Universe International Journal of Interdisciplinary Research
(Peer Reviewed Refereed Journal)

© UIJIR | ISSN (O) – 2582-6417
FEB. 2021 | Vol. 1 Issue 9
www.uijir.com

EMPLOYEE AWARENESS AND PERCEIVED SERVICE QUALITY OF SOCIAL HEALTH INSURANCE BENEFIT IN TANZANIA: EVIDENCE FROM DAR ES SALAAM NSSF MEMBERS

Author's Name: [1]Zakia Mohamedi Salumu, [2]Josephine Manase

Affiliation: *[1]Principal Social Welfare Officer; Ministry of Health, Community Development, Gender, Elderly and Children in Tanzania*

[2]Research Officer in Sociology; Food and Nutrition Centre in Dar es Salaam Tanzania

E-Mail: rainbow_inc@yahoo.com

DOI No. – 08.2020-25662434

Abstract

The government of Tanzania decided to implement reforms in health care services by introducing cost sharing to overcome several challenges which were facing health sector in 1990s. One of the reforms was introduction of health insurance schemes. This study assessed employee awareness and perceived service quality of Social Health Insurance Benefit (SHIB) in Tanzania by drawing evidence from National Social Security Fund (NSSF) members in Dar es Salaam Region. A cross sectional study design was adopted to collect information by using survey method. Simple random sampling was used to select respondents. The study used structured questionnaire as an instrument of data collection. Data was analysed through Statistical Package for Social Science (SPSS) version16 to generate descriptive statistics including frequencies and percentages which presented in tables and figures. The results show that many SHIB members (76.5%) were aware about the role of NSSF in the enrollment of new SHIB members in comparison to small percent (34.7%) of non-SHIB members who have such awareness. Also, many SHIB members (74.5%) were aware of the period of at least three months of employee contribution in NSSF is a criterion for an individual to apply for SHIB membership while small percentage of non-SHIB members (42.2%) were aware about that criterion. Many respondents agreed with service quality provided by SHIB accredited health care institutions with regard to reliability (54.9%) and empathy (53.9%) of health care services while disagreed with tangibles (60.9%), responsiveness (56%) and assurance (65.7%) of health care services offered when they compared with their expectations. The study recommends to the NSSF management to continue raising awareness through providing education regarding the package of SHIB scheme while making collaboration with accredited private and government health care facilities so that they can improve the quality of health care services to meet customer expectations.

Keywords: *School children, Knowledge, Practice*

INTRODUCTION

Health is one of fundamental aspects of well-being of individuals in every society. Health insurance is referred as a person or group purchasing health care service coverage through premium payment. It helps a patient to avoid direct payment of cash when seeking for health care from accredited health care facilities (Netra and Rao, 2019). Although good health is important, many poor people particularly from low- and middle-income countries (LMIC) still do not have capacity to afford costs of quality health care services (Panda et al., 2016). Therefore, poor people are highly vulnerable to illness due to poor access to health care insurance. Therefore, poor people need healthcare services of good quality for prevention and cure of diseases. It is estimated that 84% of world population comprises of people from LMIC while these countries have burden of incidences of diseases due to inadequate budget for improvement of health care services (Panda et al., 2016). Direct costs for consultation, diagnosis and treatment are too high to people with no health insurance. The burden of high costs

discourage many people especially the poor from seeking health care services in private and public health facilities which as a result leads to many health complications and increase of incidences related to chronic sickness. Moreover, in public health care facilities, the low budgetary allocations have negative consequences by increasing reliance of the people on alternative health care providers including traditional healers who are unqualified since they service is cheap (Gautham et al., 2011). In fact, insufficient fund allocation for improvement of public health facilities makes these facilities rely on out-of-pocket (OOP) payments from patients who are seeking health care services (Panda et al., 2016).

The out-of-pocket payments in LMIC are still remaining as dominate mode of coast sharing in health care services due to inadequate budget allocated to health sector. For instance, approximately 7% of GDP in Tanzania is allocated on the improvement of health sector. Meanwhile, out-of-pocket expenditures occupy about 52% of total expenditure in health sector in Tanzania (Brinda et al., 2014). Like Tanzania, the out-of-pocket payment system is dominant in some countries of Latin American. For instance, high out-of-pocket payments were witnessed in Peru (86.9%) and Mexico (91.5%) (World Bank, 2014). In Tanzania, immediately after independence in1961, the government started to strengthen her human capital by identifying and addressing the "major enemies of development" including ignorance, diseases, and poverty (Mujinja and Kida, 2014). After independence, the government of Tanzania was a sole provider of health care services for more than 30 years while embracing the Ujamaa political ideology. The government restricted individuals, private organizations and firms to own means of production and operate the health care services especially after the Arusha Declaration 1967 (Mujinja and Kida, 2014). However, following country's economic deterioration in the 1990s which the country witnessed an increase of poverty, the government was not able to provide free health care services to all Tanzanians as it was doing before.

In order to address emerged challenges which constrained the health care services in 1990s, the government of Tanzania embarked reforms in the overall health sector. The reforms aimed at improving the quality of health care services by introducing cost sharing in health services. However, it was very essential to have reforms which contribute to the improvement in access to health services complying with relevant policies which address social justice, equity values and the right to health. The health sector reforms were started to be complied in specific areas including decentralization of health services and financial reforms. The reforms in health sector introduced user charges in public facilities, health insurance and community health funds (MOH, 1994). Therefore, from early 2000 private and public health insurance schemes started to operate in Tanzania.

The government of Tanzania in implementing the health sector reforms started by introducing Community Health Fund (CHF) and National Health Insurance Fund (NHIF) in 1995 and 2001 respectively to comply with cost sharing in health sector. After introducing the cost sharing, National Social Security Fund (NSSF) in 2005 introduced the third provider of social health insurance in Tanzania which known as Social Health Insurance Benefit (SHIB). SHIB scheme is contributed by NSSF members who are employees from private and government sectors. The SHIB scheme coverage includes maximum of six family members; the insured person, spouse and up to four children. The NSSF pensioner can be a member only if he or she is willing to allow a six percent monthly deduction from the pension after retirement.

The SHIB packages cover both inpatient and outpatient services aiming at reducing the cost burden of health care employees who are NSSF members to health care members. In so doing, they can remain healthier and more productive when they have access to health insurance. Health services offered by SHIB scheme include accommodation, medical consultations, medical investigations, surgeries, drugs on the Essential Medicines List and referrals for patients to higher-level hospitals. Both members and dependents have full access to SHIB packages and free of charge as all costs are being incurred by the fund. Despite free provision of health care benefit, the enrolment of members in SHIB is still low across the country. While there is low enrollment of SHIB members, the number of employees joining NSSF is rapidly increasing. Currently, there are more than 567,109 NSSF members, but only 11,618 members enrolled in SHIB scheme which is equivalent to 2% of all members. Non-membership in SHIB scheme among NSSF members creates health risks to them and their families in getting diseases and other health hazards. Lack of access to health insurance threatens both employee and organizational performance. Therefore, it is ideal to understand the awareness and perceived service quality of SHIB scheme among employees who are NSSF members so that the NSSF management can review its SHIB governing policies in order to improve the quality of health care services provided by accredited health care facilities.

Currently, there is lack of information regarding awareness and perceived service quality of SHIB among employees who are contributing to NSSF in Tanzania. Little has been done by researchers to study health care service provision using health insurance in Tanzania. For instance, Khamis and Njau (2016) determined perception on quality health care at the outpatient department (OPD) in Mwananyamala Hospital in Dar es Salaam. Another study conducted by Kuwawenaruwa et al. (2011) assessed willingness to pay for voluntary health insurance in Tanzania. The study by Mulutu (2014) carried out in Kigoma Tanzania examined factors influencing outpatient satisfaction. However, awareness and perceived service quality of SHIB among the employees who are NSSF members in Tanzania has left unexplained by previous researchers. In order to reveal useful knowledge which may assist SHIB policy review and implementation so as to enroll more SHIB members, this study sought to assessed awareness and perceived service quality of SHIB scheme among the employees in Tanzania through drawing evidence from NSSF members in Dar es Salaam Region.

LITERATURE REVIEW

SERVQUAL model

This study was guided by SERVQUAL model developed by Parasuraman et al. (1988) which is normally applied in evaluating performance by assessing service quality gap in organizations. In this study, the modal will be used to assess perceived service quality of SHIB services among NSSF members who are employees from different organizations through drawing evidence from NSSF members in Dar es Salaam Region Tanzania. According to Parasuraman et al. (1988), service quality refers as the discrepancy between a customers' expectation of a service and the customers' perception of the service offering. From this definition, Parasuraman et al. (1988) came up with model describing gaps of service quality offering from customer perspectives.

Parasuraman et al. (1985) developed a conceptual model of service quality which identified five gaps that could impact consumer's evaluation of service quality. They developed SERVQUAL model which describes five gaps in service offering using four different industries including

retail banking, credit card, securities brokerage and product repair and maintenance. These gaps of service provision explained by SERVQUAL model were; Gap 1 can exist between customer expectation and management quality perception; Gap 2 can exist between perception service quality specification gap; Gap 3 can occur between service quality specifications and service delivery of a firm or institution; Gap 4 may exist between service delivery and external communication; and Gap 5 can exist between expected service quality and perceived service quality. This study used gap 5 to assessed perceived service quality of social health insurance benefit among employees who are NSSF members in Dar es Salaam Tanzania.

Parasuraman et al. (1988) put forward that the key to ensuring good service quality is fulfillment of consumers' expectation from service offered. The judgment of high and low service quality depends on how consumers perceive the actual offering of service in regard to what they were expecting. Hence, Parasuraman et al. (1988) developed the SERVQUAL model as a multi-item scale to assess customer perceptions of service quality in service and retail businesses. In regard to this study, SERVQUAL model was used to assess perceived service quality of SHIB scheme among the NSSF members in Tanzania through drawing evidence from employees contributing to NSSF in Dar es Salaam Region. The measurement scale divides the concept of service quality in five dimensions. The SERVQUAL dimensions include tangibles, reliability, responsiveness, assurance and empathy. According to Parasuraman et al. (1988), tangibles include physical facilities, equipment, and appearance of personnel. Reliability is an ability of staff to perform the promised service dependably and accurately. Responsiveness means employee willingness to help customers and provide prompt service. Assurance explains knowledge and courtesy of employees and their ability to inspire trust and confidence. Empathy is about caring individualized attention to customers. In this study, NSSF members' perception towards tangibles, reliability, responsiveness, assurance and empathy of service quality offered by SHIB scheme in Tanzania was assessed by drawing evidence from employees who are NSSF members in Dar es Salaam Region.

Empirical literature

Khamis and Njau (2016) assessed perception of health care workers about the quality of health care at the outpatient department (OPD) in Mwananyamala hospital in Dar es Salaam, Tanzania. The study used cross-sectional design to collect qualitative data from April to May 2013. A sample of 27 participants was selected by using purposive sampling. The study used in-depth interviews and focus group discussions to collect data from hospital administrators, clinicians and nurses who are working at the OPD. The results showed that participants mentioned intrinsic factors including poor physical infrastructure, unavailability of medical equipment and/or essential drugs and poor staffing levels; and extrinsic factors include motivation for health care workers and workplace training opportunities which influence the quality of health care services.

Matutu (2014) examined factors influencing outpatient satisfaction in Kigoma Tanzania. The study used stratified random sampling to select 70 respondents and 4 were key informants who were selected purposively. Data was analysed with the aid of SPSS version 16 to reveal descriptive statistics. The study identified various factors influencing patient satisfaction including age of respondents, gender, marital status, level of education and area of residency.

More findings revealed that urban population is more satisfied with access to health care services than rural population.

Kuwawenaruwa et al. (2011) assessed willingness to pay for voluntary health insurance in Tanzania. A cross-sectional study design was adopted whereby a sample of 2224 households was used. The study used questionnaire constructed from open ended questions was used in data collection. Data was analysed by using descriptive statistical analysis and logit regression. Results showed that only 30% of uninsured rural households demonstrated willingness to pay more that Tsh. 5000 the current premium level. But in urban areas, only one percent of households showed willingness to pay more than Tsh. 5000.

Panda et al. (2015) evaluated an insurance awareness campaign intended to disseminate information regarding the community-based health insurance (CBHI) schemes in rural India. The study used a sample of 800 households which was available in pre- and post- campaign periods. The analysis of data was based on base line survey conducted in 2010 and follow-up survey carried out in 2011 whereby ordinary least square regression was done. The results revealed that there was higher understanding regarding insurance concepts among the intervention group than control group. More results show that CBHI awareness had positive effect on enrolment. The study concluded that it is essential to raise awareness of community in order to promote voluntary uptake of CBHI schemes using tools which are very interactive and contextual specific in enhancing insurance awareness.

Netra and Rao (2019) determined awareness, coverage and willingness to avail health insurance among the residents of a rural area in Central Karnataka. A cross-sectional study design was adopted whereby a sample of 600 families was selected by systematic sampling. Questionnaire and interviews administered to the heads of families were used as instruments of data collection. Descriptive statistical analysis was done by using SPSS version 16. Results showed that there were 65.7%, 45.5% and 77.1% awareness, coverage and willingness to avail health insurance among the families participated in the survey respectively.

MATERIALS AND METHODS

Study area

This study was conducted in Dar es Salaam Region in Tanzania. The selection of study area was due to the reason that Dar es Salaam is a city having many firms and institutions whose employees are members of National Social Security Fund (NSSF) by monthly contribution of their monthly salaries. Also, there are many other alternative health insurance institutions where NSSF members can opt to join apart from SHIB which is managed by NSSF.

Study design

A cross-sectional design was adopted to conduct the study whereas survey method was used to gather information. Moreover, the design incorporated the quantitative approach to collect quantitative data.

Methods of data collection

Survey method was used for data collection. The survey collected quantitative data whereby structured questionnaire was used as an instrument of data collection.

Sample size estimation

The sample size of this study was calculated by using the single proportion formula. The formula was chosen so that researcher can be able to adjust the sample to an affordable size. Assuming that an estimated proportion (p) is 15%, the margin of error (q) estimated is 4% and considered at 95% confidence level.

$$n = \frac{z^2 p(100 - p)}{q^2}$$

$$n = \frac{1.96^2 15(100 - 15)}{4^2} = 306$$

n = the minimum number of respondents required as sample size.

p = proportional of NSSF members (i.e. employees from different organizations) comprised of enrolled and not enrolled in SHIB scheme.

z = the standard normal deviation that corresponds to 5% level of statistical significant is 1.96

q = margin of error of the study assigned a value of 4% to achieve the desired level of precision.

In order to avoid the effect of non-response rate which can distort the accuracy of the sample, 7% of respondents added to avoid occurrence of survey non-responses. Therefore, the sample size used was 327 respondents.

Sampling procedure

The study used simple random sampling to select 327 respondents from employees who are NSSF members working in different organizations in Kinondoni District in Dar es Salaam. Simple random sampling was used to choose respondents so as to avoid sample selection bias.

Data analysis

Data analysis was done by using descriptive statistical analysis through application of SPSS version 16 computer software. The analysis revealed frequencies and percentages which thereafter presented in tables and figures.

RESULTS AND DISCUSSION

Demographic characteristics of respondents

The study surveyed demographic characteristics of respondents including sex, age and education. Results showed that majority of respondents who are members of Social Health Insurance Benefits (SHIB) scheme (65.7%) and non-SHIB members (77.3%) comprised of males (Table 2). Since the respondents are employees from institutions and business firms whose portions of their salaries are deducted to contribute to National Social Security Fund (NSSF), the study justified that there are fewer women employed in formal sector than men. Based on age distribution, most of non-SHIB members were within the age groups of 18-28 years (28.4%) and 29-39 years (47.1%) while most of SHIB members were within the age groups of 29-39 years (46.1%) and 40-50 years (31.4%) as shown in Table 1. The age distribution of respondents demonstrated that many NSSF members who are not yet joined SHIB scheme are younger than NSSF members who have already enrolled in SHIB scheme. The possibilities of young people for not having a burden of many family responsibilities compared to old people make them assume that deduction of portions of their social security monthly contributions to SHIB scheme is important since they can directly pay for health care services using their cash payment. More results showed that majority of SHIB members (39.2%) and non-SHIB members (39.1%) comprised employees who are primary school levers (Table 2). Other respondents

possessed secondary and tertiary education. However, more employees who are SHIB members had tertiary education (36.3%) than employees who are non-SHIB members (27.6%). There are higher possibilities for employees possessing high level of education to be more aware of the importance of health insurance membership and their families with respect to their wellbeing than employees with low level of education. Therefore, employees possessing high level of education can easily make decisions of joining in SHIB scheme compared uneducated employees.

Table 2: Distribution of respondents based on demographic characteristics

Variable		Non-SHIB (n=225)	SHIB (n=102)
Sex	Male	(174)77.3%	(67)65.7%
	Female	(51)22.7%	(35)34.3%
Age	18-28	(64)28.4%	(19)18.6%
	29-39	(106)47.1%	(47)46.1%
	40-50	(42)18.7%	(32)31.4%
	Above 50	(13)5.8%	(4)3.9%
Education	Primary school	(88)39.1%	(40)39.2%
	Secondary school	(75)33.3%	(25)24.5%
	Tertiary education	(62)27.6%	(37)36.3%

Note: Numbers in brackets represent number of respondents

EMPLOYEE AWARENESS OF SHIB SCHEME AMONG NSSF MEMBERS

Employee awareness on the role of NSSF in enrolment of members of SHIB scheme

The survey revealed that most of employees (76.5%) who are members of SHIB scheme understand that NSSF has a role of enrolling its members in SHIB scheme while only 34.7% of non-SHIB members were awareness about this (Figure 1). Other results showed that more than a half of employees (53.7%) who are NSSF members but not enrolled in SHIB scheme don't understand if there is any institution or agent who deals with employee enrollment in SHIB scheme. Also, few respondents mentioned employer, government or employee is responsible in the enrollment of NSSF members to SHIB scheme.

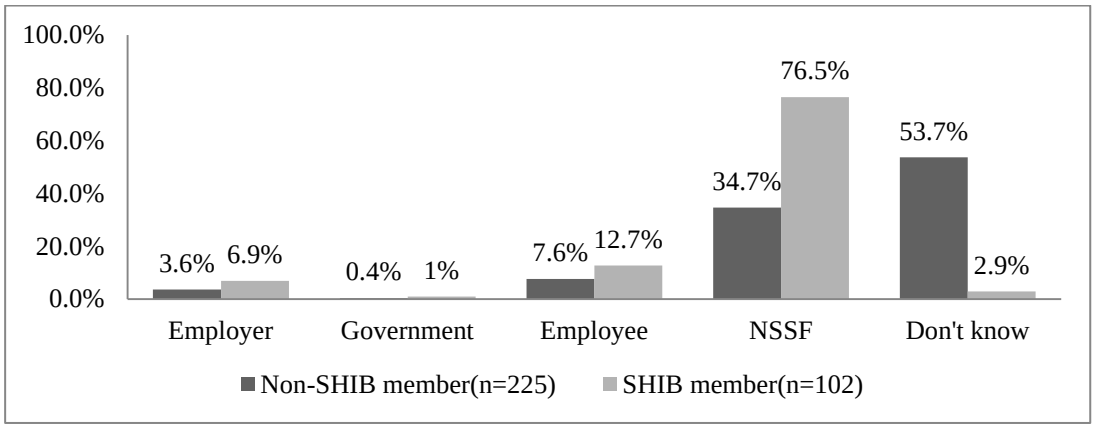

Figure 1: Awareness of respondents regarding to responsibilities in enrolment of NSSF members in SHIB scheme

Employee awareness on criteria required in the enrolment of NSSF members in SHIB scheme

With regard to awareness on criteria required for enrollment of employees who are NSSF members in SHIB scheme, the survey revealed that many employees participated (74.5%) who

are members of SHIB scheme and some non-members of SHIB scheme (42.2%) are aware that employee being NSSF member for at least three months can apply for membership in SHIB scheme (Table 3). Other respondents were not aware about the three months' criterion after being joined as NSSF member, instead, they wrongly perceive that employee can be a member of SHIB scheme if he or she has some cash of money to pay for health care services, given permission by employer, NSSF selects members, and being NSSF member for one year. Therefore, awareness on criteria required for an employee to be a member of SHIB scheme is essential to help SHIB scheme to enrollment more new members.

Table 3: Employee awareness regarding the criteria of joining SHIB scheme

Requirement in joining SHIB	Non-SHIB member (n=225)	SHIB member (n=102)
Being NSSF member for at least three months	(95)42.2%	(76)74.5%
Money to pay for health care services	(19)8.4%	(7)6.9%
Employer's permission	(68)30.2%	0(0%)
NSSF selects the members	(9)4%	(4)3.9%
Being NSSF member for one year	(34)15.2%	(15)14.7%

Note: Numbers in brackets represent number of respondents

Employee perceived service quality of SHIB scheme in providing health care services

The study assessed employee perceived service quality of SHIB scheme in providing quality health care services. The five SERVQUAL dimensions including tangibles, reliability, responsiveness, assurance and empathy were used to determine perceived service quality of SHIB scheme among the employees who are NSSF members in Dar es Salaam Region Tanzania. Results revealed by the survey regarding employee perceived service quality on SHIB scheme is shown in Table 4.

Table 4: Responses of Employee regarding perceived service quality of SHIB accredited health care service providers (n=102)

Perceived SERVQUAL dimension	Response		
	Disagree	Don't Know	Agree
There is adequate supply of medicines and availability of diagnostic equipment from SHIB accredited health care facilities (i.e. Tangibles).	(62)60.9%	(8)7.7%	(32)31.4%
SHIB accredited health care facilities are easily accessible to clients and perform promised services (i.e. Reliability).	(28)27.5%	(18)17.6%	(56)54.9%
Employees of SHIB accredited health care facilities provide treatment service in time to sick people (i.e. Responsiveness).	(57)56%	(15)14.7%	(30)29.3%
Employees of SHIB accredited health care facilities have sufficient knowledge to provide satisfied health care services (i.e. Assurance).	(67)65.7%	(17)16.7%	(18)17.6%
Caring of patients by accredited SHIB health care facilities meets client expectations (i.e. Empathy).	(36)35.3%	(11)10.8%	(55)53.9%

Note: Numbers in brackets represent number of respondents

The study used Likert scale constructed from 5-items rating scales to examine five SEVQUAL dimensions (tangibles, reliability, responsiveness, assurance and empathy). Each dimension was measured by using item of measurement comprised of 5 indicators of response (1=strongly disagree, 2=disagree, 3=don't know, 4=agree and 5=strongly agree) to assess perceived service quality of SHIB scheme among the employees who are NSSF members. Thereafter, the findings were presented and summarized by using three indicators namely; disagree (summation of

percentage responses for strongly disagree and disagree), don't know (percentage responses for don't know) and agree (summation of percentage responses for agree and strongly agree).

With regard to tangibles, the study revealed that more than a half of respondents (60.9%) disagreed with tangibles of service quality of health care services. They disagreed with to the statement explaining tangibles which said that there is adequate supply of medicines and diagnostic equipment in SHIB accredited health care facilities while few respondents (31.4%) agreed with tangibles in accredited health care facilities. Therefore, SHIB members perceived that with regard to tangibles there is inadequate availability of medicines and diagnostic equipment in accredited health care facilities.

Results pertaining to reliability of service quality of SHIB scheme revealed that majority of survey participants (54.9%) agreed that accredited health care facilities are easily accessible to clients and perform promised services while few respondents (27.5%) disagreed with the existing reliability of quality of health care services offered by accredited health care facilities. Such findings justify that members of SHIB scheme perceive that there are quality services provided by accredited health care facilities with respect to accessibilities of these facilities and services promised irrespective of the quality of other dimensions of services have been offered.

Moreover, perception of respondents on responsiveness of SHIB accredited health care facilities to patients revealed that a half of respondents who are beneficiaries of SHIB scheme disagreed (56%) with the statement said that employees of SHIB accredited health care facilities provide treatment in time to sick people. Only 29.3% agreed with quality of services offered in aspect of good responsiveness demonstrated by staff of SHIB health care accredited facilities. The findings demonstrated that employees who have enrolled in SHIB scheme perceive inadequate staff responsiveness in SHIB accredited health care facilities since the facilities do not provide treatment service to the patients in time.

In regard to assurance in service quality, the study revealed that respondents perceived inadequate service quality provided by SHIB accredited health care facilities. Many respondents (65.7%) disagreed with the statement said that employees of SHIB accredited health care facilities have sufficient knowledge to provide satisfied health care services to the patients. Only, few respondents (17.6%) showed agreement with assurance in quality of services offered by staff of accredited health care facilities. Therefore, although SHIB accredited health care facilities are refunded for health care services they provide to SHIB members, still they are lacking sufficient number of qualified health workers who can meet expectations of patients demanding health care services.

More other findings with regard to empathy of service quality provided by SHIB scheme revealed that majority of respondents (53.9%) agreed with the statement which said that care service provided by employees of accredited SHIB health care facilities meets expectations of patients while 35.3% of survey participants disagreed with this statement. The findings show that there is perceived adequate empathy in service quality offered by SHIB accredited health care facilities since NSSF members who have enrolled in SHIB scheme admitted the good quality of care services provided by staff of accredited health care facilities to sick people.

5. Conclusion

In Tanzania, employees who are members of National Social Security Fund (NSSF) allowing deduction of portions of their NSSF contributions to be channeled to Social Health Insurance Benefit (SHIB) scheme have expectations of access to quality health care services from

accredited health care facilities. In order to promote employee enrollment in SHIB scheme, NSSF members are supposed to be aware of the procedures and criteria required for an individual to be a member of SHIB scheme. Currently, many employees who are members of SHIB scheme are more aware of the role of NSSF in the enrollment of SHIB members compared to non-SHIB members. Also, SHIB members are more aware of the criterion of three months NSSF contribution for an employee to qualify for membership in SHIB scheme in comparison to employees who are non-SHIB members. With regard to service quality offered by SHIB accredited health care facilities, there was perceived inadequate quality of services with respect to tangibles since there is lack of medicines and diagnostic equipment. In addition to that, in the accredited health care facilities, there is inadequate service quality due to failure of staff to comply with timely and promptly responsiveness when patients seek health care services. Moreover, SHIB accredited health care facilities have inadequate performance with regard to health service assurance due to the fact that many employees lack sufficient knowledge and skills to effectively attend the patients. Although SHIB accredited health care facilities demonstrated inadequate provision of health care service with respect to tangibles, responsiveness and assurance, still, the facilities provide quality services in regard to reliability and empathy. Based on aspect of reliability, many SHIB accredited health care facilities are perceived to be easily accessible to customers while staff performs promised services despite having insufficient knowledge and skills. In addition to that, SHIB accredited health care facilities have demonstrated empathy by providing quality care services to the patients. This study recommends to the NSSF management to increase awareness creation to its members especially on procedures and criteria of members enrollment in SHIB scheme. In addition to that NSSF should keep on improving the quality of health care services particularly some service quality dimensions including tangibles, responsiveness and assurance which are currently perceived by customers as being inadequately performing in providing health care services contrary to customer expectations.

REFERENCES

1. Brinda, E.M., Antonio, R. and Enermark, U. (2014). Correlates of out-of-pocket and catastrophic health expenditures in Tanzania: Results from a national household survey. *BMC International Health and Human Rights*, 14(5):1- 8.
2. Khamis, K. and Njau, B. (2016). Health care worker's perception about the quality of health care at the outpatient department in Mwananyamala Hospital in Dar es Salaam, Tanzania. *Tanzania Journal of Health Research*, 8(1):1-9.
3. Kuwawenaruwa, A., Macha, J., and Borghi, J. (2011). Willingness to pay for voluntary health insurance in Tanzania. *East African Journal*, 88(2):54-64.
4. Matutu, M. (2014). *Factors influencing outpatient satisfaction with health insurance in Tanzania: A case study of the National Health Insurance Fund (NHIF) in Kigoma Region.* Dissertation submitted for Degree of Master of Public Administration of the University of Dodoma, Tanzania.
5. Ministry of Health (MOH) (1994). "*Mwongozo wa Utekelezaji wa Sera ya Wananchi Kuchangia Gharama za Hudama ya Afya Nchini (i.e. A guide of implementation of citizens' cost sharing policy in National Health Care Services)*". Ministry of Health, the Government of Tanzania.

6 Mujinja, P.G.M. and Kida, T.M. (2014). *Implication of health sector reforms in Tanzania: policies, indicators and accessibility to health services. THDR 2014: Background Paper No. 8, ESRF Discussion Paper 62*, The Economic and Social Research Foundation (ESRF), Tanzania.

7 Netra, G. and Rao, B.A.V. (2019). A study on awareness, coverage and willingness to avail health insurance among the residents of a rural area in Central Karnataka India. *National Journal of Community Medicine,* 10(4):190-196.

8 Panda, P., Chakraborty, A. and Dror, D.M. (2015). Building awareness to health insurance among the target population of community-based health insurance schemes in rural India. *Tropical Medicine and International Health,* 20(8):1093-1107.

9 Panda, P., Dror, I.H., Koehlmoos, T.P., Hossain, S.A.S., John, D., Khan, J.A.M. and Dror, D.M. (2016). *Factors affecting uptake of voluntary and community-based health insurance schemes in low-and middle-income countries: a systematic review*, 3ie Systematic Review 27. London: International Initiative for Impact Evaluation (3ie).

10 Parasuraman, A., Zeithaml, V. A. and Berry, L. L. (1985). A conceptual model of service quality and its implications for future research. *Journal of Marketing*, 49:41-50.

11 Parasuraman, A., Zeithaml, V. A. and Berry, L. L. (1988). SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality, *Journal of Retailing*, 64(1):12-40.

12 World Bank (2014). *World Development Indicator, 2014*. Washington D.C.: The World Bank.