER FIVE
DISCUSSION CONCLUSION AND RECOMMENDATION

5.1 Introduction

From the analysis and data collected the following discussions, conclusions and recommendations where made. The response was based on the objectives of the study.

5.2 Discussion

The managers of the Hospitals who totalled 24% of the respondents, and the supervisors contributed 20%. These were the majority of the respondents as they are in constant contact with health insurance companies. Through the sample, it showed the major reasons that influenced the service quality of the National Hospital Insurance Fund; understanding/knowing the customer, tangible aspects of the service and credibility of the service provider.

The respondents' service expectations of health insurance providers were on average 3.87 and the perception of NHIF was at 2.29. This clearly shows that there is an average gap of 1.58 between the service quality dimensions. On all the ten service quality dimensions a clear gap exists between understanding/knowing the customer (Ga=2.73, 66.42%) and responsiveness (Ga=2.52, 63.47%). The low service expectation of the respondents were stipulated in the low scores of courtesy and access with a mean score of 3.5, 3.59 respectively.

As stipulated in the gap analysis (annex 8), responsiveness as a service dimension, major gaps existed in prompt responses on the feedback of claims (Gap=1.71), address of complaints (Gap=3.34) and gaining an average of 2.55. Competence deals with the staff knowledge on health insurance policies (Gap=1.54). NHIF scored the lowest on the perceived service in courtesy due to the staff treatment to administrators respectively and politely Gap=1.63. The credibility dimension on the usefulness of health insurance feedback had a Gap= 1.15 and the fairness of setting and evaluating the claiming procedure Gap=1.12 with an average Gap of 1.13. The security dimension was covered

with an average Gap of 1.56, it was analysed using the safety of information given in the health insurance policy (Gap=2.74), and the personal safety while visiting health insurance offices (Gap=0.39). For access, the opening hours (Gap= 1.37), accessibility of offices (Gap=0.86) and with an average (Gap=1.12). In any service dimension communication is key hence it scored an average gap of (1.18) the usefulness of feedback (Gap=1.33), clear knowledge of what is expected of you (Gap=1.078) and staff communication skill Gap=1.14).

The key service dimensions that enable the hospital administrators evaluate NHIF highly in the perception of services rendered to them where reliability Mp=2.88, credibility Mp=2.87, communication Mp=2.72 and tangibility Mp=2.71.

In contrast to other studies by Odawa (2004) Njoroge (2003), Mwaura (2002) and Ngatia (2000) there score for average service expectations means where above 4.0 for all the ten service dimensions, whereas in this study the service quality dimension had an average service expectation mean ranging between 3.5 to 4.22. The service expectations score averages that were below 4.0 were, 'reliability (3.74)', 'responsiveness (3.97)' 'competence(3.87)', 'courtesy (3.5)', 'security (3.83)', 'access (3.59)',and lastly communication (3.91).

In the case of the hospital administrators, credibility, understanding/knowing the customer and tangibility are the pivotal issues that are important to hospital administrators in dealing with NHIF. This contrasts with the findings of Njoroge (2003) in which responsibility and responsiveness are the pivotal service attributes in the case of Kenya Power Lighting Company (KPLC) customers. This reflects the uniqueness of National Hospital Insurance Fund as service delivery requirements in comparison to other industries.

For the perceived service quality for NHIF, the mean score along the service quality dimensions ranges from 1.38 to 2.88, and an overall service quality gap of 1.42 or 36.69% which is quite significant. The highest gap is understanding/knowing the

customer responsiveness, and courtesy. In other studies, for Njoroge(2003) in his study fro KPLC and Odawa (2004) study on University of Nairobi(UoN) the highest gap dimensions were responsiveness, reliability, tangibles, communication , credibility and access.

The high service quality gaps on the dimension shows that quite a number of services issues need to be addressed by NHIF. The coefficient of variation for the received service ranges form 15.22% to a high of 60.19% and an over average of 25.10%, an indication of a general high level of disagreement in the assessment of received services by hospital administrators.

5.3 Conclusion

The hospitals are influenced to partner with NHIF as a service provider because of its reliability as an insurance service provider. The hospitals administrators have a high expectation for the entire service dimension. High expectations are on the service dimension of; understanding/knowing the customer, tangible, credibility and responsiveness. Low service expectations were for the dimension of courtesy and access. Perceptions of NHIF service delivery from the hospital administrators are reliability, credibility and communication. The low perceptions were in dimension of understanding the customer and responsiveness. There exists a service quality gap for all the ten dimensions of service, with an average gap of 1.42, which is quite significant.

5.4 Recommendations

NHIF key competency is reliability as it has been in existence for over forty years. Many health insurance providers have come into the market but have collapsed with huge amounts of money being owed to their creditors and customers. There by NHIF, should continue ensuring that they will provide health insurance service to a majority of Kenyans accessibly and affordably. NHIF can enhance there reliability through up dating the information given in the website. This information should include an interactive forum for people to download information and ask questions about NHIF services.

Provision of prompt services should be enhanced during the claiming and accreditation procedures given to the hospitals. Staff should be willing to assist the administrators form the first point of contact. Hence, NHIF staff should be trained on the various processes and procedures that govern NHIF and further training on health insurance issues that affect NHIF.

Responsiveness as a service dimension needs to be improved through the prompt response on claim forms, of which NHIF gives credit period of fourteen days, before payments made. Hence some hospitals have witnessed that payments are not made in time. NHIF should maintain this quality standard of fourteen days.

There is need for improvement in courtesy due to the fact that NHIF is in the business of selling services; hence customers need to be treated to be more respectfully, politely and honestly.

All services need to be created through the knowledge and understanding ones customer. Hence, NHIF need to create products that put the customers first. This can be done through frequent discussion forums with hospital administrators and other stakeholders on various insurance concepts. Appropriate research on what the customers need in health insurance.

Overall NHIF has quite a number of service gaps that will need to be addressed for it to run efficiently and effectively. Therefore it is important for NHIF management to provide mechanisms that enable collection of feedback on its performance and improvement opportunities. NHIF needs to embrace more on the market orientation concept in its relationship with hospital administrators. Hospital administrators expect quality and professionalism in the provision of services. This means that NHIF must try to exceed the hospitals expectations.

Limitations of Study

The sample covered the Nairobi area; the road network in Nairobi and its environs was so prohibitive for the researcher to reach the designated hospitals. Some respondents did not have patients and lack of awareness on NHIF service hence prohibiting them from feeling the questionnaire.

Recommendations for further Research

A similar study should be undertaken focusing on all the hospitals in Kenya. The respondents should be broadened not only to the middle and top management but also to all the people who work in the hospitals like nurses' doctors' clinicians and others.

A study on the contributors (people who pay NHIF rebates) should also be undertaken.

REFRERENCES

ASI Quality Systems, (1992), "Quality Function Development", **Practitioner Workshop,** American Supplier Institute Inc., USA.

Asubonteng P, Mc Clearly, K. J. and Swan, J. E. (1996), "Servqual revisited: a critical review of service quality", **Journal of Service Marketing**, Vol. 10, No. 6, pp.62-81.

Bateson , J. E. G. (1977), "Do We Need Marketing In Marketing Consumer Services", **New Insight Cambridge** , MA .pg 77-115.

Berry, L. L. (1988), "Delivering Excellent Service in Retailing", Arthur Anderson **Retailing Issues Letter**, April.

Brooks, R. F.,Lings, I. N. Bostchen, M.A. (1999) "Internal Marketing And Customer Driven Wavefronts", **Service Industries Journal**, Vol. 19, No.4,pg. 49-67.

Bradshaw, and Della, (1998), "Delivering Excellent Service in Retailing", Arthur Anderson **Retailing Issues Letter**, April.

Brown, S. W. and Bond, E. U.III (1995), "The International/ External Framework and Service Quality: Toward Theory In Service Marketing", **Journal Of Marketing Management,** February . pg.25-39.

Brysland, A. and Curry, A. (2001), "Service Improvements In Public Service Using Serqual", **Managing Service Quality ,** Vol.11, No.6,pg389-401.

Bither, M. (1990), Evaluating Service Encounter: The Effects of Physical Surrounding and Employee Response", **Journal of Marketing**, pg 54.

Bolis, K. J. (1978), "The Marketing of Service: An Approach", **European Journal of Marketing,** 2

Bolton, R. Drew, H. (1991), "A Multistage Model of Customers' Assessment of Service Quality and Value", **Journal of Consumer Research**, pg 17.

Campell, R. (2000), **Marketing.** The Chartered, Insurance Institute Publishing Division, London

Coxe, W. (1990), **Marketing Architectural and Engineering Services**, 2nd Edition: Malabar,Krieger Publishing Company.

Charles, W. L. H., Gareth R. J. (1998), **Strategic Management Theory**, Horghton Mifflin Company, 4th edition.

Christian Health Association of Kenya, (2004), "For the health of the nation", **CHAK Times**, 18 September- December 2004 pg6-7

Christopher P. and Ballantayne, (1997), **Relationship Marketing; Consumer and Industrial Buying Behaviour,** New York: North Holland and Publishing Company.

Cronin, J. J and Taylor, S. A. (1992), Measuring Service Quality: A re-examination and Extension**", Journal of Marketing,** 56 July pg 55-68

Crosby, P. B. (1979), **Quality is free: the Act of Making Quality certain,** New American Library, New York.

George, P. and Shirley –Ann H. (1996): "The Measurement Of Service Quality: A New P-C-P Attributes Model, Management And Information Systems, Division School Of Management", **The Queens University Belfast, Northern Ireland, U. K International Journal Of Quality And Reliability Management**, MCB University Press, Vol. 14 No3, 1997 pp 260-286

Government of Kenya, (2003), **Economic Recovery Strategy for wealth and Employment Creation** (2003- 2007)

Government of Kenya, (1994), **Kenya Health Policy Framework Paper, Nairobi.**

Government of Kenya, 1998), **GOK, NHIF Act Cap. 255 No. 9 of 1998,** Government Printers.

Government of Kenya, (1997), **Sessional Paper No. 4 of 1997 on Aids in Kenya.**

Government of Kenya, (1985), **The insurance Act.**

Government of Kenya, (2000), **Interim Poverty Reduction Strategy** Paper 2000-2003.

Gronroos, C. A, (1978), "Service Oriented Approach to Marketing of Services", **European Journal of Marketing,** 12 Pg 588-601.

Holbrook, M. B. and Corfman, K.P. (1985), **Quality and Value in the Consumption Experience,** Lexington M.A: Lexington Books Inc.

Jayanti, R. (1998), "Affective Responses towards Service Providers: A Categorization Theory Perspective", **Journal of Consumer Satisfaction, Dissatisfaction and Complaining Behaviour,** 11 Pg 51-61

Kibera, F. and Waruingi,B. (1998), **Fundamentals of Marketing: an African Perspective,** KLB

Kotler, P. and Armstrong, G. (1999), **Principles of Marketing,** 8th Edition: New Jersey, Prentice Hall Inc,

Kotler, P. and Armstrong, G., Sanders, J and Wong, V (1999), **Principles of Marketing,** Second European Edition: London, Prentice Hall Europe

Lewis, R. C and Boom, B. H. (1983)," The marketing aspects of quality, emerging perspectives of service marketing", **American Marketing Association** Pg 99-107

Lovelock, C. H. (1981), "Why Marketing Management Needs To Be Different For Services", **Marketing of Services,** Chicago, American Marketing Association, Pg 5-9

Lovelock, C. H. and Wright, L.K (1999), **Principals of Service Marketing and Management:** London, Prentice Hall Inc,

MacStravic, S. (1997), " Question Of Value In Health Care Quality; The Moderating Role Of Outcomes", **Journal Of Healthcare Marketing**. 18(4) Pg 50-53

Masinde, C. K. M (1996), "Perceived Quality of Service: The Case of Kenya Airways", **Unpublished MBA Project,** University of Nairobi

McDonald, M. and Payne, A. (1996), **Marketing Planning for Services;** Oxford, Butterworth-Heinermann Ltd

Ministry of Health, (2001), **Kenya National Health Accounts 2001-2002,** MOH

Ministry of Health, (2003), **Household Health Expenditure and Utilisation Survey Report**, 2003

Ministry of Health, (1999), **National health sector Strategic Plan,** 1999 – 2004, MOH

Mugo, A. (2000), " Determinants of service quality among Internet service providers in Kenya", **Unpublished MBA project**, University of Nairobi.

Mukiri, P.M. (2001), "Perceived Service Quality: the case of mobile service user", **Unpublished MBA project**, University of Nairobi.

Mwaura, A. K (2002), Perceived Service Quality: the case of matatu industry", **Unpublished MBA project**, University of Nairobi.

Mwendar, A. M. (1987), "Perceived service quality of port services: the case of Kenya Ports Authority", **Unpublished MBA project**, University of Nairobi

National Hospital Insurance Fund, (2001) **Strategic Plan** (2001-2006) NHIF.

Ndegwa, R. M. (1996), "Analysis of Customer Service Offered by Kenya Commercial Banks", **Unpublished MBA project**, University of Nairobi.

Ngatia, E. M. (2000), "A comparative study of service quality in the retailing industry", **Unpublished MBA project**, University of Nairobi

Njoroge, J. K. (2003), "Customers Perception of Service Quality in a Decentralised System In The Public Utility Sector In Kenya: the case of Kenya power and lighting company limited", **Unpublished MBA project,** University of Nairobi.

Olashazsky, R. W. (1985), **Perceived Quality in Consumer Decision Making. An Integrated Theoretical Perspective,** Lexington Books Inc

Oliver, R. (1997), **Satisfaction: a behavioural perspective on the consumer**, McGraw Hill, New York

Oliver, R (1980), "A Cognitive Model of Antecedents and consequences of Satisfaction Decisions", **Journal of Marketing Research,** 17Pg 460-469

Parasuraman A., Ziethmal,V.A. and Berry, L. L. (1985), "A Conceptual Model of Service Quality and its Implications For Future Reserch", **Journal of Marketing**, 49 Pg 41-50

Parasuraman A., Ziethmal,V.A. and Berry, L.L.(1991), "Refinement and reassessment of the SERVQUAL dimensions", Journal of Retailing, 67 Pg 420-450

APPENDIX 1
INTRODUCTION LETTER

LYNN N. GITOBU
University of Nairobi
School of Business
Department of Business Administration
P.O BOX 30197
NAIROBI

23rd May 20006

Dear Respondents

RE: REQUEST FOR RESEARCH DATA
I am a postgraduate student at the University of Nairobi, at the Faculty of Commerce. In order to fulfil the degree requirements, I am undertaking a management research project on the service quality that is rendered by NHIF. The study is entitled:

"Perception of hospitals on the service quality rendered by national hospital insurance fund".

You have been selected as part of this study. This is kindly to request you to assist me collect the data by filling out the accompanying questionnaire. The information data you provide will be used exclusively for academic purposes. My supervisor and you assure you that the information you give will be treated with strict confidence.

Your cooperation will be highly appreciated.

Thank you in advance.

Yours faithfully,

LYNN N.GITOBU **M. OMBOK**

_____ _____

Student **Lecturer/Supervisor.**

APPENDIX 2

QUESTIONNAIRE

The aim of the questionnaire is to ascertain the perception of hospitals on the service quality rendered by national hospital insurance fund. To make these study a success, we kindly request you to assist us by completing this questionnaire.

SECTION A

1. Name of hospital _____
2. Job/title of respondent
   a) Supervisor ( ) (b) Manager ( ) (c) Director ( )
3. Year hospital was NHIF accredited _____
4. How many years has your organisation worked in partnership with NHIF?
   a) Less than one year.
   b) 1-5 years
   c) 6-9 years
   d) 10 or more years

SECTION B

5. The following are the aspects of service quality, on a scale of 1-5 where by **5- very large extent and 1 – not at all**. Indicate the extent to which each of them meets your expectations in terms of the quality offered by a health insurance company.

	Very large extent	**Large extent**	**Moderate extent**	**Small extent**	**Not at all**
a. Ability to offer dependable service					
b. Ability of officers to solve problems correctly					
c. Provision of prompt service					
d. Up to date reliable information offered by website and staff					
e. Staff willingness to assist administrators.					
f. Availability of information on the packages.					
g. Prompt response on feedback of claim forms					
h. Address of complaints					
i. Staff knowledge on health insurances policies offered by the organisation					
j. Opening hours					
k. Accessibility of offices					
l. Usefulness of feedback					

m. Clear knowledge of what is expected of you.					
n. Staff communication skills.					
o. Support given by staff to administrators who do not understand various procedures.					
p. Frequency of hospital insurance's and administrators discussion forums on issues relating to hospital insurance policies.					
q. Size and comfort of Offices.					
r. Staff dressing					
s. Safety of information given in the health insurance policy.					
t. Personal safety while visiting insurance's offices.					
u. Staff treatment to the administrators respectively and politely					
v. Usefulness of health insurance feedback					
w. Fairness in setting and evaluating the claiming procedure.					

SECTION C

5. The following are the aspects of service quality, on a scale of 1-5 where by **5- very large extent and 1 – not at all**. Indicate the extent to which each of is your perception towards the quality of service rendered by NHIF.

	Very large extent	**Large extent**	**Moderate extent**	**Small extent**	**Not at all**
a. Ability to offer dependable service					
b. Ability of officers to solve problems correctly					
c. Provision of prompt service					
d. Up to date reliable information offered by website and staff					
e. Staff willingness to assist administrators.					
f. Availability of information on the packages.					
g. Prompt response on feedback of claim forms					
h. Address of complaints					
i. Staff knowledge on health insurances policies offered by the organisation					
j. Opening hours					
k. Accessibility of offices					
l. Usefulness of feedback					

m. Clear knowledge of what is expected of you.					
n. Staff communication skills.					
o. Support given by staff to administrators who do not understand various procedures.					
p. Frequency of hospital insurance's and administrators discussion forums on issues relating to hospital insurance policies.					
q. Size and comfort of Offices.					
r. Staff dressing					
s. Safety of information given in the health insurance policy.					
t. Personal safety while visiting insurance's offices.					
u. Staff treatment to the administrators respectively and politely					
v. Usefulness of health insurance feedback					
w. Fairness in setting and evaluating the claiming procedure.					

THANK YOU FOR YOUR COOPERATION

APPENDIX 3

PANDYA MEMORIAL HOSPITAL

(Owned and Managed by Pandya Memorial Society)

EXCELLENCE IN PATIENT CARE

DEDAN KIMATHI AVENUE
P. O. Box 90434, MOMBASA - KENYA
TEL: 2313577 / 2223247 / 2314140 / 2314141, FAX: 2313884 / 2221787
E-mail: pandyahospital@wananchi.com

Ref: PMH/NHIF/117/03/05

29 March 2006

Ms. Mwangemi
Claims Manager
National Hospital Insurance Fund
P.O. Box 30443
NAIROBI

Dear Madam

OUTSTANDING ACCOUNT FOR THE YEAR BETWEEN 2001 TO 2003 FOR KSHS.202,950/-

We wish to express our appreciation to the discussion of 24th February 2006 between Mr. Mwatabu, your Branch Manager, Mombasa and the undersigned, regarding unpaid NHIF claims dated back to the years 2001 to 31st December 2003.

We agreed that we forward all unpaid claims to your good office for payment.

Enclosed, herewith, please find our Statement of account together with detailed unpaid claims for your ease of reference and for payment.

Your urgent response to this matter will be highly appreciated

Yours faithfully
PANDYA MEMORIAL HOSPITAL

NARINDER SINGH
HON. SECRETARY

Cc: Mr. Mwatabu
Branch Manager
Mombasa

APPENDIX 4

INFOSENSE KENYA LIMITED
www.infosense.co.ke

The Chief Executive
National Hospital Insurance Fund
P.O. Box 30443
NAIROBI

06 DEC 2005
RECEIVED
P.O. Box 30443

Attention: General Manager - Operations

6th December 2005

Dear Sir,

RE: COMPLAINT ON SERVICE RENDERED IN THE PAYMENTS SECTION

We would hereby like to voice our dissatisfaction with the service rendered by your staff at the payments section by highlighting an incident that occurred yesterday afternoon.

Our staff member came to your offices to make NHIF payments when he was hurriedly and impatiently informed by the staff member who checked the diskette providing the soft copy details of staff particulars that the layout on the diskette he provided did not conform with the format previously provided by the NHIF. Despite attempts by our office assistant to seek clarification on the matter, the lady was impatient with him bordering on being rude. She deleted the staff details previously provided on the diskette and informed him that he should come back to the office and ask the person who prepared the diskette to fill in the details once again. This is unfortunately next to impossible since we do not have the details that were on the diskette in any form in our offices and feel that instead of deleting the information already provided on the diskette, the lady should have created a separate document with the new format thus giving us the opportunity to copy and paste the details as required.

Our dissatisfaction at the manner in which the situation was handled further arises from the fact that this is not the first time someone sent from our offices has encountered unfriendly and abrasive staff at your payment counters who always seem to be in a hurry to finish off with one customer and move to the next without providing adequate clarification to questions asked.

We believe that friendly and efficient customer service is important to the success of any organisation and therefore hope that your office will take the necessary steps to ensure that customers at the payments section are treated courteously.

Yours faithfully,

Caroline Luzze
Administrative Assistant

APPENDIX 5

LIST OF HOSPITALS IN NAIROBI

NAME	PO Box	Town	Category
Jamaa Home & Maternity Hospital	17153	Nairobi	Private
Mater Misericordiae Hospital	30325	Nairobi	Community
Emmaus Inner core Nursing Home	78123	Nairobi	Private
Mathare Mental Hospital (General Ward)	40663	Nairobi	Government
Kenyatta National Hospital	20723	Nairobi	Government
The Radiant Health Clinic	31278	Nairobi	Private
Nyina Wa Mumbi Maternity Hospital	21283	Riruta	Private
Metropolitan Hospital	33080	Nairobi	Private
City Nursing Home Nairobi	14591	Nairobi	Private
Kayole Hospital	67617	Nairobi	Private
Masaba Nursing Home	53648	Nairobi	Private
Chiromo Lane Medical Centre	73749	Nairobi	Private
St James Medical Centre	10275	Nairobi	Mission
Maria Maternity &Nursing Home	34736	Nairobi	Private
Kamiti Hospital	40061	Nairobi	Government
Coptic Church Nursing Home	21570	Nairobi	Private
Prime Care Hospital	75209	Nairobi	Private
Westland's Cottage Hospital	28367	Nairobi	Private
Kikuyu Nursing Home	305	Kikuyu	Private
Kilimanjaro Nursing & Maternity Home	43920	Nairobi	Private
Pumwani Maternity Hospital	30108	Nairobi	Government
A.I.C Kijabe Medical Centre	20	Kijabe	Mission
Avenue Hospital LTD	45280	Nairobi	Private
Gertrudes Garden Children's Hospital	42325	Nairobi	Private
H.H Agakhan Hospital	30270	Nairobi	Private
Limuru Nursing Home	31416	Limuru	Private
Magadi Soda Company Hospital	10	Magadi	Private
S.S League M.P Shah Hospital	14497	Nairobi	Community
South 'B' Hospital	49255	Nairobi	Private
Marie Stopes Kenya	59328	Nairobi	Community
St. Anne's Maternity Home	54337	Nairobi	Private
St John Health Clinic	51754	Nairobi	Private
St. James Hospital	46024	Nairobi	Private
Nairobi Equator Hospital	44995	Nairobi	Private
Madina Nursing Home	78370	Nairobi	Private
National Spinal Injury Hospital	20906	Nairobi	Government
P.C.E.A Kikuyu Orthopaedic Rehabilitation	1010	Kikuyu	Government
St. Teresa Kikuyu Maternity & Nursing Home	1370	Kikuyu	Private
Nairobi Women's Hospital	10552	Nairobi	Private
Matasia Health Clinic	185	Kiserian	Private
Komorock Nursing Home	19749	Nairobi	Private

Mariakani Cottage Hospital	12535	Nairobi	Private
Sinai Mt. Hospital	52874	Nairobi	Private
Nairobi West Hospital	43375	Nairobi	Private
Kiambu District Hospital (Amenity)	39	Kiambu	Government
Radent Hospital	48234	Nairobi	Private
Lily Women Hospital	34882	Nairobi	Private
P.C.E.A Hospital Kikuyu	45	Kikuyu	Mission
Dorkcare Nursing Home Ltd	33541	Nairobi	Private
Edina Nursing Home	56270	Nairobi	Private
Guru Nanak Ramgarhia Sikh Hospital	33071	Nairobi	Community
Huruma Nursing &Maternity Home	72934	Nairobi	Private
Kasarani Nursing &Maternity Home	31524	Nairobi	Private
Marura Nursing Home	75520	Nairobi	Private
Mabagathi Hospital	20725	Nairobi	Private
Melchizedek Hospital	20085	Nairobi	Private
Midhill Marternity &Nursing Home	21138	Nairobi	Private
Mother & Child Marternity & Nursing Home	12658	Nairobi	Private
Nazareth Hospital Riara Ridge	49682	Nairobi	Private
Ngong Hills Marternity	572	Ngong	Private
North Kinangop Catholic Hospital	88	N. Kinangop	Mission
Parkraod Nursing Home	19850	Nairobi	Private
Tigoni District Hospital	124	Tigoni	Government
Nairobi Hospital	30026	Nairobi	Private

APPENDIX 6

Data analysis: service quality score sheet for expectation of the hospital administrators.

Hospital measure of Expected service quality														
	FREQUENCIES					SCORE					MEAN			
	5	4	3	2	1	5	4	3	2	1	Me	Ve	Se	Ce
Reliability														
a. Ability to offer reliable services.	25	14	13	2	0	125	56	39	4	0	4.15	0.313	0.56	0.134
b. Ability of officers to solve problems correctly	23	15	16	0	0	115	60	48	0	0	4.13	0.31	0.53	0.129
c. Provision of prompt service	27	9	14	2	2	135	36	42	4	2	4.06	0.29	0.49	0.12
d. Up to date information offered by website and staff	3	19	16	9	7	15	76	48	18	7	3.04	0.19	0.43	0.14
e. Staff willingness to assist administrators	7	15	12	18	2	35	60	36	36	2	3.13	0.19	0.44	0.14
f. Availability of information	23	8	20	3	0	115	32	60	6	0	3.94	0.27	0.47	0.12
AVEARGE											**3.74**	**0.26**	**0.5**	**0.13**
Responsiveness														
g. Prompt response on feedback of claims.	18	8	24	3	4	90	32	72	6	4	3.78	0.25	0.49	0.13
h. Address of complaints.	12	30	15	0	0	60	120	45	0	0	4.17	0.32	0.56	0.14
AVEARGE											**3.97**	**0.28**	**0.53**	**0.13**
Competence														
l. Staff knowledge on health insurance polices offered by the organization	14	15	23	5	0	70	60	69	10	0	**3.87**	**0.26**	**0.51**	**0.13**
Courtesy														
u. Staff treatment to administrators respectively and politely.	12	9	27	6	0	60	36	81	12	0	**3.5**	**0.21**	**0.46**	**0.13**
Credibility														
v. Usefulness of health insurance feedback	17	20	17	0	0	85	80	51	0	0	4	0.28	0.53	0.13
w. Fairness in setting and evaluating the claiming procedure	20	15	19	0	0	100	60	57	0	0	4.02	0.28	0.53	0.13
AVEARGE											**4.01**	**0.28**	**0.53**	**0.13**

Security														
s. Safety of information given in the health insurance policy	30	15	12	0	0	150	60	36	0	0	4.56	0.43	0.65	0.14
t. Personal safety while visiting health insurances' offices	6	24	14	0	0	30	96	42	0	0	3.11	0.23	0.44	0.015
AVEARGE											**3.83**	**0.33**	**0.5**	**0.14**
Access														
J. opening hours	10	16	22	6	4	50	64	66	12	4	3.63	0.23	0.48	0.13
k. Accessibility of offices	14	7	30	1	2	70	28	90	2	2	3.56	0.22	0.47	0.13
AVEARGE											**3.59**	**0.22**	**0.5**	**0.13**
Communication												0		
l. Usefulness' of feedback	24	16	14	0	0	120	64	42	0	0	4.19	0.32	0.57	0.13
m. Clear knowledge of what is expected of you	16	10	28	0	0	80	40	84	0	0	3.78	0.241	0.5	0.13
n. Staff communication skills	9	24	21	0	0	45	96	63	0	0	3.78	0.247	0.5	0.13
AVEARGE											**3.91**	**0.27**	**0.5**	**0.13**
Understanding or Knowing the customer												0		
o. Support given by staff to administrators who do not understand various procedures.	13	24	15	4	0	65	96	45	8	0	3.96	0.289	0.53	0.13
p. Frequency of hospitals insurance's and administrators discussion forums on issues relating to hospital insurance policies.	19	30	5	0	0	95	120	15	0	0	4.26	0.33	0.63	0.15
AVEARGE											**4.11**	**0.31**	**0.6**	**0.14**
Tangible												0		
q. size and comfort of offices	30	12	12	0	0	150	48	36	0	0	4.33	0.36	0.6	0.14
r. Staff dressing	15	30	9	0	0	75	120	27	0	0	4.11	0.38	0.55	0.134
AVEARGE											**4.22**	**0.37**	**0.6**	**0.136**

APPENDIX 7

Data analysis: service quality score sheet for the perception of the hospital administrators.

Hospital Perception of Service Quality														
	FREQUENCIES					SCORE					MEAN			
	5	4	3	2	1	5	4	3	2	1	Mp	Vp	Sp	Cp
Reliability														
a. Ability to offer reliable service	0	30	6	0	18	0	120	18	0	18	2.89	0.19	0.57	0.2
b. Ability of officers to solve problems correctly	0	39	4	0	12	0	156	12	0	12	3.33	0.199	0.57	0.17
c. Provision of prompt service	0	33	10	8	3	0	132	30	16	3	3.35	0.2	0.47	0.14
d. Up to date reliable information offered by website and staff	0	6	19	24	5	0	24	57	48	5	2.48	0.214	0.46	0.19
e. Staff willingness to assist administrators	0	5	20	19	10	0	20	60	38	10	2.37	0.226	0.44	0.19
f. Availability of information on the packages.	0	21	16	6	11	0	84	48	12	11	2.87	0.19	0.44	0.15
AVERAGE											**2.88**	**0.203**	**0.49**	**0.17**
Responsiveness														
g. Prompt response on feedback form claim forms	0	0	19	20	15	0	0	57	40	15	2.07	0.27	0.52	0.25
h. Address of complaints	9	21	16	0	8	45	0	0	0	0	0.83	0.632	0.79	0.95
AVERAGE											**1.45**	**0.451**	**0.66**	**0.6**
Competence														
I. staff Knowledge on health insurance policies	0	0	27	18	9	0	0	81	36	9	**2.33**	**0.231**	**0.48**	**0.21**
Courtesy														
u. Staff treatment to the administrators respectively and politely	0	0	13	21	20	0	0	39	42	20	**1.87**	**0.309**	**0.56**	**0.3**
Credibility														
v. Usefulness of health insurance feedback	0	18	15	16	5	0	72	45	32	5	2.85	0.191	0.44	0.15
u. Fairness in setting and evaluating the claiming procedure	**0**	**14**	**25**	**10**	**5**	**0**	56	75	20	5	2.89	0.19	0.44	0.15
AVERAGE											**2.87**	**0.19**	**0.44**	**0.15**
Security														
s. Safety of information given in the health insurance policy	0	0	8	28	18	0	0	24	56	18	1.81	0.296	0.49	0.27
t. Personal safety while visiting insurance's offices	**0**	**15**	**19**	**10**	**10**	0	60	57	20	10	2.72	0.196	0.44	0.16

AVERAGE											**2.27**	**0.246**	**0.46**	**0.21**
Access														
j. Opening hours	0	6	20	10	18	0	24	60	20	18	2.26	0.24	0.45	0.2
k. Accessibility of offices	0	19	10	5	29	0	76	30	10	29	2.69	0.198	0.48	0.18
AVERAGE											**2.47**	**0.219**	**0.46**	**0.19**
Communication														
l. staff Knowledge on health insurance policies	0	24	10	8	12	0	96	30	16	12	2.85	0.191	0.49	0.17
m. Clear knowledge of what is expected of you	0	21	7	15	11	0	84	21	30	11	2.7	0.197	0.44	0.16
N. staff communication	0	20	8	12	14	0	80	24	24	14	2.63	0.202	0.43	0.17
AVERAGE											**2.73**	**0.196**	**0.45**	**0.17**
Understanding or Knowing the customer														
o. support given by staff to administrators who do not understand various procedure	0	0	4	10	40	0	0	12	20	40	1.33	0.451	0.44	0.33
P. Frequency of hospital insurances and administrators discussion forums	0	0	12	0	41	0	0	36	0	41	1.426	0.422	0.49	0.34
AVERAGE											**1.38**	**0.437**	**0.46**	**0.33**
Tangible														
q. Size and comfort of offices	0	21	14	7	21	0	84	42	14	21	2.98	0.189	0.49	0.16
r. Staff dressing	0	0	30	18	6	0	0	90	36	6	2.44	0.235	0.47	0.19
AVERAGE											**2.71**	**0.212**	**0.48**	**0.18**

APPENDIX EIGHT

Gap Analysis for the Hospital Administrators on the Service Quality Dimension

		GAP ANALYSIS	
	Me	**Mp**	**Gap**
Reliability			
a. Ability to offer reliable services.	4.14815	2.89	1.258148
b. Ability of officers to solve problems correctly	4.12963	3.33	0.79963
c. Provision of prompt service	4.05556	3.35	0.705556
d. Up to date information offered by website and staff	3.03704	2.48	0.557037
e. Staff willingness to assist administrators	3.12963	2.37	0.75963
f. Availability of information	3.94444	2.87	1.074444
AVEARGE	**3.7407**	**2.88**	**0.860741**
Responsiveness			
g. Prompt response on feedback of claims.	3.77778	2.07	1.707778
h. Address of complaints.	4.16667	0.83	3.336667
AVEARGE	**3.9722**	**1.45**	**2.522222**
Competence			
I. Staff knowledge on health insurance polices offered by the organization	**3.8704**	**2.33**	**1.54037**
Courtesy			
u. Staff treatment to administrators respectively and politely.	**3.5**	**1.87**	**1.63**
Credibility			
v. Usefulness of health insurance feedback	4	2.85	1.15
w. Fairness in setting and evaluating the claiming procedure	4.01852	2.89	1.128519
AVEARGE	**4.0093**	**2.87**	**1.139259**

Security			
s. Safety of information given in the health insurance policy	4.55556	1.81	2.745556
t. Personal safety while visiting health insurances' offices	3.11111	2.72	0.391111
AVEARGE	**3.8333**	**2.27**	**1.563333**
access			0
J. opening hours	3.62963	2.26	1.36963
k. Accessibility of offices	3.55556	2.69	0.865556
AVEARGE	**3.5926**	**2.47**	**1.122593**
communication			
l. Usefulness of feedback	4.18519	2.85	1.335185
m. Clear knowledge of what is expected of you	3.77778	2.7	1.077778
n. Staff communication skills	3.77778	2.63	1.147778
AVEARGE	**3.9136**	**2.73**	**1.18358**
Understanding or Knowing the customer			
o. Support given by staff to administrators who do not understand various procedures.	3.96296	1.33	2.632963
p. Frequency of hospitals insurance's and administrators discussion forums on issues relating to hospital insurance policies.	4.25926	1.426	2.833259
AVEARGE	**4.1111**	**1.38**	**2.731111**
Tangible			
q. Size and comfort of offices	4.33333	2.98	1.353333
r. Staff dressing	4.11111	2.44	1.671111
AVEARGE	**4.2222**	**2.71**	**1.509259**