

UNIVERSITY OF KWAZULU-NATAL

**CUSTOMER PERCEPTIONS AND EXPECTATIONS OF
SERVICE QUALITY IN THE MEDICAL INSURANCE
SECTOR IN ZIMBABWE**

**By
Tsitsi Mufudza
214578506**

**A thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Philosophy**

**School of Management, IT and Governance
College of Law and Management Studies**

Supervisor: Dr Vannie Naidoo

August 2018

DECLARATION

I, Tsitsi Mufudza, declare that:

- (i) The research reported in this thesis, except where otherwise indicated, is my original research.
- (ii) This thesis has not been submitted for any degree or examination at any other university.
- (iii) This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
- (iv) This thesis does not contain other persons' writing, unless specifically acknowledged as being sourced from other researchers. Where other written sources have been quoted, then:
 - a) their words have been re-written but the general information attributed to them has been referenced;
 - b) where their exact words have been used, their writing has been placed inside quotation marks, and referenced.
- (v) Where I have reproduced a publication of which I am an author, co-author or editor, I have indicated in detail which part of the publication was actually written by myself alone and have fully referenced such publications.
- (vi) This thesis does not contain text, graphics or tables copied and pasted from the Internet, unless specifically acknowledged, and the source being detailed in the dissertation/thesis and in the References sections.

Signature:



Date: 08 August 2018

ACKNOWLEDGEMENTS

First and foremost, I give my heartfelt gratitude to the Almighty God who enabled me to walk through this PhD journey. He gave me life, strength and everything needed for this journey to be a success.

My sincere appreciation also goes to my supervisor, Dr Vannie Naidoo, for her continued guidance, support and critical comments at different stages of the study. Without her, this study could have been a non-event. I am also grateful to the University of KwaZulu-Natal and the Higher Degrees Committee of the School of Information Technology, Management and Governance for affording me the opportunity to undertake my PhD studies at this university. Special thanks go to Ms Deborah Cunynghame for her unmatched administrative skills. She assisted with many administrative issues and kept me updated with important information during the study. This made the journey easier.

I am also grateful to my work colleagues at Chinhoyi University of Technology for their encouragement and moral support. I will always cherish you; you made the journey possible. Special thanks also go to some individuals at the Association of Healthcare Funders of Zimbabwe (AHFoZ) and the Ministry of Health and Child Welfare (MOHCW) for their guidance on how to conduct the study. I also extend my appreciation to the following health institutions, for allowing me to collect data for this study within their premises: Parirenyatwa Group of Hospitals, Harare Central Hospital, West End Medicare, Baines Imaging Group and Dr A Mazvuru and Partners Dental Surgeons. Special thanks also go to all the respondents who took their time and effort to complete the questionnaires. The completion of this study would not have been possible without you. I am also grateful to my research assistants for working tirelessly to make this project a success.

I am also grateful to my parents, Mr Pheres and Mrs Alice Munyonho. You are my inspiration and your prayers have seen me this far. I know you always sincerely desire the best for me in life. I will forever be grateful to have parents like you. My brothers and sisters, you have always been a source of encouragement to me. Thank you for all the support. My in-laws, you are wonderful people. Thank you for understanding me in such difficult times and for all the support.

Special thanks also go to my beloved husband, Keven Mufudza. You have always been there for me throughout my academic journey. Thank you for the support, encouragement, understanding and above all, taking care of the family during the study period. Tinashe, Tinomudaishe and Nissi, my dearest sons, thank you for being there for me and understanding. We will surely make up for the family time lost.

ABSTRACT

This study sought to evaluate customers' perceptions and expectations of service quality in the medical insurance sector in Zimbabwe. This will help to identify the service quality gaps experienced and to come up with strategies to improve service delivery in the industry. Literature has shown that service quality has been least reflected on by researchers in private health insurance, and efforts to improve quality in the sector were mainly centred on regulations and benchmarking against practices adopted in developed countries. Therefore, an empirical assessment of service quality in the Zimbabwean medical insurance industry will greatly contribute to understanding the service quality dimensions, which could bring efficiency, profitability and sustainability to the industry threatened by increased competition and economic challenges. Furthermore, to ensure continued subscription by members in such a volatile situation, medical insurance companies need to align their service offerings with customer needs.

The theoretical underpinnings of the study were the SERVQUAL and gaps models of Parasuraman, Zeithaml and Berry (1985). A positivist research philosophy and quantitative methodology were adopted. The population constituted of 1000 000 members of five major medical insurance companies in Zimbabwe, namely PSMAS, CIMAS, First Mutual Health, Fidelity and Altfin. A sample of 384 was chosen from five major health institutions in Harare using quota and convenience sampling. Data was collected using a questionnaire adapted from a generic instrument (SERVQUAL scale), based on a five-point Likert-type scale. The Statistical Package for Social Sciences (SPSS) version 20 was used for data analysis in which both descriptive and inferential statistics were used.

The major findings were that medical insurance customers in Zimbabwe are dissatisfied with service offerings in the industry with highest levels of dissatisfaction being expressed towards the quality dimension, reliability and lastly tangibility. Levels of dissatisfaction also varied across the service quality dimensions in terms of age groups, periods of membership to medical insurance companies and other demographic variables. The study also found that service quality was lower in government-owned than in privately owned medical insurance companies. Strategies to improve service quality in the industry are suggested, with some managerial and theoretical implications being highlighted.

TABLE OF CONTENTS

| | |
|---|-------|
| DECLARATION | i |
| ACKNOWLEDGEMENTS | ii |
| ABSTRACT | iii |
| TABLE OF CONTENTS | iv |
| LIST OF TABLES | xvi |
| LIST OF FIGURES..... | xviii |
| LIST OF APPENDICES | xix |
| LIST OF ACRONYMS AND ABBREVIATIONS..... | xx |
| CHAPTER ONE | 21 |
| BACKGROUND AND INTRODUCTION TO THE STUDY | 21 |
| 1.1 Introduction..... | 21 |
| 1.2 Background to the study | 21 |
| 1.3 Motivation of the study..... | 24 |
| 1.4 Statement of the problem | 25 |
| 1.5 Aim of the study..... | 26 |
| 1.5.1 Research objectives | 27 |
| 1.5.2 Research questions | 27 |
| 1.5.3 Research hypotheses..... | 27 |
| 1.6 Scope of the study | 29 |
| 1.7 Research methodology and design..... | 29 |
| 1.8 The thesis statement..... | 31 |
| 1.9 Significance of the study..... | 32 |
| 1.9.1 Significance from the academic viewpoint | 32 |
| 1.9.2 The significance of medical insurance customers' service quality | 32 |
| 1.9.3 Significance of service quality to the medical insurance industry | 33 |
| 1.9.4 Formulation of service quality strategies..... | 33 |
| 1.10 Delineation of the study | 33 |
| 1.11 Limitations of the study | 34 |
| 1.12 Definition of key words | 34 |
| 1.13 Structure of the study | 34 |

| | |
|--|-----------|
| 1.14 Summary | 35 |
| 1.15 Conclusion | 36 |
| CHAPTER TWO | 37 |
| BACKGROUND AND OVERVIEW OF THE MEDICAL INSURANCE INDUSTRY IN ZIMBABWE | 37 |
| 2.1 Introduction..... | 37 |
| 2.2 Definition of medical insurance..... | 38 |
| 2.3 Types of medical insurances | 40 |
| 2.4 Private health insurance | 41 |
| 2.5 The Zimbabwean health insurance | 42 |
| 2.6 The governance of medical insurance companies in Zimbabwe..... | 43 |
| 2.7 Justification for government intervention in the medical insurance industry | 44 |
| 2.7.1 Problems experienced in medical insurance..... | 44 |
| 2.7.1.1 Adverse selection | 44 |
| 2.7.1.2 Risk selection | 45 |
| 2.7.1.3 Moral hazard | 45 |
| 2.8 Medical insurance companies in Zimbabwe..... | 46 |
| 2.9 Ownership of medical insurance companies in Zimbabwe..... | 47 |
| 2.9.1 The government form of ownership | 47 |
| 2.9.2 Corporate general insurance companies | 48 |
| 2.9.3 Private health insurance schemes | 48 |
| 2.9.4 Urban councils..... | 48 |
| 2.9.5 Provider-initiated ownership | 49 |
| 2.10 Approaches to managing service quality in the medical insurance sector in Zimbabwe..... | 50 |
| 2.10.1 Definition of the managed health care system..... | 51 |
| 2.10.2 A review of the managed health care system in Zimbabwe | 51 |
| 2.11 Summary | 52 |
| 2.12 Conclusion | 53 |
| CHAPTER THREE..... | 54 |
| LITERATURE REVIEW..... | 54 |
| 3.1 Introduction..... | 54 |

| | |
|---|----|
| 3.2 Service quality | 54 |
| 3.2.1 Services..... | 54 |
| 3.2.2 Characteristics of services | 55 |
| 3.2.2.1 Intangibility nature of services..... | 55 |
| 3.2.2.2 Heterogeneity nature of services..... | 56 |
| 3.2.2.3 Instantaneous production and consumption..... | 56 |
| 3.2.2.4 Perishability | 56 |
| 3.2.3 Service quality | 57 |
| 3.3 Service quality in health insurance | 59 |
| 3.4 Efforts to improve service quality in private health insurance..... | 62 |
| 3.5 Customer perceptions of service quality | 64 |
| 3.5.1 Service quality versus customer satisfaction | 65 |
| 3.5.2 Transaction versus cumulative perceptions | 67 |
| 3.6 Dimensions of service quality..... | 67 |
| 3.6.1 Reliability | 68 |
| 3.6.2 Responsiveness | 69 |
| 3.6.3 Assurance..... | 70 |
| 3.6.4 Empathy..... | 71 |
| 3.6.5 Tangibles | 73 |
| 3.7 Service encounters | 77 |
| 3.7.1 Types of service encounters | 77 |
| 3.8 Customer expectations of service | 78 |
| 3.8.1 The zone of tolerance | 79 |
| 3.8.2 Determinants of customer service expectations | 79 |
| 3.8.2.1 Factors that determine desired service expectations..... | 79 |
| 3.8.2.2 Determinants of adequate service expectations | 80 |
| 3.8.2.3 Factors that influence predicted and desired expectations of services | 81 |
| 3.8.3 Commonly asked questions about customer service expectations | 82 |
| 3.8.3.1 What should a service provider do with unrealistic customer expectations? ... | 82 |
| 3.8.3.2 Is it proper for a company to attempt to delight customers?..... | 83 |
| 3.8.3.3 How do companies surpass the expectations of customers?..... | 83 |
| 3.8.3.4 Do service expectations of customers continually rise? | 84 |

| | |
|---|------------|
| 3.8.3.5 How does a company outcompete rivals in meeting customer expectations? .. | 84 |
| 3.9 Comparison of service quality in publicly and privately owned institutions | 84 |
| 3.10 Models of Service Quality | 85 |
| 3.10.1 Lehtinen’s service model (1982) | 85 |
| 3.10.2 Gronroos’s 1982 model | 86 |
| 3.10.3 The Haywood-Farmer service quality model | 88 |
| 3.10.4 The gaps model..... | 90 |
| 3.10.4.1 Limitations of the model..... | 93 |
| 3.10.5 The SERVQUAL model..... | 93 |
| 3.10.6 The Cronin and Taylor SERVPERF model..... | 97 |
| 3.10.7 Theoretical models adopted for the study..... | 98 |
| 3.11 Strategies to improve service quality | 98 |
| 3.11.1 Proper selection and training of employees..... | 98 |
| 3.11.2 Employee empowerment | 99 |
| 3.11.3 Building strong customer relationships | 99 |
| 3.11.4 Use of information technologies..... | 100 |
| 3.11.5 Coming up with proper systems and structures that enhance the delivery of service quality..... | 100 |
| 3.12 Proposed research framework for the role of service quality in the Zimbabwean medical insurance sector..... | 101 |
| 3.13 Conclusion | 102 |
| CHAPTER FOUR | 103 |
| RESEARCH METHODOLOGY | 103 |
| 4.1 Introduction..... | 103 |
| 4.2 Research problem..... | 103 |
| 4.3 Research objectives..... | 103 |
| 4.4 Research questions..... | 104 |
| 4.5 Research hypotheses | 104 |
| 4.6 Research philosophy | 106 |
| 4.6.1 The positivist philosophical paradigm..... | 106 |
| 4.6.2 The interpretivism philosophical paradigm..... | 107 |
| 4.7 Research design | 107 |

| | |
|---|-----|
| 4.8 Research approach | 108 |
| 4.9 Research strategy | 109 |
| 4.10 Study population | 110 |
| 4.11 Sample size | 110 |
| 4.12 Sampling strategy..... | 111 |
| 4.13 Quota sampling | 112 |
| 4.14 Convenience sampling | 113 |
| 4.15 Data collection methods..... | 113 |
| 4.16 Research instruments | 114 |
| 4.16.1 Questionnaire..... | 114 |
| 4.17 Data collection process | 116 |
| 4.16 Ethical considerations | 116 |
| 4.17 Validity and reliability | 116 |
| 4.17.1 Validity | 116 |
| 4.17.2 Reliability | 117 |
| 4.18 Data analysis | 118 |
| 4.18.1 The exploratory data analysis approach | 118 |
| 4.18.1.1 Frequency distributions..... | 118 |
| 4.18.1.2 Bar charts | 118 |
| 4.18.1.3 Pie charts..... | 119 |
| 4.18.2 Descriptive statistics | 119 |
| 4.18.2.1 Measures of central tendency..... | 119 |
| 4.18.2.1.1 The mode | 119 |
| 4.18.2.1.2 The median..... | 119 |
| 4.18.2.1.3 The mean..... | 119 |
| 4.18.3 Measures of dispersion | 120 |
| 4.18.3.1 The range | 120 |
| 4.18.3.2 The standard deviation | 120 |
| 4.18.4 Inferential statistics..... | 120 |
| 4.18.4.1 Tests for normality | 121 |
| 4.18.4.2 The Mann–Whitney test..... | 121 |
| 4.18.4.2 The Kruskal–Wallis test..... | 122 |

| | |
|---|-----|
| 4.18.4.3 The Spearman's rho coefficient | 123 |
| 4.19 Summary | 123 |
| 4.20 Conclusion | 123 |
| CHAPTER FIVE..... | 124 |
| PRESENTATION AND ANALYSIS OF RESULTS | 124 |
| 5.1 Introduction..... | 124 |
| 5.2 Reliability..... | 124 |
| 5.3 Presentation of demographic data | 125 |
| 5.3.1 Age groups of respondents | 125 |
| 5.3.2 Gender | 126 |
| 5.3.3 Medical insurance company subscribed to..... | 126 |
| 5.3.4 Sector of the economy employed | 127 |
| 5.3.5 Period of membership with a medical insurance company | 127 |
| 5.3.6 Switching between medical insurance companies..... | 128 |
| 5.3.7 Reasons for switching between medical insurance companies | 129 |
| 5.4 Presentation of results on customer expectations of service quality by medical insurance companies | 129 |
| 5.4.1 Tangible expectation..... | 130 |
| 5.4.2 Reliability expectation | 130 |
| 5.4.3 Responsiveness expectation | 131 |
| 5.4.4 Assurance expectation | 132 |
| 5.4.5 Empathy expectation | 133 |
| 5.5 Presentation of results on customer perceptions of service quality by medical insurance companies | 134 |
| 5.5.1 Tangible perception | 134 |
| 5.5.2 Reliability perception | 135 |
| 5.5.3 Responsiveness perception | 136 |
| 5.5.4 Assurance perception..... | 137 |
| 5.5.5 Empathy perception..... | 138 |
| 5.5 Results of general questions about medical insurance companies in Zimbabwe and how service quality can be improved..... | 139 |
| 5.6 Measures of central tendency and dispersions for the service quality dimensions | 140 |

| | |
|--|-----|
| 5.7 Descriptive statistics for the gap scores of medical insurance customers..... | 141 |
| 5.8 Comparison of service quality gaps between customers in government-owned and privately owned medical insurance companies..... | 142 |
| 5.9 Strategies that medical insurance in Zimbabwe can employ to improve service delivery in the industry | 145 |
| 5.9.1 Reliability | 145 |
| 5.9.2 Responsiveness..... | 146 |
| 5.9.3 Assurance..... | 146 |
| 5.9.4 Empathy..... | 146 |
| 5.9.5 Tangibles | 147 |
| 5.10 Inferential statistics | 147 |
| 5.10.1 Hypothesis 1.1: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers in different age groups..... | 148 |
| 5.10.2 Hypothesis 1.2: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers. | 150 |
| 5.10.3 Hypothesis 1.3: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy. | 151 |
| 5.10.4 Hypothesis 1.4: There are no statistically significant differences in the perceptions of medical insurance service quality along all the dimensions amongst customers with different periods of membership with their medical insurance companies. | 153 |
| 5.10.5 Hypothesis 1.5: There are no statistically significant differences in the perceptions of medical insurance service quality between customers who either have or have not switched between medical insurance companies..... | 155 |
| 5.10.6 Hypothesis 2.1: There are no statically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups. | 156 |
| 5.10.7 Hypothesis 2.2: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers. | 158 |
| 5.10.8 Hypothesis 2.3: There are no statistically significant differences in the customer expectations of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy. | 160 |
| 5.10.9 Hypothesis 2.4: There are no statistically significant differences in medical insurance customers' expectations of service quality along all the dimensions amongst | |

| | |
|--|-----|
| customers with different periods of membership with the medical insurance company. | 161 |
| 5.10.10 Hypothesis 2.5: There are no statistically significant differences in the expectations of medical service quality along all the dimensions between customers who have either or not switched between medical insurance companies. | 163 |
| 5.10.11 Hypothesis 3.1: There are no statistically significant differences in service quality gaps experienced by medical insurance customers in different age groups. | 165 |
| 5.10.12 Hypothesis 3.2: There are no statistically significant differences in service quality gaps experienced between male and female medical insurance customers. | 166 |
| 5.10.13 Hypothesis 3.3: There are no statistically significant differences in service quality gaps experienced by medical insurance customers employed in different sectors of the economy. | 167 |
| 5.10.14 Hypothesis 3.4: There are no statistically significant differences in service quality gaps experienced by medical insurance customers with different periods of membership with the medical insurance companies. | 168 |
| 5.10.15 Hypothesis 3.5: There are no statistically significant differences in service quality gaps experienced by medical insurance customers who have either switched or not switched between medical insurance companies. | 170 |
| 5.10.16 Hypothesis 4.1: There are no statistically significant differences in customer perceptions of service quality between government-owned and privately owned medical insurance companies. | 171 |
| 5.10.17 Hypothesis 4.2: There are no statistically significant differences in customer expectations of service quality between government-owned and privately owned medical insurance companies. | 173 |
| 5.10.18 Hypothesis 4.3: There are no statistically significant gaps in service quality experienced by customers in government-owned and privately owned medical insurance companies. | 174 |
| 5.11 Correlation among the service quality dimensions | 175 |
| 5.2 Conclusion | 176 |
| CHAPTER SIX | 177 |
| DISCUSSION OF RESULTS | 177 |
| 6.1 Introduction..... | 177 |
| 6.2 Demographic data | 177 |
| 6.2.1 Age groups of participants..... | 177 |
| 6.2.2 Gender of participants | 178 |
| 6.2.3 Medical insurance subscribed to and employment by economic sector..... | 178 |

| | |
|---|-----|
| 6.2.4 Period of membership with medical insurance companies and switching between medical insurance companies | 179 |
| 6.3 Research objectives..... | 179 |
| 6.3.1 Research objective 1 | 179 |
| 6.3.1.1 Customer perceptions of the tangibles..... | 180 |
| 6.3.1.2 Customer perceptions of reliability | 181 |
| 6.3.1.3 Customer perceptions of responsiveness | 181 |
| 6.3.1.4 Customer perceptions of assurance | 182 |
| 6.3.1.5 Customer perceptions of empathy | 183 |
| 6.3.2 Research objective 2..... | 183 |
| 6.3.3 Research objective 3 | 185 |
| 6.3.4 Research objective 4..... | 186 |
| 6.3.5 Research objective 5..... | 187 |
| 6.3.5.1 Channelling resources to improve the delivery of core services (especially providing financial coverage to the sick)..... | 187 |
| 6.3.5.2 Coming up with different medical insurance plans that suit the different expectations of clients in different categories..... | 192 |
| 6.3.5.3 Building strong customer relationships | 193 |
| Using information technologies | 194 |
| 6.4 Discussion around the general questions | 194 |
| 6.5 Discussion around the hypotheses | 197 |
| 6.5.1 Perceptions of service quality dimensions by the age groups of the respondents . | 197 |
| 6.5.2 Perceptions of service quality dimensions by gender..... | 198 |
| 6.5.3 Perceptions of service quality by employment in economic sector..... | 198 |
| 6.5.4 Perceptions of service quality by period of membership to the medical insurance company..... | 198 |
| 6.5.5 Perceptions of health insurance by whether customers have switched between medical insurance companies or not..... | 199 |
| 6.5.6 Expectations of service quality by age groups of respondents | 199 |
| 6.5.7 Expectations by employment in economic sector | 200 |
| 6.5.8 Expectations by customer’s period of membership to the medical insurance company..... | 201 |
| 6.5.9 Service quality gaps experienced by medical insurance customers in different age groups | 202 |

| | |
|--|------------|
| 6.5.10 Service quality gaps for medical insurance customers employed in the three different sectors of the economy | 202 |
| 6.5.11 Service quality gaps for medical insurance customers with different periods of membership with the medical insurance companies | 203 |
| 6.5.12 Service quality gaps for medical insurance customers who have either switched or not switched between medical insurance companies | 203 |
| 6.5.13 Comparison of customer perceptions of service quality between government-owned and privately owned medical insurance companies..... | 204 |
| 6.5.14 Comparison of customer expectations of service quality between government-owned and privately owned medical insurance companies..... | 204 |
| 6.5.15 Comparison of service quality gaps experienced between government-owned and privately owned medical insurance companies | 205 |
| 6.5 Summary | 206 |
| CHAPTER SEVEN..... | 207 |
| CONCLUSIONS AND RECOMMENDATIONS | 207 |
| 7.1 Introduction..... | 207 |
| 7.2 Conclusions..... | 207 |
| 7.2.1 Literature review-based conclusions | 207 |
| 7.2.2 Conclusions based on empirical results..... | 209 |
| 7.2.2.1 Medical insurance customers’ perceptions of service quality variables, namely tangibles, reliability, responsiveness, assurance, and empathy | 209 |
| 7.2.2.2 Medical insurance customers’ expectations of service quality variables, namely tangibles, reliability, responsiveness, assurance, and empathy | 209 |
| 7.2.2.3 Service quality gaps experienced by medical insurance clients in Zimbabwe..... | 209 |
| 7.2.2.4 Comparison of service quality experienced by customers in government-owned and privately owned medical insurance companies..... | 209 |
| 7.2.2.5 Strategies on how companies in the medical insurance industry can improve service quality | 210 |
| 7.2.2.6 No statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions among customers in different age groups..... | 210 |
| 7.2.2.7 No statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers | 211 |
| 7.2.2.8 No statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy..... | 211 |

| | |
|---|-----|
| 7.2.2.9 No statistically significant differences in the perceptions of medical insurance service quality along all the dimensions among customers with different periods of membership with their medical insurance companies | 211 |
| 7.2.2.10 No statistically significant differences in the perceptions of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies | 212 |
| 7.2.2.11 No statistically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups | 212 |
| 7.2.2.12 No statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers | 213 |
| 7.2.2.13 No statistically significant differences in the customer expectations of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy | 213 |
| 7.2.2.14 No statistically significant differences in medical insurance customers' expectations of the service quality along all the dimensions amongst customers with different periods of membership | 214 |
| 7.2.2.15 No statistically significant differences in the expectations of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies | 214 |
| 7.2.2.16 No statistically significant differences in service quality gaps experienced by medical insurance customers in different age groups | 214 |
| 7.2.2.17 No statistically significant differences in service quality gaps experienced between male and female medical insurance customers..... | 214 |
| 7.2.2.18 No statistically significant differences in service quality gaps experienced by medical insurance customers employed in different sectors of the economy..... | 215 |
| 7.2.2.19 No statistically significant differences in service quality gaps experienced by medical insurance customers with different periods of membership to the medical insurance companies | 215 |
| 7.2.2.20 No statistically significant differences in service quality gaps experienced by medical insurance customers who have either switched or not switched between medical insurance companies | 215 |
| 7.2.2.21 No statistically significant differences in customers' perceptions of service quality between government-owned and privately owned medical insurance companies | 215 |
| 7.2.2.22 No statistically significant differences in customers' expectations of service quality between government-owned and privately owned medical insurance companies | 215 |

| | |
|--|-----|
| 7.2.2.23 No statistically significant differences in service quality gaps experienced by customers in government-owned and privately owned medical insurance companies | 216 |
| 7.3 Recommendations..... | 216 |
| 7.3.1 General recommendations to close service quality gaps..... | 216 |
| 7.3.2 Recommendations to managers of medical insurance companies..... | 217 |
| 7.3.2.1 Channelling resources towards providing reliable financial coverage to the sick | 218 |
| 7.3.2.2 Building strong customer relationships | 218 |
| 7.3.2.3 Investing in information technologies | 218 |
| 7.3.2.4 Coming up with different medical insurance plans which suit the different expectations of customers in different categories | 218 |
| 7.4 Contribution to the body of knowledge | 219 |
| 7.5 Areas for further research | 220 |
| 7.6 Conclusion | 220 |
| REFERENCE LIST | 224 |

LIST OF TABLES

| | |
|---|-----|
| Table 2.1: Medical insurance companies in Zimbabwe and their status..... | 46 |
| Table 3.1: The four provider gaps | 91 |
| Table 3.2: The five determinants and their definitions | 94 |
| Table 4.1 Sample size determination | 113 |
| Table 5.1: Results for reliability..... | 124 |
| Table 5.3: Descriptive statistics for gap score of SERVQUAL dimensions..... | 142 |
| Table 5.4: Descriptive statistics for government and privately owned medical insurance companies..... | 143 |
| Table 5.5: t-test for equality of means between government-owned and privately owned medical insurance companies..... | 144 |
| Table 5.6: Normality test output | 148 |
| Table 5.7: Ranks table for customers’ perceptions by age group | 148 |
| Table 5.8: Test statistics table for no differences in customers’ perceptions by age groups | 149 |
| Table 5.9: Ranks table for customer perceptions by gender | 150 |
| Table 5.10: Test statistics for no differences in perceptions by gender | 151 |
| Table 5.11: Ranks table for customer perceptions by sector of the economy employed in | 151 |
| Table 5.12: Test statistics for no differences in customers’ perceptions by sector of the economy employed in | 152 |
| Table 5.13: Ranks table for customer perceptions by period of membership with the medical insurance company..... | 153 |
| Table 5.14: Test statistics for no differences in perceptions by period of membership.... | 154 |
| Table 5.15: Ranks table for customers’ perceptions by whether members have either switched between medical insurance companies or not..... | 155 |
| Table 5.16: Test statistics for no differences in customers’ perceptions between those who have or have not switched between medical insurance companies..... | 156 |
| Table 5.17: Ranks table for customer expectations by age | 157 |
| Table 5.18: Test statistics table for no differences in customers’ expectations by age group | 158 |
| Table 5.19: Ranks table for customer expectations by gender..... | 159 |
| Table 5.20: Test statistics table for no differences in customer expectations by gender .. | 159 |
| Table 5.21: Ranks table for customer expectations by sector of the economy in which they are employed | 160 |
| Table 5.22: Test statistics table for no differences in customer expectations by sector of the economy in which they are employed..... | 161 |
| Table 5.23: Mean ranks table for customer expectations by period of membership with the medical insurance company | 162 |
| Table 5.24: Test statistics table for no differences in customer expectations by period of membership with the medical insurance company | 163 |
| Table 5.25 Mean ranks table for customer expectations by whether customers have either switched between medical insurance companies or not..... | 164 |

| | |
|---|-----|
| Table 5.26: Test statistics for no differences in customer expectations by whether customer have either switched between medical insurance companies or not | 164 |
| Table 5.27: Ranks and test statistics table for no differences in service quality gaps in customers of different age groups | 165 |
| Table 5.28: Test statistics for no differences in gap scores in customers by gender | 166 |
| Table 5.29: Test statistics for no differences in service quality gaps in customers with regard to different sectors of the economy they are employed in | 167 |
| Table 5.30: Mean rank of all the dimensions with regard to different sectors of economy | 167 |
| Table 5.31: Test statistics for no differences in service quality gaps in customers with regard to periods of membership..... | 168 |
| Table 5.32: Ranks table for gap scores of all the dimensions with regard to period of membership..... | 169 |
| Table 5.33: Test statistics table for no differences in service quality gaps in customers who have either or not switched between medical insurance companies | 170 |
| Table 5.34: Ranks table for service quality gaps with regard to whether or not customers switched between companies | 171 |
| Table 5.35: Ranks table comparing customer perceptions of service quality between government-owned and privately owned medical insurance companies | 172 |
| Table 5.36: Mann–Whitney U test output for equality of means of customer perceptions between government-owned and privately owned medical insurance companies..... | 172 |
| Table 5.37: Ranks table comparing customer expectations of service quality between government-owned and privately owned medical insurance companies | 173 |
| Table 5.38: Mann–Whitney U test output for equality of means of customer perceptions between government-owned and privately owned medical insurance companies..... | 173 |
| Table 5.39: Ranks table comparing gap scores between government-owned and privately owned medical insurance companies | 174 |
| Table 5.40: Mann–Whitney U test output for equality of means of gap scores between government-owned and privately owned medical insurance companies | 175 |
| Table 5.39: Spearman's rho correlation output | 176 |

LIST OF FIGURES

| | |
|---|-----|
| Figure 2.1: Ownership of medical insurance companies in Zimbabwe. | 47 |
| Figure 2.2: Relationships between health care funders, providers and consumers..... | 50 |
| Figure 3.1: Customer perceptions of quality and customer satisfaction. | 66 |
| Figure 3.2: The Gronroos’s model | 87 |
| Figure 3.3: Haywood-Farmer’s three dimensional classification scheme | 88 |
| Figure 3.4: Seth <i>et al.</i> ’s (2005) Attribute service quality model..... | 89 |
| Figure 3.5: Original gaps model..... | 91 |
| Figure 3.6: Gaps model of service quality | 92 |
| Figure 3.7: Proposed research framework | 101 |
| Figure 5.1: Distribution of age | 125 |
| Figure 5.2: Distribution of age | 126 |
| Figure 5.3: Distribution of participants by medical insurance company | 126 |
| Figure 5.4: Sector of economy. | 127 |
| Figure 5.5: Period of membership..... | 128 |
| Figure 5.6: Clients who switched between medical insurance companies. | 128 |
| Figure 5.7: Reasons for switching..... | 129 |
| Figure 5.8: Summary of statement regarding tangible expectation | 130 |
| Figure 5.9: Distribution of statements regarding reliability expectation. | 131 |
| Figure 5.10: Distribution of statement regarding responsiveness expectation..... | 132 |
| Figure 5.11: Summary of statements regarding assurance expectation. | 133 |
| Figure 5.12: Distribution of statement regarding empathy expectation..... | 134 |
| Figure 5.13: Distribution of statements regarding perception of tangible aspects..... | 135 |
| Figure 5.14: Distribution of statements for perception of reliability. | 136 |
| Figure 5.15: Distribution of statements regarding responsiveness perception. | 137 |
| Figure 5.16: Distribution of statements regarding assurance perception. | 138 |
| Figure 5.17: Distribution of statements regarding empathy perception..... | 139 |
| Figure 5.18: Distribution of statements regarding general knowledge. | 140 |

LIST OF APPENDICES

| | |
|---|-----|
| APPENDIX 1: QUESTIONNAIRE..... | 244 |
| APPENDIX 2:LETTER OF INFORMED CONSENT..... | 256 |
| APPENDIX 3: GATEKEEPERS' LETTERS | 258 |
| APPENDIX 4: ETHICAL CLEARANCE APPROVAL..... | 264 |
| APPENDIX 5: ENGLISH LANGUAGE EDITING CERTIFICATE..... | 265 |
| APPENDIX 6: TURNITIN REPORT..... | 266 |

LIST OF ACRONYMS AND ABBREVIATIONS

| | |
|--------|---|
| ACA: | Affordable Care Act |
| AHFoZ: | Association of Healthcare Funders of Zimbabwe |
| CIMAS: | Commercial and Industrial Medical Aid Society |
| ESAP: | Economic Structural Adjustment Programme |
| FFS: | fee for service |
| FLMAS: | Fidelity Life Medical Aid Society |
| MHCS: | Managed Health Care System |
| MDGs: | Millennium Development Goals |
| MoHCW: | Ministry of Health and Child Welfare |
| NAMAS: | National Association of Medical Aid Societies |
| NHIS: | National Health Insurance Scheme |
| PSMAS: | Public or Premier Service Medical Aid Society |
| PSMI: | Premier Service Medical Investments |
| UKZN: | University of KwaZulu-Natal |
| ZIMA: | Zimbabwe Medical Doctors Association |

CHAPTER ONE

BACKGROUND AND INTRODUCTION TO THE STUDY

1.1 Introduction

Health care services are progressively being considered as services of great significance to society, since they are key in meeting other social, physical, and emotional needs (Purcarea, Gheorghe & Petrescu, 2013:276). Illness has been associated with a high risk of impoverishment to households and to the nation at large, and medical insurance has emerged to reduce this risk. In recent years, there has been increased interest in improving quality of service, and ultimately efficiency, in the health care industry, as marked by increased research interest in this area. Understanding, maintaining, and building quality have also become topical concerns of business today, as confirmed by increased research into the discipline of service quality. Service quality has been considered an important means of gaining competitive advantage in several industries, including the medical insurance industry. Service quality helps companies to differentiate themselves from competitors. However, not much research has been centred on medical insurance companies, and therefore this study examined service quality perceptions and expectations of customers in the medical insurance sector in Zimbabwe to enhance service quality in this important field. Issues to be covered in this introductory chapter comprise the background to the study, motivation of the study, the problem statement, research objectives, research hypotheses, the theoretical framework, the methodology to be used, the thesis statement, and the significance of the study.

1.2 Background to the study

Worldwide, the general strengthening of competitive pressures, largely as a result of globalisation, is forcing many businesses to take service quality seriously, as a way of gaining a competitive edge in their different industries (Hussain, Nasser & Hussain, 2015; Warraich, Warraich & Asif, 2013). High competitive pressures have also been experienced in the Zimbabwean health insurance sector, which has witnessed a remarkable increase in the number of competitors to around 30 medical insurance companies (Sanyanga, 2014). This sharp increase has been experienced in an environment characterised by a shrinking customer base, precipitated by prevailing harsh economic conditions in the form of a liquidity crisis, deflation as a result of a scant demand for services and goods, reduced economic growth being estimated to be at 3 per cent, and closure of companies in various industries (Sanyanga, 2014:9). It is therefore imperative for companies in this industry to take serious measures to build some competitive advantage through excellent service delivery, gained as a result of a thorough understanding of clients' expectations and perceptions of service quality. Thus, companies will be able to establish themselves as customers' first preference in the industry, ensuring sustainability. Studies have confirmed that customers' satisfaction with the service offerings of their current insurer is a significant

factor influencing the decision to continue membership with that insurer (Amo-Adjei, Anku, Amo & Effah, 2016:317; Reitsma, Van Rooijen, De Jong & Rijken, 2011:95; Wendel, De Jong & Curfs, 2011:310;).

As service quality is amongst the most important factors for determining an organisation's ability to compete, a business can distinguish itself against its rivals by providing exceptional client service (Siddiqi, 2011:12). Service quality refers to the discrepancy between customers' perceptions of service and their expectations of service. If the latter exceeds the former, customers experience dissatisfaction (Büyüközkan, Çifçi & Gülerüz, 2011:9408). Comprehensive knowledge about an entity's service quality is indispensable to managers in enhancing business efficiency and creating sustainable competitive strategies (Mei, Dean & White, 1999:136). In several studies conducted on service quality, using the SERVQUAL model, mixed results were obtained in terms of the service quality dimensions most significant in various fields. Nevertheless, an assessment of the literature on this topic reveals limited reflection by researchers on service quality in private health insurance (and particularly in the Zimbabwean context). Hence, a claim can be made that service quality variables most influential in creating sustainable competitive strategies in private health insurance are not fully understood or known by firms in this industry.

Sekhri and Savedoff (2005:128) define private health insurance as a "voluntary, for profit commercial coverage in contrast to mandatory, publicly financed and publicly managed insurance". Worldwide, the emergence and adoption of private health insurance has been generally slow, due to allegations that it intensifies societal differences and inequalities (Griffin, 1989:1; Pauly, Zweifel, Scheffler, Preker & Bassett, 2006:369; Sekhri & Savedoff, 2005:127). On the other hand, it has been contended that it allows patients to access health care when needed, without experiencing the poor service and inefficiencies encountered largely in public medical institutions (Preker, Scheffler & Bassett, 2007:3). Private health insurance has drawn the attention of many stakeholders in developing countries as a result of "huge cash payments for health care made by people in these countries" (Sekhri & Savedoff, 2005:127). However, persistent inability by governments of most third world economies to provide adequate medical financial coverage to their citizens has compelled them to seriously consider this type of medical insurance (Pauly et al., 2006:369). Zimbabwe is amongst the few African third world economies to implement private health insurance with success. In support of this, Sekhri and Savedoff (2005:132), state that "... of all of the rest of the developing world, only two countries (Zimbabwe and South Africa) have private health insurance that covers more than a quarter of private spending on medical care". Despite such positive remarks, these authors further argue that research on private health insurance is limited and policy makers have limited knowledge about it. Moreover, they claim that the nature and dimensionality of the service quality variables significant in the health insurance sector are not clear. This vagueness impedes efforts aimed at enhancing service quality in this industry.

Of the 31 medical insurance companies operational in Zimbabwe, 10 belong to specific industries (and are called in-house medical insurance companies), whilst the other 21 have open membership (Association of Healthcare Funders of Zimbabwe [AHFoZ], 2014; Chinyadza, 2014). It is generally agreed that medical insurance companies in Zimbabwe cater for 1.5 million of the 13 million populace (AHFoZ, 2014). The health insurance industry falls under the Ministry of Health and Child Welfare (MoHCW), which registers members into the industry and regulates its activities in line with the *Medical Services Act*. However, manpower deficiencies in the MoHCW to effectively control and monitor the activities of medical insurance companies greatly puts the beneficiaries' interests at risk (Shamu, Loewenson, Machededze, Mabika & Africa, 2010:2–3), as quality control and assurance cannot be effectively implemented. The Zimbabwean medical insurance industry has its own association responsible for maintaining general standards in the industry, as well as for standardising tariffs in the industry (AHFoZ, 2008). This association is known as the Association of Healthcare Funders of Zimbabwe (AHFoZ), earlier known as the National Association of Medical Aid Societies (NAMAS).

Medical insurance companies in Zimbabwe are commonly known as Medical Aid Societies, since they are considered as not for profit organisations. However, major changes have been experienced in the industry, which have caused many to question this non-profit making position. For instance, various amendments effected to the *Medical Services Act*, together with the 1990 economic reforms, have caused firms in this industry to invest their surpluses in related businesses in the industry, causing them to operate as profit making entities (Shamu et al., 2010:2). These changes have thus promoted huge investments in the industry, resulting in increased competition. Companies in this industry have also acquired related firms as a way of controlling expenses from doctors, pharmacists, and other related services. Some cartels have also been created in the process as a result of the amalgamation of some firms in this sector (Shamu et al., 2010:14).

Medical insurance clients still reported the continuous payment of co-payments when purchasing drugs and consulting medical practitioners, despite the claims to use acquisitions to reduce such payments (Shamu et al., 2010:2). Furthermore, very few medical insurance plans have been reported to give full medical cover for services accessed outside the amenities of their medical insurance companies. Written consent from the medical aid company was also required to access medical services not provided by their own companies (Shamu et al., 2010:2). Thus, changes in the industry have promoted the creation of monopolies, which have been heavily criticised for limiting patients' choices of service providers. These monopolies have also been criticised for promoting recommendations to beneficiaries, driven by the motive to cut expenses of health insurers at the expense of the medical care requirements of customers. Medical insurance companies have further been accused of reducing clients' bargaining power with their service providers (Shamu et al., 2010:2). Nonetheless, most of these claims have not

been proved by empirical research and comprised therefore the thrust of this study through investigating the perceptions of customers about service quality in this industry.

The claims mentioned above raises questions regarding the realisation of the benefits of private health insurance in Zimbabwe in terms of enabling clients to access medical care without difficulties, delays, and the poor quality prevalent in most public health institutions. There have been calls for improving quality in the industry to retain and attract new members, since there are fears that medical insurance clients might withdraw their membership from medical insurance, especially those perceived to have sound health (AHFoZ, 2014). There have also been calls for implementing medical insurance practices from first world economies like America and other emerging economies like India, who engage their suppliers based mainly on the quality and prices they charge (AHFoZ, 2014). This was alluded to at the *Annual All Stakeholder Conference* for AHFoZ in 2014 held in Victoria Falls, where presenters emphasised the impetus to improve quality and reduce expenses prevailing in this sector as a way of reducing challenges currently experienced in the industry. Furthermore, it is reported that some health insurance companies in Zimbabwe have made efforts to obtain accreditation with the Standards Association of Zimbabwe, where 5.3 per cent have just embarked on the registration process, 52.6 per cent are in the preparatory stage, and 10.5 per cent have already obtained certification (Sanyanga, 2014:7). These are significant moves towards improving the levels of quality in the industry, although it is very uncertain whether such progress is centred on the knowledge of clients' perceptions and expectations of service quality in the industry. Hence, before efforts to improve quality standards in the industry are made, industry practitioners need to be acquainted with the knowledge of customers' perceptions and expectations of service quality in the sector so that they are certain to include aspects most valuable to customers in the new quality models to be adopted. It is against this background that this particular study sought to examine the customers' perceptions and expectations of service quality offered by Zimbabwean health insurance companies, which will go a long way in informing both existing and prospective investors on best service quality strategies that enhance efficiency in the sector.

1.3 Motivation of the study

Medical insurance has been considered as a major source of funding in health care and has also been regarded as an important means of reducing the high risk of impoverishment associated with illness in many societies (Kasule, 2012:62; Preker et al., 2007:2–3). However, the economic challenges experienced in Zimbabwe, together with the increased number of players in the medical insurance industry, have threatened the sustainability of this important sector. Continued membership of a medical insurance scheme in such a harsh economic environment requires customers to be highly satisfied. Therefore, as a way of building and maintaining a competitive edge in such a volatile environment, medical insurance providers need to identify service quality variables that are most significant in

determining members' perceptions and exploit these in offering unbeatable service quality. This study was motivated by the following factors:

- A literature review on service quality has shown that very limited research exists on private health insurance in Zimbabwe (Mohammed, Sambo and Dong, 2011:20). Research closest to this area has been conducted on the National Health Insurance Schemes and the health care industry in general; however, very few of these studies concentrated on customer perceptions and expectations of service quality variables most significant in enhancing service delivery in the health insurance sector (Amo-Adjei et al., 2016; Atinga, 2011:144–161; Dalinjong & Laar, 2012). Although the service quality dimensions significant in private health insurance are not well comprehended, they are key in building competitive advantage that can be utilised by medical insurance companies to attract and retain clients in the industry. Therefore, the present study contributes to the current body of knowledge by investigating customers' perceptions and expectations of service quality across the various service quality dimensions in the perspective of medical insurance in Zimbabwe. The study will further create service quality-based strategies that will enhance the sustainability of the sector.
- There have been extensive calls for enhancing quality standards in the Zimbabwean medical insurance sector and for implementing medical insurance practices employed in developed countries, where medical service providers are contracted based on quality and price (AHFoZ, 2014). It is the researcher's belief that efforts to restructure service quality in the industry need to be informed by the full understanding of the service quality dimensions considered as significant by customers. This will ensure the inclusion of aspects considered as most valuable by customers in the new quality models to be implemented.
- Conducting a service quality survey among medical insurance customers has the potential of revealing the gaps in service quality experienced in the medical insurance industry in Zimbabwe. Strategies to close the gaps can then be used as a basis to formulate customer retention strategies that enhance the sustainability of the sector.

1.4 Statement of the problem

Customer satisfaction with the service offerings of their current health funder or insurer has been confirmed as a significant determinant of continued membership to that health insurer (Amo-Adjei et al., 2016:317; Reitsma-Van Rooijen et al., 2011:95; Wendel et al., 2011:310). Measuring service quality within medical insurance companies in Zimbabwe is an indicator of whether medical insurance clients are contented or discontented with the service offerings. Thus, in the face of increased competition in the medical insurance industry in Zimbabwe, coupled with the prevailing harsh economic conditions threatening the sector, delivery of excellent service quality to medical insurance customers becomes a

central issue that determines continued subscription by members and the sustainability of most medical insurance companies.

Although Zimbabwe (together with South Africa) is listed amongst few developing African countries to effectively implement private medical insurance (Sekhri & Savedoff, 2005:132), customer perceptions and expectations of these services remain unknown, since limited research on service quality is recorded in this area (Mohammed et al., 2011). Furthermore, it remains uncertain whether these services are meeting or exceeding the expectations of medical insurance customers, as there have been extensive calls for improving quality standards in the medical insurance industry in Zimbabwe (AHFoZ, 2014). The magnitude of these gaps also remains unknown.

The above emphasises the enormous challenge of improving service quality in the Zimbabwean medical insurance. The situation is aggravated by the controversy surrounding the issue of whether or not private health insurance creates inequalities in society, which has led to the slow adoption of health insurance by nations worldwide (Griffin, 1989; Pauly et al., 2006:369). Furthermore, both researchers and policy makers seem to have limited knowledge on private medical or health insurance (Sekhri & Savedoff, 2005:127). It can thus be concluded that knowledge is lacking regarding the service quality dimensions most critical for enhancing customer satisfaction and improving service quality in the medical insurance sector.

Moreover, empirical investigation on service quality in the context of medical insurance is inadequate. Studies in this area were mainly centred on public or national health insurance and focused on health care services and not medical insurance services per se (Atinga, 2011:144–161; Dalinjong & Laar, 2012:1; Wu, Liu & Hsu, 2008:1307–1319). This dearth of research in private health insurance, particularly in the Zimbabwean context, indicates a gap in the literature, which this study sought to fill. The study aimed to establish empirically the service quality perceptions and expectations of medical insurance customers in Zimbabwe, identify the service quality gaps that exist, and suggest strategies to close these gaps to improve service delivery and customer satisfaction in this inadequately researched area.

1.5 Aim of the study

This study aimed to evaluate customer perceptions and expectations of service quality around five variables empirically, namely tangibles, reliability, responsiveness, empathy, and assurance. Since prior research has shown that customers' contentment with the service offerings of their current health insurer is a significant determinant for staying insured with the same health insurer (Amo-Adjei et al., 2016:317; Reitsma-Van Rooijen et al., 2011:95; Wendel et al., 2011:310), this study will assist in identifying individual and overall service quality gaps that exist in the industry, as well as in determining the levels of customer satisfaction or dissatisfaction experienced. This will promote the formulation of

strategies to close service quality gaps and enhance the survival, profitability, and sustainability of the industry.

1.5.1 Research objectives

The objectives of this study were to:

- 1) ascertain medical insurance customers' perceptions of service quality with respect to reliability, tangibles, responsiveness, empathy and assurance;
- 2) establish medical insurance customers' expectations of service quality offerings provided by medical insurers with respect to reliability, tangibles, responsiveness empathy and assurance;
- 3) measure the service quality gaps experienced by medical insurance clients in Zimbabwe;
- 4) compare service quality gaps experienced by customers in government-owned and privately-owned medical insurance companies; and
- 5) suggest strategies that medical insurance companies in Zimbabwe can employ to improve service quality in the industry.

1.5.2 Research questions

This study sought to address the following research questions:

- 1) What are the medical insurance customers' perceptions of service quality with respect to reliability, tangibles, responsiveness, empathy and assurance?
- 2) What are the medical insurance customers' expectations of service quality offerings provided by medical insurers with respect to reliability, tangibles, responsiveness, empathy and assurance?
- 3) To what extent are service quality gaps experienced by medical insurance clients in Zimbabwe?
- 4) How do service quality gaps experienced by customers in government-owned medical insurance companies differ from those experienced by customers in privately owned companies?
- 5) How can the information obtained from the study help medical insurance companies in Zimbabwe to enhance service quality?

1.5.3 Research hypotheses

To address the research questions above, the following null hypotheses were tested:

H1.1: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers in different age groups.

H1.2: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers.

- H1.3: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy.
- H1.4: There are no statistically significant differences in the perceptions of medical insurance service quality along all the dimensions amongst customers with different periods of membership to their medical insurance companies.
- H1.5: There are no statistically significant differences in the perceptions of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies.
- H2.1: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups.
- H2.2: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers.
- H2.3: There are no statistically significant differences in the customer expectations of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy.
- H2.4: There are no statistically significant differences in medical insurance customers' expectations of the service quality along all the dimensions amongst customers with different periods of membership.
- H2.5: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies.
- H3.1: There are no statistically significant differences in service quality gaps experienced by medical insurance customers in different age groups.
- H3.2: There are no statistically significant differences in service quality gaps experienced between male and female medical insurance customers.
- H3.3: There are no statistically significant differences in service quality gaps experienced by medical insurance customers employed in different sectors of the economy.
- H3.4: There are no statistically significant differences in service quality gaps experienced by medical insurance customers with different periods of membership to the medical insurance companies.
- H3.5: There are no statistically significant differences in service quality gaps experienced by medical insurance customers who have either switched or not switched between medical insurance companies.

H4.1: There are no statistically significant differences in customers' perceptions of service quality between government-owned and privately owned medical insurance companies.

H4.2: There are no statistically significant differences in customers' expectations of service quality between government-owned and privately owned medical insurance companies.

H4.3: There are no statistically significant differences in service quality gaps experienced by customers in government-owned and privately owned medical insurance companies.

1.6 Scope of the study

Within the field of marketing management, this study focused on medical insurance clients who are members of the five major medical insurance companies in Zimbabwe, namely Premier Service Medical Aid Society (PSMAS), Commercial and Industrial Medical Aid Society (CIMAS), First Mutual Health, Fidelity Life Medical Aid Society, and Altfin. The survey targeted members of these medical insurance companies or their relatives who were willing to participate, including only those who had visited the five major health institutions in Harare, namely Parirenyatwa Group of Hospitals, Harare Central hospital, West End Medicare, Baines Imaging Group, and Dr Mazvuru and Partners Dental Surgeons. Medical insurance customers who had not visited the above mentioned health institutions were not included in the scope.

1.7 Research methodology and design

A descriptive quantitative research design was adopted in this study, which involved some testing of objective theories by measuring relationships among variables which could be measured and analysed using statistical procedures (Battacherjee, 2012:119; Creswell, 2013:12–13; Shukla, 2008:32). Quantitative methodologies are usually used to measure the attitudes, knowledge, opinions, and behaviours of customers (Cooper & Schindler, 2011:160). Hence, this design was considered suitable for the study in measuring service quality expectations and perceptions of customers in medical insurance firms using the SERVQUAL model suggested by Parasuraman, Zeithaml and Berry (1988:12–40).

The research philosophy adopted was positivism, in which service quality was regarded as an observable social reality, which could be reduced to simplest elements (Saunders, Lewis & Thornhill, 2009:117) in the form of five service quality variables, namely reliability, tangibles, responsiveness, empathy and assurance. It was assumed that generalisations about the service quality dimensions most significant to the medical insurance sector in Zimbabwe could be made and used to improve service offerings in this industry. A deductive research approach was also employed in which existing theories (Gaps model and SERVQUAL model) were used to develop the hypotheses, which were tested (Saunders et al., 2009:117).

The study was also a cross-sectional survey, which is considered suitable for collecting huge data quantities from a substantial population in a highly cost-effective manner (Saunders et al., 2009:148). The population of the study constituted 1 000 000 clients of the five major medical insurance companies in Zimbabwe, namely PSMAS, First Mutual Health, CIMAS, Fidelity Life Medical Aid Society, and Altfin.

A sample of 384 medical insurance subscribers was selected using quota sampling. These members were conveniently selected at the five health institutions in Harare, namely the Parirenyatwa Group of Hospitals, Harare Central hospital, West End Medicare, Baines Imaging Group, and Dr Mazvuru and Partners Dental Surgeons.

Secondary and primary data collection techniques were employed in the study. Secondary data were collected through documentary analysis of acts, journals, and books on medical insurance and service quality in general. Although literature on service quality in medical insurance was limited, documentary analysis was useful in constructing the various service quality dimensions in a way that suited service delivery aspects of the medical insurance industry.

Primary data were collected using questionnaires, which were constructed to encompass all the research questions. The questionnaire comprised four sections. Section A contained demographic questions, while Section D was comprised of general questions on customers' views on medical insurance companies in Zimbabwe and how service quality can be improved. Section B and C had 22 questions on medical insurance customers' expectations and perceptions on the five dimensions of service quality (namely reliability, responsiveness, tangibles, assurance and empathy) suggested by Parasuraman et al. (1988:12–40). A five-point Likert scale was utilised to indicate the extent of the respondents' agreement or disagreement with statements around the five dimensions on a scale ranging from 'strongly disagree' (1) to 'strongly agree' (5).

The above research instrument was peer reviewed by my supervisor, senior academics at Chinhoyi University with a good understanding of research methodology and a proficient statistician. A pilot study was also conducted involving 44 medical insurance members to check for areas that needed further corrections and to determine the time needed to complete the questionnaire, among others. Areas that needed corrections were identified and corrected. This was done to ensure the validity of the questionnaire.

The data collection procedures conformed to the University Research Ethical Policy under which the researcher obtained a research clearance to carry out the research. Gatekeepers' letters from the five health institutions where data was collected were obtained and copies of these have been included in the appendices section.

Collected questionnaires were coded through numbering them to simplify the data capturing process. Coding and capturing of the data was done using the CSpro version 6.0 before putting it on an Excel

spreadsheet for data cleaning purposes. The data was then analysed using the Statistical Package for Social Sciences (SPSS) version 20. The Cronbach alpha was used to test for reliability, of which the value for the overall data was 0.897, showing that the data were reliable since the value was above 0.7. Descriptive as well as inferential statistics were used in analysing the data. Measures of central tendency were utilised to explain the results obtained from the study. Frequency distributions together with bar charts and pie charts were also employed, mainly in presenting demographic data. Furthermore, data were tested for normality using the Kolmogorov Smirnov test, which indicated that the data were not normally distributed. This resulted in the choice of using non-parametric tests for hypotheses testing, which included the Mann–Whitney and the Kruskal–Wallis tests.

1.8 The thesis statement

Health insurance schemes in many less-developed countries are still in their implementation stages and there is insufficient literature in developing African countries that deals with client satisfaction under a health insurance scheme setting (Mohammed et al., 2011:20). While there is a lack in research on service quality in the health insurance sector, there has also not been consensus on the service quality dimensions most significant in determining service quality in other studies in the health care sector (Purcarea et al., 2013:576). Other related studies focused on the National Health Insurance Scheme; however, they did not investigate the services of health insurers and there has been little discussion about the expectations of the insured (Atinga, 2011:144–161; Dalinjong & Laar, 2012:1; Wu et al., 2008:1307–139). Furthermore, these studies focused on social or public health insurance and not private health insurance, which is the focal point of this study.

Service quality is a critical aspect in the medical insurance sector from the perspective of both the customers and the insurance providers. Medical insurance customers pay their hard-earned income in anticipation of financial protection or coverage against the impoverishing risks and costs of ill health. Excellent service quality therefore ensures the continual subscription and membership of medical insurance customers to their respective companies. Medical insurance companies also tend to strategically benefit from the provision of exceptional services through gaining some competitive advantage, which ensures profitability, survival, and sustainability of the industry.

It can safely be claimed that the service quality dimensions are not well comprehended in private health insurance and yet, as earlier pointed out, they are key in building competitive advantage to attract and retain clients in the industry. It is therefore important to investigate empirically the medical insurance customers' perceptions and expectations, as well as the existence of significant differences in service quality gaps among medical insurance companies in the industry. This will assist in extending the service quality knowledge in the context of medical insurance. Considering this foregoing discussion, the significance of this study is highlighted in the section below.

1.9 Significance of the study

Although extensive research has been conducted into service quality in many service disciplines, there has been little interrogation of service quality in the field of private health insurance. Universally, the growth of the private health insurance in many economies has encountered some extensive resistance because of fears that it widened the disparities between the rich and the poor and that it also promoted social inequalities (Sekhri & Savedoff, 2005:127). It is also claimed that private health insurance is not well documented and understood in research as well as policy-making spheres. The significance of this study was that it drew on both the theoretical and the practical points of view. Theoretically, the study will be very useful in building the academic body of knowledge, while practically the study should make a significant contribution to the society and the medical insurance industry in ways highlighted below.

1.9.1 Significance from the academic viewpoint

From the academic perspective, this study is critical in closing the gap in the literature and in extending the body of knowledge of service quality from the viewpoint of the medical insurance sector in Zimbabwe. Researchers previously conducted their studies on the National Health Insurance Schemes, which differ widely from private health insurance schemes (Atinga, 2011:144–161; Dalinjong & Laar, 2012:1; Iloh, Ofoedu, Njoku. Okafor, Amadi & Godswill-Uko, 2013:31–37; Wu et al., 2008:1307–1319). Furthermore, most of these studies were centred on service quality in the health care sector in general and not precisely in the medical insurance industry (Purcarea et al., 2013:573–585; Butt & Cyril de Run, 2008:658–673).

1.9.2 The significance of medical insurance customers' service quality

Medical insurance customers' service quality is of great importance to both insurance members and medical insurance companies. Medical insurance members expect medical insurance companies to meet certain levels of coverage or financial protection against the impoverishing risks and costs of ill health. They also want to be assured that health care will be available to them at any given time, without the dreadful out-of-pocket payments that could financially ruin individuals with severe illness. The ability to fulfil the above promise builds great trust in the policy holder and his or her willingness to keep the contract alive, whereas the rejection of a medical claim disillusiones the claimant, causing him or her to regret being associated with the insurance company (Jain, Mittal & Pahuja, 2014:39).

In addition, the continual subscription of medical insurance members to their respective companies is an important determining factor for the company's survival, profitability and sustainability in the face of increased competition and economic crisis in Zimbabwe. Thus, service quality of medical insurance companies is important, since negative perceptions about a medical insurance company may result in the withdrawal of members from the company and the spread of negative word-of-mouth accounts to

potential members. Failure by medical insurance companies to address negative customers' service quality perceptions will make it difficult for the companies to make profits and to be sustainable. It may also threaten the survival of the whole industry when members fail to perceive the benefits of medical insurance and resort to out-of-pocket payments for health care services, which in return also threatens the well-being of the society at large.

1.9.3 Significance of service quality to the medical insurance industry

The study wanted to show whether the Zimbabwean medical insurance industry is meeting customers' expectations. Thus, customers' judgement of service quality rather than management assumptions on what customers expect will be used as the basis for improving service quality in the industry. Although the industry may have its own standards and means to ensure service quality, for instance through organisations like AHFoZ, this study is likely to provide further insights into the industry's service quality strategies, which will complement such efforts.

1.9.4 Formulation of service quality strategies

The empirical assessment of the expectations and perceptions of medical insurance clients concerning the five service quality variables will help to identify individual and overall service quality gaps that exist in the industry, as well as to determine the levels of customer satisfaction or dissatisfaction experienced. This will allow the formulation of strategies to close service quality gaps and promote the survival, profitability, and sustainability of the firms in the industry. The findings will also provide a basis for policy formulation by the government intended to promote efficient service quality in this crucial industry.

1.10 Delineation of the study

The following aspects have been considered in delineating the study:

- Although the study focuses on service quality as a strategic tool that can be used by medical insurance companies to attain competitive advantage in the industry, it does not investigate the general strategic management issues that can be employed by medical insurance companies to improve profitability and performance.
- The study does not deal with service quality issues in the health care sector in general (although they are very closely linked), but it will concentrate on service quality issues related to the funding aspect of health care through medical insurance.
- Although service delivery in the medical insurance industry could be affected greatly by the economic crisis prevailing in Zimbabwe, the emphasis of this study will not be on the effects of the economic crisis on service quality delivery.

- The study does not intend to damage the reputation of any specific medical insurance company, but rather seeks to enhance the delivery of service in the entire medical insurance industry.

1.11 Limitations of the study

The study had the following limitations:

- This study was conducted at five health institutions in Harare only, and was not extended to health institutions in other towns in Zimbabwe. This was due to budgetary and time constraints.
- A non-probability sampling technique (quota sampling) was employed, which makes it difficult to draw and apply generalisations to other medical insurance companies in Zimbabwe.
- The use of closed-ended questions in the questionnaires made it difficult to do follow-ups with respondents on some service quality issues.
- The validation of the service quality dimensions were only based on the literature reviewed and not on a qualitative investigation of these.

However, despite the above limitations, some new knowledge about service quality in the scant researched area of medical insurance was obtained and some insights were gained into how to improve service quality in the industry.

1.12 Definition of key words

In this thesis, **service quality** is used to refer to the “degree and direction of discrepancy between customers’ perceptions and expectations” (Parasuraman et al., 1988:19). **Customer perceptions** refers to personal judgements by customers about the services they experienced (Zeithaml, Bitner & Gremler, 2009:102), while the term **customer expectations** is used to refer to “beliefs about service delivery that serve as standards or reference points against which performance is judged” (Zeithaml et al., 2009:75). **Medical insurance or health insurance** is a mechanism for financing health care that guarantees that health care is made available at any time without the appalling out-of-pocket payments that would financially overwhelm individuals with ill health (Kasule, 2012:62). Whereas **private health insurance** is a voluntary, for profit or not for profit health insurance scheme that is managed and financed privately (Sekhri & Savedoff, 2005:127), **public or social health insurance** is a mandatory (or voluntary) publicly financed and managed health insurance scheme (Sekhri & Savedoff, 2005:127).

1.13 Structure of the study

The thesis is composed of seven themed chapters.

Chapter 1 presented the general introduction of the whole thesis, which provides an outline of the background of the study, the motivation of the study, a statement of the problem, the research aims and objectives, the research questions and hypotheses. It also discussed the contribution of the study to the

knowledge body through highlighting the significance of the study. The chapter further discussed the position of the study in the academic discourse of medical insurance service quality and highlighted the methodology of the study, the delimitations, delineation, as well as the limitations of the study. It also provided the definitions of key terms as well as the chapter summary and conclusion.

Chapter 2 provides an overview of the background of the medical insurance sector in Zimbabwe, and also providing a detailed explanation of medical insurance. The chapter gives an overview of the types of medical insurance that generally exist and indicates the type that prevails in Zimbabwe. Governance issues in medical insurance are discussed, as well as some common problems related to medical insurance and how they are addressed in Zimbabwe. The chapter concludes by looking at some approaches to managing service quality employed in Zimbabwe, mainly centred on managed health care systems.

Chapter 3 is mainly centred on the review of the literature on service quality in general and on medical insurance. Though literature on service quality in private health insurance was scant, related literature was drawn upon from studies on social or national health insurance and on health care in general. Literature was also reviewed around the five dimensions of service quality, which are tangibility, reliability, responsiveness, assurance and empathy, as well as on customers' perceptions and expectations in general. Some theoretical underpinnings, which guided the study, are also discussed in this chapter.

Chapter 4 details and reports on the methodology used in the study to address the research questions. Aspects discussed include the research design, philosophy, approach, and research strategy. The chapter also defines the study population and how the sample was selected. It further explains the data collection techniques employed and indicates how the data collected will be presented and analysed.

Chapter 5 is concerned with the presentation and analysis of the data collected. The service quality gaps, along with the significant relationships among service quality variables in the medical insurance industry in Zimbabwe, are highlighted in an effort to provide answers to the research problem.

Chapter 6 presents the research findings in the context of the study objectives and questions, also focusing on the hypotheses formulated in Chapter 1.

The final chapter is mainly centred on the conclusions and recommendations of the study. It includes a discussion of the implications of the findings and identifies areas for future research. A list of references used and the appendices, which also reflect the questionnaire employed in the study, the gatekeepers' letters, and the University of KwaZulu-Natal (UKZN) ethical clearance certificate, are attached.

1.14 Summary

Health care services are becoming increasingly important in meeting other societal needs. Medical insurance has been discovered as a means to reduce the impoverishing risk of illness. From the

perspective of medical insurance customers, superior service quality ensures that customers receive value in exchange for the money paid in anticipation of coverage against the impoverishing risks of ill health. From the perspective of medical insurance companies, delivery of superior service quality provides a competitive edge, leading to profitability, survival, and sustainability.

This study is therefore centred on the medical insurance customers' perceptions and expectations of service quality. Measuring service quality represents one way of determining whether medical insurance companies are happy or unhappy with the delivery of service in the industry. There is scant research on service quality in the medical insurance industry due to the slow adoption of medical insurance by nations worldwide. An empirical study was therefore imperative for this particular industry in Zimbabwe. The thesis statement was that service quality is critical to both medical insurance customers and companies. The medical insurance customer requires superior service quality to encourage continued membership to the insurance company, which ensures the survival, profitability and sustainability of the industry.

To address the issue, research questions were formulated, based on existing literature and service quality models. Justification for conducting the study from both the academic and practical perspectives was also provided.

1.15 Conclusion

This chapter provided a general introduction to the study in which the background of the research, the motivation for the study, as well as the statement of the problem were outlined. The chapter further presented the research questions, objectives and hypotheses to be tested. The methodology used to investigate the research questions was also discussed briefly. The chapter further indicated the delimitations, delineation, as well as the limitations of the study. It also defined key terms and outlined the structure of the thesis. The following chapter provides the background and review of the medical insurance industry in Zimbabwe.

CHAPTER TWO

BACKGROUND AND OVERVIEW OF THE MEDICAL INSURANCE INDUSTRY IN ZIMBABWE

2.1 Introduction

This study was carried out in Zimbabwe, which is cited amongst few developing African countries that managed to adopt “private health insurance” with great success (Sekhri & Savedoff, 2005:132). This success can be attributed to its long history of being a former British colony. The British colonisers adopted medical insurance in Zimbabwe (then Rhodesia) in an effort to embrace British health standards in their colonies. This history gives Zimbabwe a unique socio-economic background and ultimately a unique medical insurance industry when compared to its European and Asian counterparts. Thus, generalisations of research findings from such countries are not applicable to the Zimbabwean medical insurance industry.

Illness carries a high risk of impoverishment to households and the nation as a whole. Medical insurance emerged as a means to reduce this risk, thereby freeing resources to be applied to other non-medical consumption activities. It also positively contributes to the overall wellbeing of a society, labour market productivity, savings, and investment activities (Preker *et al.*, 2007:2–3). Kasule (2012:62) also supports this view and adds that “healthy citizens are more economically productive and contribute to” wealth creation in the whole economy. Worldwide, medical insurance is considered a key source of medical-care funding. It is also a major resource mobilisation technique, which is indispensable in attaining health-related Millennium Development Goals (MDGs). For instance, in Zimbabwe, medical insurances account for 80 per cent of the revenue for the private health care providers (AHFoZ, 2008:2). Furthermore, more than 20 per cent of the nation’s overall health expenses comes from medical insurances (Foster, 2012:31; Sekhri & Savedoff, 2005:129).

The history of medical insurance in Zimbabwe dates back to 1930, when the Public Service Association appointed a special committee to start the Public Service Medical Aid Society (PSMAS). As the name suggests, it catered mainly for government employees. In September 1931, its membership was at 258 beneficiaries and it grew to 660 in 1934 and to 3 564 in the 1940s, though it fluctuated due to the Second World War. The membership continued to grow to 23 687 in the 1950s, to 33 589 in the 1960s and to 41 266 in the 1970s. Due to independence, a significant increase was experienced in 1980 when membership rose to 143 311 beneficiaries, since medical aid was given as a condition of service (AHFoZ, 2014).

Prior to the nineties, PSMAS and CIMAS were the major players in the industry, together with a few in-house medical insurance companies that catered for specific industries. CIMAS was mainly designed for members who worked in the private sector. Membership of PSMAS grew to 400 000 in the 1990s.

The industry started experiencing the entry of new players with the adoption of the Economic Structural Adjustment Programme (ESAP) in the country, which brought about the deregulation of the industry. Currently, there are 31 players in the industry, 10 of which being in-house companies for specific industries (AHFoZ, 2014).

The survival of the medical insurance industry in Zimbabwe mainly hinges on the formal employment sector which caters for only 7 per cent of the population (Musungwini, 2012). This sector is continuously dwindling, owing to the poor macro-economic conditions prevailing in the country. As these conditions are stiffening competition in the sector, there is need for companies to improve service quality to increase their chances of survival in the industry. Not so much research has been conducted on service quality in medical insurance, and although voluntary medical insurance has been widely studied in first world countries, very few studies have been conducted in third world countries (Preker *et al.*, 2007:9). This study is therefore an endeavour to close this knowledge gap to come up with service quality variables most significant for the medical insurance industry in Zimbabwe.

2.2 Definition of medical insurance

The meaning of medical insurance can be traced back to the definition of insurance in general. Insurance is the business of covering a person against some risks or mishaps. When it comes to medical insurance, this refers to the coverage or financial protection against the impoverishing risks or costs of ill health (Jenson & Fernandez, 2007; Kasule, 2012:62; Preker *et al.*, 2007:3). In most literature, medical insurance is referred to as health insurance. Preker *et al.* (2007:5) highlight that “health insurance involves some transfer of resources from the rich to poor, healthy to sick and gainfully employed to inactive.”

Austin and Hungerford (2010:11) support the above views and define medical insurance as a method of pooling risks undertaken to distribute the financial burden of health care among many people. According to these authors, health insurance is based on the premise that some insured members will get sick and incur significant medical costs, while a relatively large proportion of the members will remain relatively healthy and incur little or no health costs. This then allows money to be transferred from healthy members to those who become sick.

Kasule (2012:62) defines health insurance as “a form of social mutual self-help that ensures medical care for the insured”. He further describes it as a mechanism to finance health care that ensures that health care is made available any time but without the terrible out-of-pocket payments that would financially ruin individuals suffering from ill health. In general, insurance has been found to have a psychological and financial effect on the lives of people. Psychologically, insurance assures the safety of a person in the case of a mishap in the future. Financially, in the case of a catastrophe, it ensures that help will be provided in the form of money, goods, and services, and thus the insured and beneficiaries will not be financially ruined by catastrophic payments (Cylus & Papanicolas, 2015:1130; Kasule,

2012:62). In the words of Kasule (2012:62), “health insurance coverage provides a financial mechanism to protect and promote good health by making sure that patients have access to health care”. Without health insurance, many ill people will not be able to seek care because of the huge medical bills that will be beyond the capacity of an average citizen (Kasule, 2012:61). According to Kasule (2012:61–62), lack of health insurance results in poor quality of treatment, “related to absence of a usual source of care”.

Jain *et al.* (2014:39) define insurance as a business of settling claims. They emphasise that such claims should be settled with the minimum effort of the policyholder or claimant. According to Jain *et al.* (2014: 39), a person shopping for health insurance is shopping for payment and coverage of medical expenses. They consider the moment of truth or the most important incident during the relationship of a policyholder and the insurer to be the settlement of his or her claim. The claimant therefore waits patiently for the moment when the insurer will fulfil the promise to pay the sum assured. The ability to fulfil the promise builds great confidence in the policy holder and his or her willingness to keep the contract active, whereas the rejection of a medical claim disheartens the claimant, causing regret of being associated with the insurance company (Jain *et al.*, 2014:39).

It is also contended that the health insurance market is closely knitted with other parts of the health care system, which causes many parties to be greatly involved in the health insurance market (Austin & Hungerford, 2010). The various parties involved in health insurance include health care providers, the state, and local governments and employers. This therefore poses some challenges in evaluating the quality of service provided by health insurers. According to Austin and Hungerford (2010), health insurers act as intermediaries between health care providers and patients. They are not only responsible for reimbursing health care providers, but they also negotiate payment contracts for health services and have some control over the types and number of services covered in the contracts. It is believed that in most cases there are very few traditional medical insurance plans that offer unlimited reimbursement for a fixed premium, as most plans are managed health care insurance plans, as will be discussed below (Austin & Hungerford, 2010; Claxton, Gabel, DiJulio, Pickreign, Whitmore, Finder, Jacobs & Hawkins, 2007).

The health insurance market is thus a complicated market, which heavily relies on intermediaries. This, together with other characteristics, pushes it away from a perfect competition market structure and causes inefficient outcomes to be anticipated (Austin & Hungerford, 2010). Moreover, it is believed that there is lack of symmetric information in the sector since there is heavy reliance on specialised expertise and knowledge of physicians, employers, labour unions, and many others. For instance, consumers are believed to benefit from the specialised expertise and bargaining power of employers and health insurers. They also depend on health insurers and physicians to negotiate with a wide range of health care providers, such as specialised surgery centres and imaging centres. This is therefore taken to insulate customers from important information about prices and costs for specific health care services

and goods (Austin & Hungerford, 2010). According to Austin and Hungerford (2010), the complex interactions among employers, health insurers, health care providers, and the government, among others, have caused health care costs to increase, which calls for health insurance sector reforms to be put in place. However, before such reforms are put in place, especially in Zimbabwe, customer perceptions and expectations of service quality in the industry must be determined. Then reforms can be initiated that are in line with customer needs.

2.3 Types of medical insurances

Literature shows that medical insurance comes in different forms, although the boundaries existing between the various forms are increasingly becoming blurred (Sekhri & Savedoff, 2007:245). From the various forms, two broad types of medical or health insurance can be identified, namely private health insurance and public health insurance. According to Sekhri and Savedoff (2007:245), the following factors determine classification of medical insurances into the above broad classes:

1. Whether the medical insurance is voluntary or mandatory;
2. Whether contributions are calculated based on risk (minimum risk transfer), transfers between the healthy and ill (community rated), or based on transfers between highly paid groups and lowly paid groups (community rated); and
3. Whether the medical insurance plan is run on a profit or commercial basis, private non-profit basis, or is of a public or quasi-public nature.

Based on the above considerations, private health insurance appears to be voluntary, whereas public health insurance appears to be compulsory, although research has proved that this is not always the case. Moreover, in terms of the calculations of monthly subscriptions, private health insurance tends to be risk- or community-based, whilst contributions to public insurance tend to be more income-based, although it is not always the case. In addition, private health insurance tends to be more profit oriented, or private non-profit, although research has shown that in countries like Australia and India, the leading 'private' health insurance companies are owned publicly. Furthermore, in most public health insurance organisations, private institutions have been seen managing publicly financed health insurance funds (Sekhri & Savedoff, 2007:245).

From the above, it can be deduced that private health insurance encompasses both commercial and non-profit schemes, although it is usually described as voluntary for profit commercial coverage. On the other hand, public health insurance encompasses a wide variety of insurance plans known as national insurance or social insurance.

2.4 Private health insurance

Private health insurance falls within the health policy concerns that are regarded as most controversial in many countries (Colombo, 2007:211–212). It is widely believed that private health insurance results in large numbers of uninsured people and makes health care accessible to the rich only. The sluggish adoption of private health insurance in third world countries has been attributed to the fact that most first world countries (where most innovations originate) use social insurance. Private health insurance was, however, grudgingly adopted by governments in third world economies due to their persistent inability to provide adequate medical financial coverage as well as sufficient medical care services to their citizens (Pauly *et al.*, 2006:369). It is also claimed that in Africa, the adoption of private health insurance has been mainly as a result of extensive spread and acceptance of capitalistic views which positively influenced many governments to adopt liberal policies with regard to the private sector (Sekhri & Savedoff, 2005:127).

Private health insurance is generally depicted by its voluntary or intentional and profit-making nature, which is differentiated from the obligatory or mandatory characteristic of government owned health insurance (Sekhri & Savedoff, 2005:128). It is often classified together with social security and taxation as means available to governments to financially cover citizens from financial burdens caused by illness (Sekhri & Savedoff, 2005:128). However, most third world economies find it difficult to collect revenues through taxation due to the informal nature of their various economic sectors. Private health insurance, therefore, remains as the next best alternative for easing the financial obligations of medical services consumed by a nation (Pauly *et al.*, 2006:369; Sekhri & Savedoff, 2005:127).

In earlier researches, private health insurance has been regarded with great contempt as a result of its effects on societal imbalances (Griffin, 1989:1). This resulted in some proposals for social health insurance in Zimbabwe which, however, failed to materialise (Zigora, 1996:118–119). Yet, Campbell, Quigley, Collins, Yeracaris and Chaora (2001:2) show that this stance gradually changed. It is documented that by 2001 almost 8 per cent of the Zimbabwean populace had obtained medical insurance cover, which catered for about 23 per cent of the expenses in the private health sector. It has also been “argued that private health insurance cannot be ignored, but it can be harnessed to serve public interest if governments implement effective regulations and focus public funds on programmes for those who are poor and vulnerable” (Sekhri & Savedoff, 2005:127). Sekhri and Savedoff (2005) highlight the extensiveness of private insurance in the past decades and the need to carry more research into this area.

According to Austin and Hungerford (2010), a large percentage of private health insurance is offered through employers. Under such schemes, employers provide health benefit plans through an insurance company at a negotiated price. However, in other cases employers may self-insure and administer the whole plan and bear the insurance risk. In Zimbabwe these are called closed or in house medical insurance plans, since membership is restricted to a certain group of people economically engaged in a

particular company or industry (Table 2.1). According to Buchmueller and Monheit (2009), research has shown that 80 per cent of large employers opt for self-insurance instead of purchasing coverage from other health insurers. They add that choices of health insurance options tend to vary with firm size. Smaller firms have been found to offer only one plan, whereas larger firms have been found to offer two or more health insurance choices to their employees. This results in limited choices for health insurers on the part of employees who have to join membership within the range of insurers negotiated with their employers. This view is reinforced by Austin and Hungerford (2010) who contend that interlinkages among providers and intermediaries limit consumer choices; in particular a person's job limits his or her health insurance choices. These authors further argue that the interaction of intermediaries in the health insurance market can impede or improve efficiency, quality of service, and cost control.

Although private health insurance is criticised on the grounds of the inequalities it causes in societies, its proponents argue that it helps in providing quality care and enables the government to expand coverage, thereby relieving pressure on public funding (Munyuki & Jasi, 2009:2; Pauly *et al.*, 2006:369). However, Munyuki and Jasi (2009) and Pauly *et al.* (2006) point out that poor quality care has been reported, together with some fragmentation of risk pools, which requires some further investigation. The thrust of this study will therefore be to investigate how companies in this emerging industry can build strategies and ultimately competitive advantages using service quality.

2.5 The Zimbabwean health insurance

The type of health insurance that prevails in Zimbabwe can best be described as voluntary, private non-profit. Because of this, medical insurance companies in Zimbabwe are referred to as 'Medical Aid Societies' (Munyuki & Jasi, 2009:9; Shamu *et al.*, 2010:2). These are defined as "non-profit organisations that collect premiums from business and or government organisations and use that money to pay health care providers for services provided to beneficiaries" (Shamu *et al.*, 2010:9).

Although it has been concluded that profit making medical insurance companies do not exist in Zimbabwe (Campbell *et al.*, 2000:2), tendencies by insurers to invest their surplus funds in non-core activities have raised debates. Questions are usually centred on the taxation of the businesses they have acquired and the way funds are transferred between non-profit activities and profit-making institutions (Shamu *et al.*, 2010:27). This has led to the conclusion that medical insurance in Zimbabwe is just 'non-profit' on paper, maybe for tax purposes, but in real terms they are profit-making organisations. Munyuki and Jasi (2009:11) describe these institutions as "misleadingly described as not for profit operations", which they call "a description adopted for tax purposes".

Membership to medical insurance companies in Zimbabwe is on a voluntary basis. Agents are not used, and medical insurance companies deal directly with customers and employers. This enables medical insurance companies to avoid agents' costs. Shamu *et al.* (2010:8) describe medical insurance in

Zimbabwe as “employer-driven through group-based insurance premiums” that are cheaper and easy to manage. This set up has been criticised for limiting employees’ choice between available medical insurance companies, thereby negatively affecting competition (Austin & Hungerford, 2010; Shamu *et al.*, 2010). With high unemployment levels prevailing in the country, this forces some medical insurance companies to resort to unorthodox means (like bribes and corruption) to gain clients from the few surviving organisations.

Medical insurance companies, which offer different schemes to different members, have been criticised for discriminating between management and lower level employees. Schemes catering for clients with high paying jobs give them access to both public and private health facilities, whilst schemes for lower level employees limit client access to public health facilities. They can access private health facilities only if they are able to pay for the shortfalls involved (Shamu *et al.*, 2010:16).

2.6 The governance of medical insurance companies in Zimbabwe

The Zimbabwean medical insurance market is liberalised and allows private companies to establish medical insurance schemes. However, the government regulates the health insurance industry through the Ministry of Health and Child Welfare and its various arms. This is mainly done to address issues of adverse selection, moral hazard, and cost escalation, and to ensure equity in health risks and income distribution (Shamu *et al.*, 2010:16).

On commencing a business in the medical insurance industry, a company is obliged to register with the Ministry of Health and Child Welfare (MoHCW). This should be done in line with the *Medical Aid Societies Statutory Instrument 330 of 2000* and *Medical Services Act of 1998*. Medical Insurance Companies are also supposed to be registered and accredited by the Association of Healthcare Funders of Zimbabwe (AHFoZ). This association was previously known as the National Association of Medical Aid Societies (NAMAS). NAMAS was formed in 1969 to register and accredit medical insurance companies, standardise tariffs in the industry, and to form mutual cooperatives with health care providers (AHFoZ, 2008). AHFoZ is not responsible for setting health care charges, but only produces a guideline for the tariffs to be charged.

AHFoZ obtains authority to perform its duties from the MoHCW, as stipulated in the Act and the statutory instrument mentioned above. The Minister of Health also appoints AHFoZ representatives to sit in various boards, which include the Standing Committee on Health services, the Medical Research Council of Zimbabwe, and the Public Health Advisory Board (AHFoZ, 2008). This helps the association to gain some insights useful in the execution of its duties and to make some meaningful contributions to these boards.

2.7 Justification for government intervention in the medical insurance industry

As highlighted above, the medical insurance industry in Zimbabwe is regulated by the government through the MoHCW and it is mandated to address some common problems experienced in health insurance. These problems include, among others, moral hazard, cost escalation, and adverse selection, as mentioned above. Roberts, Hsiao, Berman and Reich (2004:1) support this view and add that public intervention is necessary in generally regulating financial institutions, preventing market failures associated with health insurance, promoting good health, and addressing inequalities, thus promoting quality of service in general. These views are underpinned by Austin and Hungerford (2010) who argue that regulation of health insurance is also necessary for promoting social goals, which include ensuring the financial solvency of health insurers, the payment of promised benefits, and protecting consumers from insurance fraud. Handel, Hendel and Whinston (2015) also support the above views and contend that regulation is necessary for encouraging the provision of health insurance in an efficient manner. However, research has shown that poor regulation of this sector may result in anti-competitive behaviours as well as distortions in prices, quality, types, and distribution of health care services (Doherty, 2015). Although Zimbabwe is reported as being successful in implementing some regulations for quality service in the health insurance sector (Doherty, 2015:i96), customer perceptions of such measures have not been documented (Mufudza & Naidoo, 2018), which is one of the major objectives of this study.

2.7.1 Problems experienced in medical insurance

Health insurance is considered as a complex phenomenon due to interactions involved with various intermediaries like employers, health insurers, and health care providers (Austin & Hungerford, 2010). This prevents the setting in of perfect competition market conditions to determine prices as well as quantity and quality of services offered in the industry (Claxton *et al.*, 2007). Moreover, health insurance is considered complex due to the nature of health risks which are controlled by the individual and advances in the medical field which continuously change the definition of risks that can be insured (Sekhri *et al.*, 2005:4). Thus, the unstatic nature of health risks worsens their complexity. Sekhri *et al.* (2005:4) also contend that the assessment of exposures to health risks and the subsequent costing of these risks become unpredictable and difficult. Medical insurance markets are also vulnerable to various forms of market failure, which include moral hazard, risk selection, and adverse selection; hence, governments intervene in medical insurance to control these problems. The various forms of market failure will be looked at below.

2.7.1.1 Adverse selection

Adverse selection is a common form of market failure in medical insurance which emanates from information asymmetry or irregularities concerning health costs and risks (Austin & Hungerford, 2010; Handel *et al.*, 2015; Sekhri & Savedoff, 2005). It is normally experienced when medical insurance

companies have insufficient knowledge about the health status of prospective beneficiaries. In response to this risk, medical insurance companies tend to charge very high insurance premiums. This discourages healthy members from purchasing health insurance policies of which the costs may be higher than the benefits (Austin & Hungerford, 2010; Hackman, Kolstad & Kowalski, 2015; Handel *et al.*, 2015). In addition, less than healthy individuals might be buying health insurance and ultimately “a higher than expected average level of risk in the insurance pools” will be the result (Sekhri & Savedoff, 2005:252). Hence, adverse selection has been found to result in ever-increasing premiums and a growing pool of high risk insurance members in an ever-shrinking market (Austin & Hungerford, 2010; Sekhri & Savedoff, 2005). Austin and Hungerford (2010) support this view, asserting that an increase of sicker and older individuals in the pool normally results in higher rates being charged to members, thereby forcing younger and healthier members to drop out of health insurance.

This problem is worsened in situations where health insurance contributions are calculated based on transfers between higher income earning and lower income earning groups (community rated). In this case, insurance prices are driven much higher, leading to the collapse of the health insurance market (Austin & Hungerford, 2010; Leibowitz, 2005; Sekhri & Savedoff, 2005). Thus, the government intervenes through regulations to avoid this from happening. In support of this, a study conducted by Hackman *et al.* (2015) found that an individual mandate that requires both the sick and the healthy to purchase insurance coverage could mitigate adverse selection welfare loss.

2.7.1.2 Risk selection

Risk selection arises when health insurers make some effort to avoid adverse selection or increase profits through discouraging people with ill health from buying health insurance coverage or through encouraging individuals with low health risks to get insurance coverage (Nuscheler & Knaus, 2005; Sekhri, Savedoff & Thripathi, 2005). This results in health insurance being out of reach of many sick people who may even be willing to pay for it. Hence, government regulation is necessary to match demand and supply conditions in the health insurance market. Common regulations adopted to address risk selection and adverse selection include mandatory requirements that health insurers accept all applicants, compulsory purchase of health insurance plans, putting limits “on exclusion and waiting periods” and plans that equalise “risks” amongst beneficiaries (Sekhri & Savedoff, 2007:252; Sekhri *et al.*, 2005).

2.7.1.3 Moral hazard

Moral hazard refers to the tendency of health insurance beneficiaries to consume more health services than they would use if they were not insured. This increases the costs of health insurance coverage, thus preventing health insurance markets from operating effectively (Austin & Hungerford, 2010). Ways to reduce this problem include co-payments or other cost-sharing measures, but these have been viewed as defeating the whole purpose of health insurance (Sekhri *et al.*, 2005). Doctors have also been reported

as participating in moral hazard through over-prescribing medications and ordering unnecessary services with the misguided rationale that the health insurance, and not the client, will pay for the costs (Austin & Hungerford, 2010; Sekhri *et al.*, 2005).

Owing to the problems highlighted above, government intervention in medical insurance has become a common phenomenon adopted in both developed and developing countries to address problems associated with market failures in medical insurance (Austin & Hungerford, 2010). However, although government intervention has been found to result in better problem-solving outcomes than laissez-faire approaches, economists caution against its usage due to its tendency to distort efficient market functioning (Austin & Hungerford, 2010; Sekhri & Savedoff, 2005:253).

2.8 Medical insurance companies in Zimbabwe

As mentioned earlier, the medical insurance industry in Zimbabwe allows private investments by individual companies. This allows various companies to operate ‘open’ or ‘closed’ schemes (Shamu *et al.*, 2010:7). In open schemes, any person is free to be a member, whereas in closed schemes only employees of a particular industry are admitted. Table 2.1 below shows the medical insurance companies that exist in Zimbabwe and their status.

Table 2. 1 Medical insurance companies in Zimbabwe and their status

| Name of medical insurance company | Status | Name of medical insurance company | Status |
|-----------------------------------|--------|--------------------------------------|--------|
| PSMAS | Open | Railmed | Closed |
| CIMAS | Open | Strategies Health and Life Assurance | Open |
| Altfin | Open | Northern Medical | Open |
| First Mutual Savings Fund | Open | Sovereign Health (Pvt) Limited | Open |
| Fidelity Life | Open | World Bank Medical Benefits Plans | Open |
| Alexander Forbes | Open | Zimpapers | Closed |
| Blanket Mine | Closed | Zenith Medical Benefit | Open |
| BP and Shell | Closed | IGI – Kuchi Holdings | Closed |
| Cynergy | Open | Cellmed | Open |
| Galaxy | Open | Shelter | Open |
| Grainmed | Closed | Healthmed | Open |
| Generation Medical Fund | Closed | Shield | Open |
| Harare Municipal | Closed | TN Medical Services | Open |
| Kwekwe City Council | Closed | Municipality of Masvingo | Closed |
| MASCA | Open | Municipality of Bulawayo | Closed |
| ZIMA | Open | | |

**Open: Medical insurance allows anyone to be a member if they can afford the registration fee.*Closed: These are restricted to a certain group of people such as those employed in a particular industry.*

Source: Data obtained from MoHCW and AHFoZ

2.9 Ownership of medical insurance companies in Zimbabwe

The following five forms of ownership have been identified in the Zimbabwean medical insurance industry (Shamu *et al.*, 2010:9):

1. the government
2. corporate general insurance companies
3. private health insurance companies
4. urban councils
5. provider-initiated ownership

These different forms of ownership are illustrated in Figure 2.2 below:

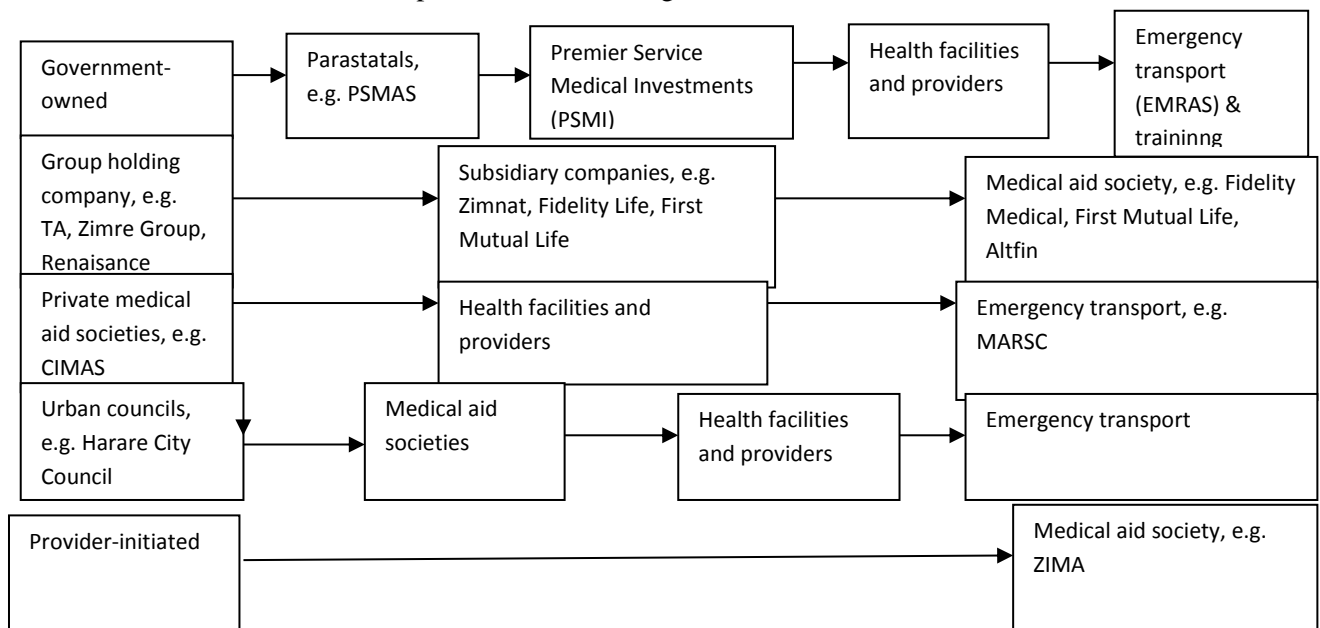


Figure 2.1: Ownership of medical insurance companies in Zimbabwe.

Source: Adapted from Shamu *et al.*, 2010:9

2.9.1 The government form of ownership

PSMAS, in Figure 2.1 above, is an example of a medical insurance company owned by the government. PSMAS, in turn, owns Premier Service Medical Investments (PSMI), which is commonly termed its ‘investment arm’. PSMI, in turn, owns several medical health care clinics, dental surgeries, hospitals, laboratories, and pharmacies, among others. It also owns emergency transport to ferry patients (EMRAS).

The formation of PSMI dates back to 2003 and this was regarded as PSMAS’s “blue ocean strategy to forward integrate medical insurance into medical services provision” (PSMI: Our History, n.d.). With this strategy it sought to provide its clients with greater access to quality health care services and value for their money. According to the PSMI website, PSMI has now more than 100 service centres strategically located in all 10 provinces of Zimbabwe, as well as some service centres in Zambia. There are some claims that the rapid expansion of PSMI is causing operational and service inefficiencies,

which have resulted in the urgent need to restructure the organisation (Chidza, 2016). However, these claims have not been proved by research. This study partly addressed the issue.

2.9.2 Corporate general insurance companies

Another form of ownership identified above is Corporate General Insurance Companies. In this form of ownership, big holding companies like First Mutual Holdings, Fidelity Life Assurance, and TA Holdings own subsidiary health insurance companies like First Mutual Health, Fidelity Life Medical Aid Society (FLMAS), and Sovereign Health respectively. Although medical insurance companies in this category do not own health facilities and providers, most of these, like First Mutual Health, claim to have established networks with providers of medical services, like doctors, specialists, pharmacies, and medical labs. These providers of medical services have been regarded as strategic partners to ensure guaranteed high-quality medical services to their clients (First Mutual Health, n.d.). First Mutual Medical Savings Fund is also reported to have recently entered into an agreement with one of the largest South African health care providers called Net Care. In this agreement, Net Care South Africa will provide health care services to all premier First Mutual Medical Savings clients (Shamu *et al.*, 2010:13).

2.9.3 Private health insurance schemes

Private medical aid societies are another form of ownership of medical insurance companies in Zimbabwe. CIMAS, for instance, was formed in 1945 as medical insurance for employees in the private sector. Since its establishment, CIMAS has grown tremendously. It is claimed that in 2010 CIMAS and PSMAS had a combined market share of 84 per cent of the medical insurance industry (Shamu *et al.*, 2010:5). As indicated in Figure 2.1 above, such medical insurance companies also own medical facilities and providers and emergency transport like MARSC.

2.9.4 Urban councils

Local authorities, like the Harare City council, are also another form of ownership of medical insurance companies in Zimbabwe. These medical insurance companies cover employees who work for the local authority only. They also own medical facilities, medical service providers, and emergency transport. This form of ownership in medical insurance is similar to those owned by certain industries and companies like ZIMPAPERS. Membership of these medical insurance companies is restricted to employees of these organisations and companies. Therefore, these medical insurance companies do not compete with the aforementioned companies, as membership is closed to those who do not work in these companies (AHFoZ, 2008; Shamu *et al.*, 2010). In most cases, service delivery in these medical insurance companies is good, as such organisations try to motivate their personnel through catering for their basic physiological needs, which is good health in this case. However, these medical insurance companies constitute a very small percentage of the populace with health insurance coverage, hence their exclusion from this particular study.

2.9.5 Provider-initiated ownership

In this form of ownership of medical insurance companies, providers of health care services (like medical doctors) form their own medical insurance companies. A good example of a medical insurance company owned by service providers is the Zimbabwe Medical Doctors Association (ZIMA).

Shamu *et al.* (2010:10) argue that the nature of competition between medical insurance companies is determined by the manner in which medical insurance companies are owned. This also determines how publicly owned or privately owned companies compete or complement each other. Moreover, it determines their core business and growth opportunities, as well as how they implement some regulations. From the ongoing discussion, it can be argued that the ownership of medical insurance companies has a bearing on service delivery and service quality. Service quality is likely to be different amongst different forms of ownership of medical insurance companies. Thus, this study sought to establish if there are statistically significant differences in the perceptions and expectations of service quality among customers of differently owned medical insurance companies. The following null hypotheses were formulated:

H4.1: There are no statistically significant differences in customers' perceptions of service quality between government-owned and privately owned medical insurance companies.

H4.1: There are no statistically significant differences in customers' expectations of service quality between government owned and privately owned medical insurance companies.

H4.2: There are no statistically significant differences in service quality gaps experienced by customers in government-owned and privately owned medical insurance companies.

The relationship between health care funders (medical insurance companies), health care providers, and consumers in Zimbabwe is shown in Figure 2.2 below.

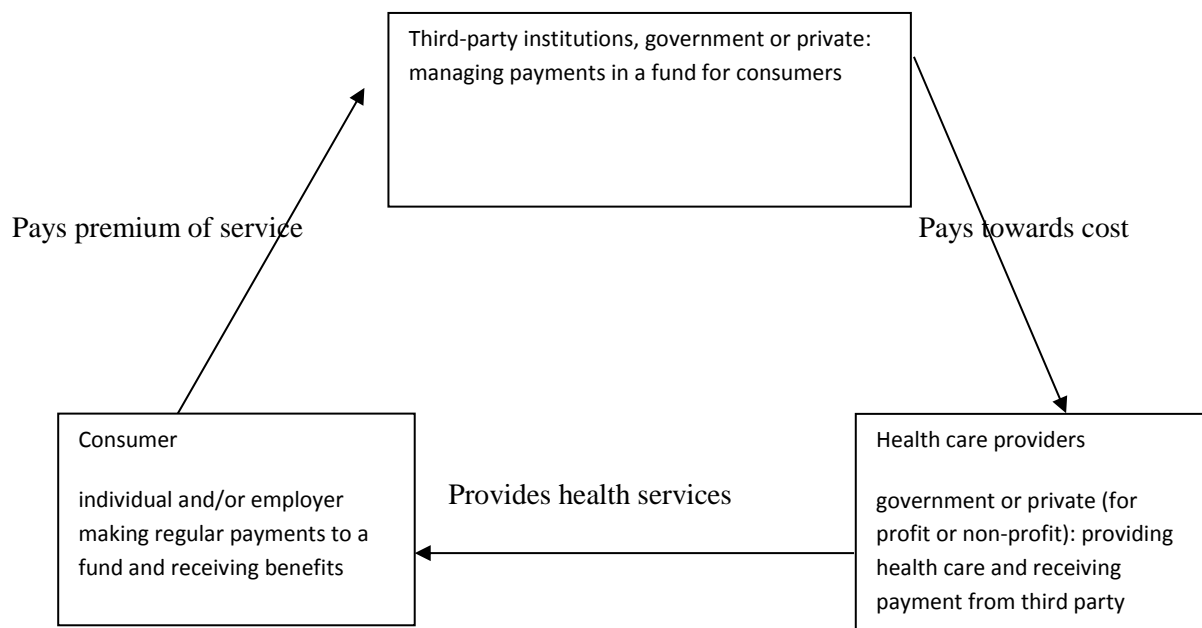


Figure 2.2: Relationships between health care funders, providers and consumers

Source: Shamu *et al.*, 2010: 7

2.10 Approaches to managing service quality in the medical insurance sector in Zimbabwe

Efforts to enhance quality of service in the medical or health insurance sector in Zimbabwe have been centred mainly on quality measures adopted in developed countries like America (AHFoZ, 2014). One of the measures adopted by medical insurance companies in Zimbabwe to improve quality is the ‘Managed health care system’, the origin of which can be traced to America (Campbell *et al.*, 2001:1; Einav & Levin, 2015). This has given rise to many acquisitions and rapid expansion by many medical insurance companies into medical-related businesses, as mentioned earlier. The economic difficulties experienced in the country in the 2000s have been cited as the main reason for the adoption of this system (Shamu *et al.*, 2010:13). Such moves by medical insurance companies were regarded as “a means to tap market opportunity and a way to manage the costs of doctors, specialists and pharmacists” (Shamu *et al.*, 2010:13). Other measures to improve service quality in the health insurance sector are through enacting some regulations in the sector. Although Zimbabwe is reported as having successfully enacted regulations directed at ensuring quality service in the health insurance sector (Doherty 2015:i96; Sanyanga, 2014:5–8), customer perceptions of service quality under such measures have not yet been documented.

2.10.1 Definition of the managed health care system

Although several authors have tried to define managed health care differently, in essence their definitions concur with each other. For instance, Kongstvedt (1997:26) defines it as “a system of health care delivery that tries to manage the cost of health, the quality of health care and access to care”, whereas Woods (1997:5) defines it as “the application of standard business practices to the delivery of health care in the best traditions of the US free enterprise system.” In addition, Kinghorn (1994:4) describes managed care as “a management process which involves contractual arrangements between health financiers and providers which uses incentives, education, regulation and review of providers’ practice to improve cost effectiveness of care.” From these definitions, Campbell *et al.* (2001:1) summarise managed care as a set of tools and concepts applied in organising the financing and provision of health care. In agreement with the above, Folland, Goodman and Stano (2013:237) explain a managed care system as a “network of organisations (e.g. hospitals, physicians, clinics) that provides or arranges to provide a co-ordinated continuum of services to a defined population”. According to Folland *et al.* (2013:238), managed care systems aim for the provision of “additional quality – enhancing features for a given price or to provide a given set of quality attributes or outcomes for a lower price”.

In managed care systems, regulations are put in place “to ensure that plans offer baseline benefits on consumer choice among approved plans and in addition, market rules that promote competition and limit incentives are also laid down” (Einav & Levin, 2015:999). However, the American managed care system has been criticised for mainly focusing on managing the costs instead of improving the health care outcomes. To balance costs against quality medical care, an invention called the ‘United States Patent’ has recently been proposed (White & Chao, 2014:1–2).

2.10.2 A review of the managed health care system in Zimbabwe

Many medical insurance companies adopted the managed care system in reaction to the hostile economic situation experienced in the country in the 2000s. For instance, between 2001 and 2007 PSMAS, through its investment arm PSMI, is reported to have acquired clinics and hospitals, laboratory services, rehabilitation services, pharmacy services, optometry, imaging, dental services, and ambulance services. The provision of these services greatly transformed it from being a health funder to incorporate functions of health care providers, training, pharmacy, and emergency transport services (Shamu *et al.*, 2010:13), as shown in Figure 2.2 above. According to PSMAS, this was also done to deal with the issues of co-payments demanded by health care providers from patients on consultations and treatment, overcharging, over-servicing, and self-referrals. CIMAS was further reported to have made similar acquisitions during the period 2001 and 2006, due to the economic challenges and as a means of controlling the overheads from pharmacists, general medical practitioners, and specialist

doctors, as well as to capitalise on market opportunities (Campbell *et al.*, 2001:1; Shamu *et al.*, 2010:13).

However, despite the acquisitions of health-related businesses by medical insurance companies to reduce overcharging and co-payments and ultimately for service delivery, a beneficiary survey carried out by Shamu *et al.* (2010:14) indicated that medical insurance patients were still making huge payments to health care providers for amounts not covered by their medical schemes. It has also been reported that very few medical insurance plans gave full financial coverage for services provided by other companies. In this particular survey, only 11 per cent of the participants in the survey revealed that they were fully refunded for health care services provided outside their managed care plans. However, 59.5 per cent indicated that they needed approval from their medical insurance companies to see health care providers not on the plan, whilst 31.9 per cent indicated that they did not need approval first (Shamu *et al.*, 2010:14). This raises a question regarding the effectiveness of the managed care system in fulfilling its purposes of reducing overcharging to patients. Since the managed care system is still operational, this study will further enquire into its ability to improve service quality in medical insurance companies through investigating the perceptions and expectations of clients regarding service quality variables, namely reliability, tangibility, responsiveness, empathy and assurance.

2.11 Summary

Illness carries a high risk of impoverishment to households and the nation at large, and medical insurance has evolved as a means to reduce this risk. Hence, medical insurance has been considered a key source of medical-care funding in the health industry world wide.

Zimbabwe is cited as one of the few African developing countries to successfully adopt private health insurance. This success has been attributed to its long history of being a former British colony. The development of private health insurance in Zimbabwe has been a gradual process which dates back to 1930.

From the various types of medical insurance that exist, two broad types can be identified: private health insurance and public health insurance. The Zimbabwean medical insurance type can best be described as voluntary private and non-profit. However, the tendency of medical insurance companies to invest their surplus funds in non-core activities has raised debates. This has led to the conclusion that the description of medical insurance in Zimbabwe has been adopted for tax purposes only.

Medical insurance companies in Zimbabwe are governed by the Government through the Ministry of Health and Child Welfare (MoHCW). Medical insurance companies are also supposed to be registered and accredited by the Association of Healthcare Funders of Zimbabwe (AHFoZ). The governance of the medical insurance industry is necessary to mitigate the problems associated with medical insurance, namely adverse selection, risk selection, and moral hazard. Currently there are 31 medical insurance

companies in Zimbabwe, which fall under five forms of ownership: government, corporate general insurance companies, private health insurance companies, urban councils, and provider-initiated. Ten of these medical insurance companies have closed membership, whilst the rest have open membership.

Efforts earmarked at improving quality of service in the medical insurance sector in Zimbabwe have been mainly centred on quality measures adopted in developed countries like America. One such measure is the managed health care system. This system has led to many acquisitions and rapid expansions by many medical insurance companies into medical related businesses. This research endeavoured to establish customers' perceptions and expectations of service quality under such a system.

2.12 Conclusion

This chapter gave an outline of the medical insurance industry in Zimbabwe. It further defined medical insurance and described the various types of medical insurance before looking at the type of medical insurance that exists in Zimbabwe. It also looked at the governance of medical insurance companies in Zimbabwe and justified the necessity for such governance in the industry. Various forms of ownership that exist in medical insurance companies in Zimbabwe were discussed, as well as the approaches used to manage service quality in these medical insurance companies. The following chapter will review literature on service quality and examine the theoretical underpinnings of the study.

CHAPTER THREE

LITERATURE REVIEW

3.1 Introduction

This chapter deals with the literature on customer perceptions and expectations of service quality in the medical insurance sector. The discussion will start by defining and reviewing literature on the basic terms used in the study, namely services, quality, service quality, and medical insurance. Then the literature on the various characteristics of service quality will be reviewed. These characteristics are reliability, responsiveness, assurance, empathy, and tangibles. Finally, the literature on customer perceptions and expectations in general will be reported and the researcher will try to identify knowledge gaps in these areas in the context of medical insurance companies.

3.2 Service quality

The service sector has experienced tremendous growth in the past years which has resulted in the complexity of the sector. This has caused greater value being placed on service quality and has also caused researchers to show great interest in the area, as evidenced by increased research in the field (Yadav, Rai & Srivastava, 2014:1). Service quality has been regarded as a requirement or strategic tool for firms to attain sustainable competitive advantage (Jain & Jain, 2015; Madan, 2012; Shekarchizadeh, Rasli & Hon-Tat, 2011:67). In the insurance business, the importance of service quality has been noted since the 90s (Stafford, Stafford & Wells, 1998; Toran, 1993). However, in these studies, service quality was measured using the complaint ratio, which is measured as the number of complaints received, divided by the amount of insurance business going on (Rai & Medha, 2013:142). Although there is limited literature on service quality in health insurance, particularly in the Zimbabwean context, a study conducted by Abdelfattah, Rahman and Osman (2015) confirmed that service quality and perceived value are great antecedents of customer loyalty in health insurance products. This study, however, did not investigate the service quality variables most significant in determining customer loyalty in the industry.

A better understanding of the service quality concept requires separate analyses of the concepts that make up the phenomenon. Therefore, the definitions of ‘services’ and ‘quality’ will be discussed individually, ahead of looking at the definition of ‘service quality’.

3.2.1 Services

The term ‘service’ refers to “a work or an action, performance or a social event which is consumed at the place where it is produced” (Collier, 1990:234). It can also be defined as “deeds, processes, and performances provided or coproduced by one entity or person for another entity or person” (Zeithaml *et al.*, 2009:4). Quinn, Baruch and Paquette (1987:51) define services as “all economic activities whose

output is not a physical product or construction, is generally consumed at the time it is produced, and provides added value in forms (such as convenience, amusement, timeliness, comfort, or health) that are essentially intangible concerns of its first purchaser". In addition, Ali and Garg (2017) describe service as any performance or act that is offered by one party to another that does not result in any ownership and is basically intangible. These definitions indicate a difference between services and goods, implying that services have their own unique characteristics. It is imperative for services managers to seriously consider the characteristics of services, as they pose some challenges and require some explicit strategies in building competitive advantage (Ali & Garg, 2017).

3.2.2 Characteristics of services

It is generally agreed that services have characteristics that are very different from goods, which pose some challenges as well as create opportunities for managers of services, as mentioned above. Services are differentiated from goods in that they are intangible, more heterogeneous, simultaneously produced and consumed, and perishable. These qualities of services make service quality a theoretical concept that is very complex to define and quantify (Büyüközkan *et al.*, 2011:9408). Although the above characteristics have been criticised based on advances in information and communication technologies which are believed to have changed the focus of services marketing (Lovelock & Gummesson, 2004; Vargo & Lusch, 2004), their validity has been substantiated by further research in the area and the various aspects of services in which they are useful have been identified (Moeller, 2010:249). For instance, Moeller (2010) found that intangibility is closely associated with the service offering, whereas heterogeneity and inseparability are closely linked with customer resources. These findings help service providers to come up with proper strategies that reduce uncertainty in the services market and increase customer loyalty (Moeller, 2010:366).

3.2.2.1 Intangibility nature of services

Firstly, services differ from goods in that the consumer is not able to touch, see, smell, hear, or feel them before purchase. This, therefore, implies that services cannot be readily exhibited and communicated to clients, making it hard for customers to evaluate and compare services (Ali & Garg, 2017). Furthermore, it is difficult to keep inventories of services and as such it is difficult to manage fluctuations in demand for services (Zeithaml *et al.*, 2009:21). This compels consumers to use price and other signs of quality in the form of physical tangibles, accessibility, communication, and word of mouth to assess quality (Ghobadian, Speller & Jones, 1994:45; Ronnback & Wittell, 2008). This also entails that service providers must provide what they promise customers, right, the first time. In such a setting, physical facilities and frontline employees play a dual role of production and marketing (Haywood-Farmer, 1988).

3.2.2.2 Heterogeneity nature of services

With heterogeneity, no two services are exactly the same, as it is very hard to duplicate a service consistently and precisely (Palmer, 2011). This is because services are performed by humans (and not machines) who differ in their conduct from time to time (Zeithaml *et al.*, 2009:21). Furthermore, customers are also different with unique preferences and demands for services which also differ now and again, even during the service delivery process. Thus, the heterogeneity associated with services is a product of contact between the service provider and the consumer and as such it is impossible to attain uniformity and standardisation of behaviour (Ali & Garg, 2017; Palmer, 2011; Zeithaml *et al.*, 2009:21). This implies a big challenge in ensuring uniform service delivery and quality in a services setting. Furthermore, many factors come into play in determining quality in services. These factors include the capability of customers to express or articulate their particular needs, the motivation and capabilities of workers to fulfil those desires, the influence of other customers, and the levels of demand for the particular service (Ghobadian *et al.*, 1994:45; Zeithaml *et al.*, 2009:21).

3.2.2.3 Instantaneous production and consumption

Unlike goods which are initially made, and then traded and used up, services are produced and used up instantaneously (Moeller, 2010). This entails that mass production is not possible. Furthermore, customer satisfaction and quality of service will be determined by the interactions between customers and employees. More so, quality deficits or mistakes cannot be hidden, due to the involvement of the client in the performance of the product (Ali & Garg, 2017). It is also most likely that the behaviour of customers will influence the service quality perceptions of other customers (Ghobadian *et al.*, 1994:45; Moeller, 2010; Zeithaml *et al.*, 2009:22).

3.2.2.4 Perishability

Services are perishable in that they cannot be saved, reused, inventoried, warehoused, or stored for consumption at a later date (Zeithaml *et al.*, 2009:22). Moeller (2010:364) concurs with Zeithaml *et al.* (2009) and defines perishability as the restricted option to stockpile or inventory services. Whereas goods are produced irrespective of existing demand, this cannot be done with services, of which production depends on the availability of customers as resources. Thus, if customers are not available, the potential capacity to perform a transformation on them perishes (Moeller, 2010:365). This implies that quality checks cannot be done afterwards; hence, the service should be executed right the first time. According to Hilton (2016:475), the aspect of service perishability usually poses challenges to service firms during peaks and troughs. For instance, when customer demand for services is higher than supply, during peaks, the customer waiting period for services is long, which is likely to cause customer dissatisfaction. This requires service providers to employ strategies for managing the service process. For instance, they can reduce waiting times through forecasting demand and employing employee allocation strategies (Hilton, 2016:475). It is therefore argued that “perishability requires careful

demand forecasting along with differential pricing and promotional strategies to even out demand where possible” (Hilton, 2016:475).

3.2.3 Service quality

Quality has been defined differently by different people. Ghobadian *et al.* (1994:47–49) categorise the meanings of quality into five major classes, namely:

- Transcendent – where the product or service is so superior that it has unmatched properties;
- Product-led – where quality is expressed in terms of the components of goodness packed in a product;
- Process- or supply-led – where quality is defined as conformance to requirements;
- Customer-led – where quality is determined by the satisfaction of customer specifications or fitness for purpose; and
- Value-led – where quality entails satisfying the consumer’s needs in terms of availability, price and quality.

Boateng-Okrah and Appiah Fening (2012:744) point to the need to understand the term quality better due to the intensification of competition and the dynamism in the business world. In line with this, modern writers describe quality as meeting or surpassing customer expectations (Beuran *et al.*, 2015:253). Beuran *et al.* (2015) contend that in health care, total quality management should “support the idea that customer (the patient) satisfaction should exceed the expectations and equal a combination of medical services (diagnoses, medicines, surgery) together with safety, security, an appropriate attitude of the nursing staff, right timing in terms of appointment, delay, service, medical treatment and surgery.” Psomas and Jaca (2016:381) concur with the above and maintain that to achieve quality in the current period requires going further than merely meeting specifications as noted by Crosby (1979) or the fitness for use definition of Juran (1992).

Clearly, the concept of service quality has been differently defined by different researchers. Yet, from the different approaches identified in literature, these differences are hardly noticeable. Service quality has been defined as the variance between the actual service performance and customers’ expectations (Mantey & Naidoo, 2016; Wang, Lin & Tseng, 2011). Parasuraman *et al.* (1988:19) also viewed perceived service quality as the “degree and direction of discrepancy between customers’ perceptions and expectations”. Literature has further shown that service quality is concerned with satisfying needs and specifications and assessing the extent to which service delivered fulfils the expectations of customers (Wang *et al.*, 2011). “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” (Büyükożkan *et al.*, 2011:9408). In support of the above, Mullins and Walker (2010) conclude that the basis of a differentiation strategy aimed at offering excellent service should be targeted at meeting or exceeding

the service quality expectations of target customers and to do this more consistently than rivals, thereby gaining competitive advantage.

As a way of measuring the discrepancies existing between the perceptions and expectations of clients about the actual service delivered, an instrument long proposed by Parasuraman *et al.* (1988:12–40), known as the SERVQUAL scale, is used. From the point of view of Ladhari (2009), the gap scores are valuable in identifying the organisation's points of strengths and weaknesses which can be used by management to diagnose target areas for improvements. The SERVQUAL model was initially brought into being in 1985 and was further revised in consequent years. This model has been tested in various service sections which include banks, tourism, maintenance and repairing, insurance, credit cards, telephone services, and appliances, among others (Madan, 2012). The ultimate structure of the SERVQUAL tool has 22 pairs of perceptions and expectations measuring objects, and it is categorised into the five service quality variables referred to above (Parasuraman *et al.*, 1988:12–40). Although the SERVQUAL tool has been subjected to great criticism (discussed below), it however remains the fundamental device employed in service quality studies and its qualities of being flexible and easy to apply cause it to gain high preference from researchers (Purcarea *et al.*, 2013:576; Trocchia & Janda, 2003:243).

In the health care field in general, several studies were conducted on service quality using the SERVQUAL scale, and diverse results were obtained in terms of dimensions most influential in determining service quality (Büyükožkan *et al.*, 2011:9411). However, in these studies some factors have emerged as more significant than others in influencing service quality. This depended heavily on the different conditions which prevailed in the situations studied. Short and extended models of the SERVQUAL scale were proposed by different research analysts in the health care area and elements such as affordability, accessibility, outcomes, and caring were added to the list of characteristics (Purcarea *et al.*, 2013:577). Due to these diverse outcomes obtained in studies conducted in health care, such findings cannot be generalised to the medical insurance sector. Hence, separate studies should be conducted in this sector. Although medical insurance services are closely related to health care services, these are totally different fields that render separate investigations about customers' perceptions and expectations of service quality in their different localities.

As highlighted above, the basis of a differentiation strategy centred on offering excellent service should be targeted at meeting or exceeding the expectations of customers on service quality and to do this more constantly than rivals (Mullins & Walker, 2010). Companies that possess some competitive advantage have been found to be more profitable than companies competing without any advantage (Thompson, Strickland & Gamble, 2010:139). A company gains a sustainable edge above its competitors when several customers prefer its services or products to those offered by its rivals, more so if the basis of the advantage is enduring (Thompson *et al.*, 2010:139). In the views of Švárová and Vrchota (2014:688), the greatest miscalculation by business organisations is to assume they are knowledgeable of their

competitive advantage, when in real terms they are not, or if they possess the benefit, but fail to exploit it. This study will therefore assist health insurers in building some competitive advantage along service quality pre-requisites that are empirically proved to be the most significant in the industry.

3.3 Service quality in health insurance

Insurance has generally been regarded as a very complex product, understood by only a few people (Austin & Hungerford, 2010; Singh, Sirohi & Chaudhary, 2014) and insurers thus took advantage of the fact that this area is least known to customers. As a result, insurance providers experienced little pressure to provide quality services. However, increased levels of education and knowledge in people have changed this position and insurers have seen the need to invest in good customer relationships and service quality in order to improve customer retention (Pashaie, Fatemi & Ahmadi, 2013:172).

The importance of service quality in the insurance sector has been ascertained by research and it has been posited that the needs of the customer should be greatly considered in developing strategies. Competition is reported to have intensified in the insurance sector and the sector is so volatile “that good relationships can quickly turn sour with even one negative encounter” (Joseph, Stone & Anderson, 2003:83). Although some studies on service quality have been conducted in the general insurance sector and the health care sector in general, an online search shows very few studies in the private health insurance sector. Closer studies were conducted on national health insurance schemes, and in most of these studies the SERVQUAL tool was not used to measure service quality.

Gopalkrishna, Rodrigues and Varambally (2008:49) are of the view that service quality researches in insurance are not fully developed, although insurance is known as one of the rapidly growing services segments. In their study they aimed to develop a metric for service quality, specifically for the insurance sector, and to apply it in investigating the perceptions of service quality. Although the study used the customised SERVPERF model and not the SERVQUAL model, it was found that insurance providers give more importance to the “tangibles of service”, whilst giving less importance to “core service” (Gopalkrishna *et al.*, 2008:59). Furthermore, the human element also ranked poorly among the five dimensions used in this study, hence the need for service providers to offer necessary instruction and development courses to their personnel to enhance their skills. It was also found that the service quality of private insurance providers is slightly better than that of the public sectors.

In a study by Tsoukatos and Rand (2006:513), the SERVQUAL dimensionality was not confirmed in the Greek insurance industry. In this study it was found that ‘tangibles’ were not significant in determining customer satisfaction, while word of mouth (WOM) was found as an antecedent of repurchasing behaviours. It was thus concluded that managers must work on improving the non-tangible rather than the tangible aspects of service and channel their support mechanisms towards building the willingness of customers to engage in positive word of mouth, which undoubtedly results in the efficient

utilisation of resources in the insurance sector. These findings concurred with those of Gopalkrishna *et al.* (2008:59) mentioned above.

In a study by Bala, Sandhu and Nagpal (2011), aimed at evaluating service quality in life insurance, it was established that the SERVQUAL instrument could not be applied to the Indian life insurance sector. However, a study conducted by Singh *et al.* (2014) on customer perceptions of service quality in life insurance companies revealed that responsiveness and assurance, convenience, empathy, and tangibles were the major determinants of customer perceptions of service quality. However, in this study it was pointed out that life insurance was more complex than other insurances because of its focus “on future benefits that are difficult to foresee and take a long time to prove” (Singh *et al.*, 2014:21). This, together with the variability of the results obtained on service quality in the insurance sector, call for separate studies to be conducted in the health insurance sector, particularly in Zimbabwe, in order to ascertain customer levels of satisfaction and suggest customer centric strategies for the sustainability of the industry.

Mohammed *et al.* (2011:20) are of the view that health insurance schemes in many less-developed countries are still in their early implementation stages and acknowledge that there has been insufficient literature on the situation in African developing countries that deals with customer satisfaction under a health insurance scheme setting. They therefore carried out a study in Nigeria which aimed at understanding the enrolees’ satisfaction with provision of health services under a health insurance plan and determining the factors influential on client contentment. The results of this research showed that the level of customers’ satisfaction with the health insurance scheme was a bit low (42 per cent). It was also found that enrolees’ satisfaction with the service offerings of health insurance was determined by a number of factors, which included lack of knowledge about health insurance, together with the beneficiary’s lack of awareness of contribution. However, in this study, customer satisfaction was not measured in terms of the SERVQUAL model and thus the service quality characteristics that mostly affect customer satisfaction remain unknown to participants in this industry.

Dalinjong and Laar (2012:1) also undertook a study to assess the influence of the National Health Insurance Scheme (NHIS) on the conduct of healthcare providers when treating both uninsured and insured customers. In this study it was established that the NHIS promoted health care accessibility to the insured and mobilised funds for health care providers and both the uninsured and the insured were contented with the care. However, a larger number of the insured experienced discrimination, verbal abuse, and long waiting times in favour of the uninsured and wealthy. This was attributed to increased workloads on the part of insurers as a result of increased utilisation of health care services by the insured. Furthermore, the delayed disbursement of funds by insurers caused service providers to prefer customers who would make immediate payments and these out-of-pocket payments from the uninsured enabled service providers to conduct operations whilst they waited for the NHIS to make payments for services provided to the insured. Although this study tried to give an overview of the quality of service

that the insured experience, it was not directed at the services of the health insurers and did not look much into the expectations of the insured from the insurers' point of view. Furthermore, the nature of the health insurance in this study is more social in nature (different from the Zimbabwean situation) and does not warrant competition among many health insurance providers. The methodology used also did not enquire much into service quality and the characteristics of service quality that can be utilised to enhance service delivery in this industry remain unknown.

In a study carried out by Atinga (2011:144–161) to examine the perceptions of premium holders of the National Health Insurance Scheme in Ghana on health care quality, the human dimensions of service quality constituted an important determinant of perceived service quality. The relations of the insured with the health care providers, as well as the attitude of service providers, were perceived to be positive. However, the perceptions were investigated on a health insurance provided by the state and not by private insurers. Furthermore, the study was not carried out with a direct focus on health insurance services, but generally on health care under a national health insurance scheme.

Boonen, Laske-Aldershof and Schut (2015:339–353) also undertook a study in which they attempted to improve the knowledge on consumers' switching behaviour in the perspective of a managed competition Dutch health insurance market. They found that the propensities of customers to switch between insurers depend not only on the price of the health plan, but also on service quality. In this study, switching decisions were also found to be determined by the age of the beneficiaries, their education, health, and their possession of group or supplementary insurance. Young age groups were found to be more price sensitive, whereas older people were more quality sensitive. However, different results are likely to be obtained in a different setting like Zimbabwe, where conditions for health insurers are different and perceptions and expectations of customers about health insurance services are least known. For instance, in the Dutch health insurance market, insurance is compulsory to all citizens. Furthermore, the benefits packages are standardised and insurance providers obtain risk-adjusted capitation compensation on top of a community-rated premium (Handel, 2013:2644). According to Boonen *et al.* (2015:340), a large number of studies on health plan choices are conducted from a US group-health insurance market perspective and most of the studies on health plan choice outside the United States are conducted in Germany, the Netherlands, and Switzerland. In these countries, individuals have the freedom to choose their desired insurer during periodic open enrolment terms. Thus, customers' perceptions of service quality under such settings are likely to differ from those of customers in a developing economy like Zimbabwe, where employers significantly influence the choices of health insurers. Furthermore, the conditions that determine customer perceptions and expectations of service quality are different in these countries. This therefore calls for a separate study to be conducted in the Zimbabwean context to ascertain customer perceptions and expectations of service quality and to come up with appropriate service quality strategies.

Today health care insurers are confronted with intensified competition from the US and the Netherlands (Knottnerus & Ten Velden, 2007:2424; Seddon, 2008:103; Van de Ven & Schut, 2008:775). In Zimbabwe, service quality and consumer satisfaction are also increasingly becoming critical aspects for health care insurers, especially in differentiating themselves from competitors (Wendel, De Jong & Curfs, 2011:311). Health insurers therefore fight for customers on the basis of quality of the insurance package and the services they are offering. Recent studies have shown that customers' contentment with the service of their current insurer is a significant factor in making the decision to stay insured with the same insurer (Brabers, Reitsma-Van Rooijen & De Jong, 2012:30; Wendel *et al.*, 2011:311)

The above findings were confirmed by Amo-Adjei *et al.* (2016:317) in their study on "perception of quality of health delivery and health insurance subscription in Ghana". The study aimed at establishing how the perception of service quality under the National Health Insurance Scheme (NHIS) determines subscription to health insurance. In this study, a high proportion of respondents (33 and 35 per cent females and males respectively) indicated that quality of health service provided to insurance policy holders was very poor, which discouraged them to own health insurance policies. The study concluded that commitment to provide quality services to insurance beneficiaries had the potential of offering significant benefits of extending the life span of the plan, coupled with providing cheaper medical services.

A closer study was conducted by Asghari and Babu (2017) in which they compared policyholders' perceptions and expectations of service quality offered by Indian health insurance companies in Bangalore using the SERVQUAL tool. In this study, service quality was found to be weak in all the five dimensions, with the highest service quality gaps being recorded in the responsiveness dimension, followed by assurance, tangibility, empathy, and lastly reliability. However, these results cannot be generalised to the Zimbabwean context, firstly due to the non-probability sampling technique used (convenience sampling). Secondly, the conditions which prevailed in the Indian Bangalore city are different from those in Zimbabwe, causing customer perceptions and expectations of service quality to be different in these areas. Therefore, since service quality has never been empirically measured in the Zimbabwean private health insurance sector, this is the thrust of this study. As mentioned earlier on, this will enable the formulation of appropriate strategies to sustain the industry.

3.4 Efforts to improve service quality in private health insurance

Remarkable moves to augment service quality in the private health insurance sector have been recognised in developed countries like USA. Such moves were done with the help of reform programmes in health insurance targeted to reduce the costs of medical insurance (Einav & Levin, 2015). The Managed Health Care System (MHCS) is one such American reform programme designed to improve service quality. MHCS regulations are put in place "to ensure that plans offer baseline benefits on consumer choice among approved plans and in addition market rules that promote

competition and limit incentives are also laid down” (Einav & Levin, 2015:999). According to Einav and Levin (2015), it is believed that structured managed competition can harness efficiency under private health insurance. However, these authors further argue that under such systems, health insurance companies may end up not having strong incentives to contest on quality and price. They also add that the impetus for insurers to compete on quality and price is dependent on members being price sensitive and informed, neither of which is guaranteed. The American managed care system has thus been criticised for focusing mainly on managing costs instead of improving the health care outcomes. Systems that instead put emphasis on the customisation of care have been proposed (White & Chao 2014:1–2). However, before such measures are implemented, there is need for a thorough investigation of customer perceptions and expectations in the health insurance sector to come up with systems that are customer centric.

The *Patient Protection and Affordable Care Act of 2010* (ACA) was also effected in America to ensure quality in the health insurance sector (Aldhizer & Juras, 2015:66). Under the ACA, the individual health insurance market is centred on regulated national insurance exchanges (Einav & Levin, 2015). In the views of Aldhizer and Juras (2015:66), this was in response to the pressures from private insurers and the government to transform the whole system from the “volume-based fee for service (FFS) model”, which promoted large quantities of services being provided at the cost of quality of care and price. Thus, in the context of this new reform programme (ACA) in the United States, emphasis would now be on rewarding excellent quality care offered at lower costs. This has been achieved through a scheme known as ‘clinical integration’, which is an integrated medical system based on management principles that ensure exceptional harmonised care that facilitates effective operations through increasing profit margins and reducing costs. This entails that with clinical integration, the consolidation of the industry has been motivated by the desire to exhibit outstanding service quality and to manage patient care as well as the need to cut overheads and increase compensation rates for Medicare under the ACA (Aldhizer & Juras, 2015:66).

Custer (2015:1) concurs with these efforts adopted in enhancing service quality in the health insurance sector and claims that “the changing health insurance marketplace places more incentives on insurers to reduce premium cost growth”. He further admits that the health insurance industry and health care delivery systems are evolving incessantly, and several trials were done to come up with the perfect combination of the preferences of stakeholders that simultaneously increases the quality of care provided and costs incurred. Thus, in Custer’s (2015:1) view, “health insurance plan design in the 21st century is evolving on three paths: providing consumers with the incentive and tools to stay healthy; creating and sustaining integrated healthcare institutions that maintain the health of the whole person and giving providers the incentives and tools to keep patients healthy”. In this context, “reference-based pricing” was advocated for. This system requires the health insurance to pay the referenced charge only and any costs over and above the reference price become accountable to the client. Such a system

enhances superiority through enabling clients to look for service providers that offer health services at the proper combination of cost and quality.

Despite the successful implementation of the above efforts to improve service quality in America, and with Zimbabwe also aspiring to adopt similar efforts (AHFoZ, 2014), the basis of such measures are not known and apparent. In addition, the efficiency of these measures has not been evaluated in the context of customers and it is not clear whether customers are happy with these health reforms. Since there has been lack of literature on the SERVQUAL model in the context of the private health insurance sector, particularly in the Zimbabwean context, this study will try to close this gap.

A study on the “conceptual framework of service quality in healthcare” was conducted by Padma, Rajendran and Sai (2009:157–191). In this study it was found that patients’ needs varied between the demographic variables of patients, including age and gender. These authors also found that different segments or categories of customers had different tastes and attitudes, which greatly affected satisfaction and quality judgements. Therefore, according to the findings of Padma *et al.* (2009:171), demographic variables have a significant effect on the perceptions of service quality by patients. Purcărea *et al.* (2013:583) further note that the perceptions of patients have progressively emerged as a significant component in influencing the quality of service in the context of health care services, even in circumstances where they vary remarkably from those of providers. Therefore, these authors emphasise the need for continuous assessment of consumer expectations and perceptions in an ever changing environment characterised by changes in lifestyles, preferences, and demographics.

Although service quality evaluations have been made in various sectors of health care to establish customers’ perceptions concerning patient satisfaction, it appears as if justice has not been done to the private health insurance domain, particularly in the Zimbabwean context. This will therefore be the main focus of this study and literature will be reviewed in the context of the objectives of the study as stated in Chapter 1. Thus, literature will be reviewed on customer perceptions and expectations of service quality and on the five dimensions of service quality, listed earlier.

3.5 Customer perceptions of service quality

Customer perceptions are personal judgements by customers of actual service encounters (Zeithaml *et al.*, 2009:102). Banerjee and Sah (2012) also describe the perceived quality of service as the way customers feel about the services’ excellence. In other words, these authors view customer perceptions as the way customers perceive services, particularly whether they feel they have experienced quality service and whether they are satisfied with the service. Thus, customer perceptions are the major determinants of customer contentment and service quality. Still, customer perceptions are believed to be influenced by various factors which include demographic variables. For instance, in several studies conducted on service quality it was found that gender considerably influences service quality

perceptions and the relative significance attached to several service quality variables (Devi Juwaheer, 2011; Kwok, Jusoh & Khalifah, 2016; Mokhlis, 2012).

Moreover, Kwok *et al.* (2016) assert that demographic variables like gender, age and income are major determinants of customer perceptions and they have been traditionally used by marketers to segment customer markets. These marketers further argue that demographics provide businesses with a means of determining the market segments which are practical in terms of attaining market penetration. In a study by Bhat and Jain (2007), gender was found to have a significant role in the insurance decision through its effect on expected medical consumption. Singh *et al.* (2014) also found age as a significant factor that determines the perception of service quality, whilst gender and other demographic variables like educational and income levels did not show a noteworthy relationship with service quality. A study by Omar, Ariffin and Ahmad (2016) also found gender as a moderating factor between customer satisfaction and service quality.

Based on the literature, this study sought to understand the variability of customer perceptions and expectations along some demographic variables, as these will form the basis for designing health insurance plans or products and service quality strategies in the medical insurance sector. This led to the formulation of the following hypotheses (section 1.5.3) to be tested in this study:

H1.1: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers in different age groups.

H1.2: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers.

H2.1: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups.

H2.2: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers.

Earlier attempts by researchers to establish the role of expectations in operationalising and conceptualising perceived service quality have stirred debate among scholars on the use of the terms 'service quality' and 'customer satisfaction'. Although there has been considerable debate on using the terms 'satisfaction' and 'quality' interchangeably, it has been established that the two aspects are disparate in terms of their fundamental causes and outcomes.

3.5.1 Service quality versus customer satisfaction

Despite similarities noted in service quality and customer satisfaction, there is consensus that customer satisfaction is regarded "as a broader concept", whilst service quality centres particularly on the characteristics of service (Zeithaml *et al.*, 2009:103). From this perspective, perceived service quality

is an element of customer satisfaction. The relationship between service quality and satisfaction is shown in the diagram below:

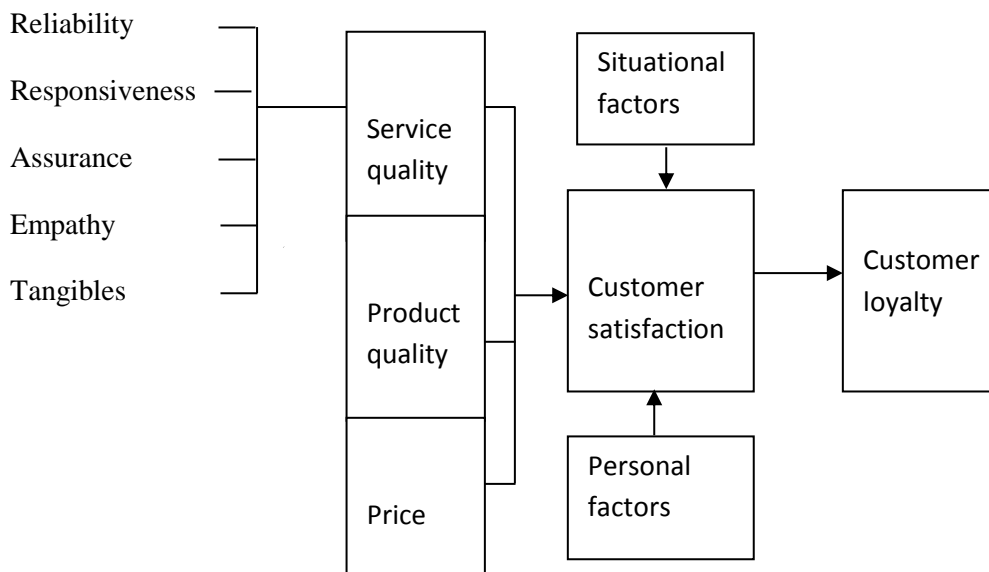


Figure 3. 1: Customer perceptions of quality and customer satisfaction.

Source: Zeithaml *et al.* (2009:103)

As indicated in Figure 3.1, service quality is a purposeful assessment that reveals the customer’s perception of the five dimensions of service as defined in this study. On the other hand, customer satisfaction is a broader concept that is determined by product quality, price, service quality perceptions, together with personal and situational factors.

Customer satisfaction is considered as the “judgement that a product or service feature, or the product or service itself, provides a pleasurable level of consumption-related fulfilment” (Oliver, 2014:13). Jain and Jain (2015) concur with Oliver (2014), considering service quality as an enduring attitude whilst regarding customer satisfaction as a momentary judgement made based on a particular service encounter. Satisfaction is further explained as a client’s assessment of a service or product in terms of the ability of the product or service to meet the expectations and desires of customers (Zeithaml *et al.*, 2009:104). It is assumed that dissatisfaction arises when expectations and needs are not met. Although some literature contend that “satisfaction” is a determinant of “service quality” (Bitner, 1990; Bolton & Drew, 1991:375), it has been scientifically proven by research that satisfaction is a result of perceived service quality (Lee, Lee & Yoo, 2000:217–231).

Baker, Parasuraman, Grewal & Voss (2002:120–141), suggest that there are three aspects that influence customers’ perceptions, namely the physical environment, the customer’s interface with the physical and non-physical aspects of the service domain, as well as the appearance, perceptions and behaviour of other customers. They further highlight that in the physical environment aspects like music, lighting,

and external and internal design affect perceptions of customers and that the behaviour of employees is a major determinant of how the service will be appreciated. The behaviour of customers also affects perceptions, mainly through word of mouth. Sweeny, Soutar and Mazzarol (2008:348) concur with the above, adding that the probability of word of mouth to affect perceptions depends on the kind of the relationship between the dispatcher and the recipient, the strength and richness of the message, and the manner in which the message is delivered. Several researches have been conducted to establish the strong link between service quality and customer satisfaction and purchase intentions (Hsiu-Lan Wu *et al.*, 2008:1311).

Basing on studies conducted in the general insurance sector, it can be claimed that client satisfaction with the service offerings of their existing medical insurer is a significant determinant factor of continued subscription to that insurer (Amo-Adjei *et al.*, 2016:317; Reitsma-Van Rooijen *et al.*, 2011:95; Wendel *et al.*, 2011:310). Furthermore, since literature has proven that service quality affects customer satisfaction directly (Banerjee & Sah, 2012; Lakshmi & Santhi, 2015), there is need for managers of medical insurance companies to understand what customers want and how they assess medical insurance service quality.

3.5.2 Transaction versus cumulative perceptions

Perceptions can be based on either a single specific transaction or cumulative perceptions of a company based on several experiences (Zeithaml *et al.*, 2009:103). Transaction-specific perceptions are formed when a customer forms a perception of a specific encounter centred on aspects of the service encountered in that particular business deal and such perceptions are at a micro level. On the other hand, cumulative perceptions are overall perceptions of the services offered by an establishment based on the total encounters that a person experienced with the organisation over a period of time. These types of perceptions are important for different reasons and they are complementary rather than competing (Olsen & Johnson, 2003:194). For instance, transaction-specific level perceptions are useful in identifying service concerns and making necessary changes, whereas cumulative perceptions determine overall loyalty to a company (Zeithaml *et al.*, 2009:104).

3.6 Dimensions of service quality

Service quality is a significant element of client perception. The original study of Parasuraman, Zeithaml and Berry (1985:41–50) established multiple factors upon which customers base their perception of quality. These dimensions have been reduced to five and are called the ‘drivers of service quality’ (Zeithaml, 2009:111), frequently referred to in this study. According to Bhattacharjee (2010:67) and Parasuraman *et al.* (1985:41–50), the five dimensions by which clients evaluate services are:

- Reliability: This implicates that the service should be performed with dependability and as per its promise.
- Responsiveness: This concerns the attitude of the service provider to be willing to provide the service. It also includes their sensitivity as well as timeliness in responding to customer requests.
- Assurance: This relates to the knowledge, skill and competence of the service providers. It also indicates their ability to generate trust and faith, and their capability of service delivery with politeness and consideration.
- Empathy: This dimension relates to caring: feeling as well as the ability to provide personalised service.
- Tangibles: This relates to a measure of the effectiveness of the physical evidence of the service provider like design layout and facilities.

3.6.1 Reliability

Reliability is defined as consistency in the service delivery (Gunawardane, 2011:1005). Ibrahimi, Taufik, Adzmir and Saharuddin (2016:15) define reliability as “the ability to deliver expected standard at all time, how the organisation handle customer services’ problems, performing right services for the first time, providing services within promised time and maintaining error records.” Many studies have shown that reliability has been considered as a key determining factor of service quality perceptions among customers (Gunawardane, 2011:1004; Omar, Sadaan & Seman, 2015; Zeithaml *et al.*, 2009:113). Reliability entails the ability of a company to fulfil its promises – promises about pricing, delivery, problem solving, and service provision (Zeithaml *et al.*, 2009:113; Weber, 2013). Keeping promises is regarded as essential in building customer relationships (Weber, 2013). Reliability can also be used interchangeably with trust, which is defined by Wendel *et al.* (2011:312) as customers’ strong belief “in an exchange partner’s reliability and integrity” to fulfil its promises. Omar *et al.* (2015) share these sentiments and argue that it is important to make customers trust in the ability of the organisation to fulfil what it promised to do. Eisingerich and Bell (2008:256–268) have found that the confidence customers have in the healthcare insurer is a critical component which has a bearing towards upholding sustainable dealings and profitability of a company. This has been considered seriously among Netherlands’ health insurers (Boonen & Schut, 2011:256).

Customers desire to deal with business organisations that are faithful in keeping promises – especially promises about core service attributes and outcomes (Zeithaml *et al.*, 2009:113). In the health insurance sector, companies promise their clients certain benefits in the different plans they offer. For instance, in the Premier Services Medical Aid Society, the excel plan offers benefits like airlifting in the case of accidents in places far away from good hospitals. However, no study has been carried out in the

Zimbabwean context to determine the extent to which such promises are kept by health insurance companies.

Lien and Kao (2008:522–526) carried out a comparative study to investigate the importance of service quality characteristics “on customers’ satisfaction across utilitarian and hedonic services”. They defined utilitarian services as those services that fulfil practical tasks and are centred on physical aspects such as dry cleaning, banking, and car repair. Hedonic services were defined as those that relate to the emotional and multi-sensory elements like hairstyling, arts, and dining restaurants. It was found that customers consider service outcome as more important than the process with which the service was produced under utilitarian services. Therefore, to enhance customer satisfaction within utilitarian services, businesses were recommended to invest heavily in improving core benefits, particularly when rivals are offering comparable choices of services. Core benefits can be classified under the reliability dimension under the SERVQUAL model. From the definitions given, health insurance services qualify under utilitarian services and it can be postulated that reliability and customer satisfaction are positively correlated in health insurance.

The above postulation also supports the findings of a study conducted by Pashaie *et al.* (2013:172) to assess general customers’ expectations and perceptions of insurers in view of services provided in the insurance service counter. This study found reliability as one of the critical determinants of service quality amongst insurers. Several other studies have also found the reliability dimension as having a positive direct relationship with perceived service quality and satisfaction (Iberahim *et al.*, 2016; Mamilla, Janardhana & Anjan Babu, 2013; Omar *et al.*, 2015). However, the significance of the reliability dimension in the Zimbabwean medical insurance service quality still needs to be confirmed by research, and this will result in the formulation of appropriate service quality strategies in the industry.

3.6.2 Responsiveness

This attribute emphasises attentiveness and speed in handling customer complaints, problems, questions, and requests. Thus, responsiveness assesses the willingness and ability of a company to provide service promptly when dealing with customers’ problems and questions (Iberahim *et al.*, 2016:15; Zeithaml, Parasuraman & Malhotra, 2002:364). Gummerus, Liljander, Pura and Van Riel (2004:183) are of the view that the ability to understand customer needs and to develop service based on responsive comments promotes service satisfaction as well as trust. According to Zeithaml *et al.* (2009:114), responsiveness is shown by the time-span that customers wait for their questions to be answered, problems to be solved, and generally to get assistance. In the health insurance sector this is shown by the waiting periods that clients need to observe before receiving membership cards that enable them to access health care, as well as the rate at which their queries are attended to and solved. Since insurance is the business of settling claims (Jain *et al.*, 2014), responsiveness in medical insurance is

also judged by the promptness in settling medical claims of customers (Nsiah-Boateng, Aikins, Asenso-Boadi & Andoh-Adjei, 2016). These views are in line with the opinion of Joseph *et al.* (2003:89) that in the insurance industry it is necessary to develop a personal relationship with the customer and customers' claims should be handled as quickly as possible.

Research has shown that prompt settlement of claims in health insurance enable the reliability of services to be attained through enabling health service providers to provide continuous and adequate services to the insured (Nsiah-Boateng *et al.*, 2016). Furthermore, research has found technology as an effective tool that enables organisations to perform their activities consistently and to fulfil customer requirements quickly in a manner that raises customers' level of satisfaction (Iberahim *et al.*, 2016). This should be seriously considered by health insurers in their efforts to provide service quality in the industry.

Lee *et al.* (2000:222) argue that, although the human factor element is important in most services sectors, the effect of people on service quality on the whole varies across service industries. They further classified service industries into people-based and facility/equipment-based industries. They concluded that the dimension of service quality that is very closely associated with people is responsiveness. Based on this premise, since health insurance can be classified as a people-based service, it can be argued that responsiveness and customer satisfaction are positively correlated in health insurance.

3.6.3 Assurance

This dimension entails inspiring trust and confidence in customers. According to Rousseau, Sitkin, Burt and Camerer (1998:395), "trust" refers to "a psychological state composing the intention to accept vulnerability based on expectations of the intentions or behaviour of another". Patient trust has been more specifically described "as the optimistic acceptance of a vulnerable situation in which the patient believes the healthcare provider will take care of the patient's interests" (Hall, Dugan, Zheng & Mishra, 2001:615). The aspect of trust was further defined in the context of the medical system as a whole, clinic, hospital, healthcare provider, and health insurance provider. According to Yousapronpaiboon (2014), assurance is the employees' ability to inspire confidence and trust to customers and their knowledge of courtesy. Trust can exist either at firm level or individual level and it is taken to exist when one party is confident in another partner's integrity and reliability (Kassim & Abdullah, 2010:356). Trust has been found to be positively correlated to corporate image and loyalty (Hussain *et al.*, 2015).

Kitapci, Akdogan and Dotyol (2014:161–169) undertook a study to examine the effect of service quality characteristics on satisfaction and how the intention to make repeat purchases and positive word of mouth is affected by satisfaction amongst Turkey outpatients. This study confirmed assurance and empathy as significant determinants of satisfaction in public health care. However, since the study was

undertaken in the public health care industry, these results cannot be generalised to the health insurance industry.

According to Zeithaml *et al.* (2009:114), assurance tends to be of great significance in services that clients consider to be more risky, or those services that clients are unable to evaluate with certainty, like legal, medical, brokerage, and banking services. These views are supported by the findings in a study by Singh *et al.* (2014), where assurance was amongst the four major factors that influence customer perception of service quality in life insurance companies. In public health care, assurance was also found as a critical determinant of customer satisfaction (Ramanujam, 2011).

It was believed that in a managed competition system, assurance could be attained through allowing health insurers to selectively contract some providers (Hall, Dugan, Balkrishnan & Bradley, 2002:197–206). This was likely to intensify rivalry among service providers and ultimately improve the superiority of care, thereby containing health care costs in the process. However, insurance providers were not willing to adopt selective contracting, due to fear of losing beneficiaries who had restrictions in the choice of care providers. Despite these fears, research confirmed that trust in the insurance provider is a vital requirement for beneficiaries to accept selective contracting (Bes, Wendel, Curfs, Groenewegen & De Jong, 2013:375). From the above, it can be claimed that assurance has a major effect on client satisfaction in health insurance.

3.6.4 Empathy

Empathy is defined as the considerate as well as personalised attention that the organisation gives its clients. The underlying principle of empathy is acknowledging that clients are valuable and distinctive and that their desires are taken care of through giving them personalised or customised service. Customers need to be understood and to feel important to their service providers (Zeithaml *et al.*, 2009:115). Barlow and Maul (2000:68) are of the view that all service providers should give individualised attention to their clientele and should nurture the ability to ‘empathise’. They further define empathetic people as individuals who are sensitive to others, understand and are able to get into another person’s feelings and motives.

From many studies conducted, empathy has been found to have a motivational influence on parties involved, adding to quality in the work place (Costa, Glinia & Drakou, 2004:334). The benefits of empathy include effective listening, which results in customer retention and an optimal experience through encounters with empathetic employees (Barlow & Maul 2000:140). Listening and empathy have been found to be positively related (Argarwal, Castleberry, Ridnar & Shepherd 2005:17) and empathy is believed to be expressed through listening (Drollinger & Comer, 2012:52). Costa *et al.* (2004:335) share these sentiments and further consider empathy as the key source of pleasurable moments and interfaces between employees and customers, which result in increased total service quality perceptions and the organisation’s competitiveness.

Although different scholars have tried to conceptualise empathy in various ways, it has been commonly agreed that “empathy results in adaptive and pro-social” behaviours (Wieseke, Geigenmuller & Kraus, 2012:317). They further assert that empathy also improves the ability of an individual to relate to other individuals and to behave in ways most suitable for the conditions. Itani and Inyang (2015:695) share similar sentiments and argue that sales people who demonstrate empathy through taking the perspective of their customers can better comprehend customers’ needs, since they are able to see things from customers’ point of view.

Itani and Inyang (2015:692–716) conducted a study on “the effects of empathy and listening of salespeople on relationship quality in the retail banking industry”. They found that it is imperative for banks to recruit salespersons who are “good listeners” or “empathetic listeners” in particular. Their findings also suggested that bank managers should consider the listening and empathy levels in their potential candidates when recruiting new salespeople. They further recommended that managers reduce levels of felt stress (FS) so that they become more empathetic.

In a study conducted by Varca (2009:51–56) to examine the relationship between empathy and role stress among front line employees, it was discovered that role conflict increases when an employee is engaged in emotionally empathetic behaviour. This study revealed that it is an emotional battle for the service providers to demonstrate courtesy, suppress frustration, and show patience when dealing with customers. Therefore, managers were encouraged to come up with flexible policies and procedures which enable employees to respond effectively to customers’ demands. He also recommends that front-line employees should be given greater autonomy to interpret policies and make unrestricted decisions during service encounters. This study was, however, conducted in a communication firm the USA and different findings might be obtained in the health insurance industry and in any other country.

Empathy is regarded as a valuable ‘people skill’ together with “self-awareness, managing emotions, motivating oneself and handling relationships” (Salovey & Mayer, 1990:332). It is achieved by placing oneself in the position of another and perceiving how the other person experiences the process. Costa *et al.* (2004:185) define empathy as a social or communication skill of paying attention to other people’s needs by being considerate to their feelings. They further allude to the fact that literature review shows that empathy has been given little attention in service researches and in most cases it has been regarded as the least significant factor in service quality. In a study by Costa *et al.* (2004:340), it was concluded that the importance of empathetic behaviour should become the centre of future studies in consumer behaviour and in staff training programmes. They further recommended that organisations should train employees to be empathetic parallel to training in other service quality characteristics.

Zhang, Xie, Huang and He (2013:82–102) carried out a study to examine the characteristics which contributed most to service quality in the car rental business in China, using the SERVQUAL model. This study revealed that empathy was the significant aspect that influenced service quality and that it

also had a great effect on customer satisfaction and loyalty. Thus, it was concluded that in the car rental business it was vital to attract customers using personalised services or empathy.

In a study by Ismail, Haron, Ibrahim and Isa (2006:738–756) that assessed the relationship between service quality and client contentment and loyalty in audit organisations, it was found that empathy had the greatest service gap of -1.9, which implied that customers expect auditors to show more caring and to be able to give personalised attention. It was also found that the service output of audit firms did not meet the expectations of audit customers in all service quality dimensions, except for tangibility. Yet, tangibility was found to be the least important dimension; thus it was concluded that the appearance of the audit firms' physical aspects was not very significant when conducting the audit tasks.

3.6.5 Tangibles

Tangibles present physical images or representations of the service that are normally used by customers, new customers in particular, to assess quality (Zeithaml *et al.*, 2009:115). Parasuraman *et al.* (1988:12–40) consider tangibles to be one of the 'solid' elements utilised in assessing service quality. Previously, tangibles had generally been regarded as the least important dimension in all service industries, but more current research has proved the opposite.

Tangibles are also referred to as the “physical environment quality” (Barber & Scacelli, 2010:71), and different researchers have tried to define it differently. For instance, Barber and Scacelli (2010:71) defined it as the “tangible elements of the service which include the appearance of the physical facilities, personnel, communication materials and other physical features used to provide the service in the service facility”. Others have split it into the actual “product consumed during the service” and “production process” and the material support that promotes production of the service (Lehtinen & Lehtinen, 1991:288). According to Johnston (1995:70), tangibles are experienced in the cleanliness of the physical elements and the comfort of the service and amenities. From some studies conducted, the determinants of perceived quality of the physical environment have been classified into facility design, social factors, and ambient conditions (Brady & Cronin, 2001:242; Raajpoot, 2002:110). According to these authors, ambient conditions consist of non-visual elements like scent, music, and temperature, whereas facility design consists of either functional (or practical) or aesthetic aspects (cleanliness and visually appealing aspects). Social elements include the number, types, and behaviour of people within the service environment (Raajpoot, 2002:111; Ryu & Jang, 2008:5).

Mixed results have been obtained from studies investigating the importance of tangibles in customer perceptions. For instance, in a study conducted by Prentice (2013) to examine the link between customer perceptions of service quality and loyalty in casinos, certain groups of customers exhibited positive perceptions of tangibles whilst the other group was found to have very low perceptions of tangibles. Such mixed results have been attributed to differences in sampling methods employed, cultural aspects, and the inherent aspects of different industries (Santos, 2002:293). Researchers have also endeavoured

to investigate the intangible–tangible dimension in services. In this respect they tried to understand how tangibles can influence service quality, and yet intangibility is one of the specific characteristics of services. In the study by Santos (2002:300), it was found that despite intangibility being a significant feature of services, tangibles play a key function in service industries with more tangible elements. This confirmed Chowdhary's (2000) finding that tangibles were more important in capital-intensive rather than in labour-intensive industries. The significance of physical elements was thus shown to differ among different service industries. The study also revealed that the debate around the importance of physical and non-physical components is more multifaceted than suggested by literature to date. Therefore, managers are encouraged to scrutinise the nature of tangibility of their service to attain excellent service quality and profitability.

It has also been concluded that all services involve the physical component which facilitates the service and can be used to determine the quality of service (Oberoi & Hales, 1990:719). This also confirms Zeithaml's (1981:187) views that customers' perceptions of quality are commonly centred on physical evidence rather than the core service. This prompts managers to build a robust corporate image based on tangibles (Santos, 2002:294). The above views are supported by Mack (2017), who argues that the creation of a good corporate image through tangibles has been found as a key strategy for strengthening market position and competitiveness in the market. Therefore, according to Mack (2017), poor service scape causes customers to look down upon a company's services.

Lockyer (2003:298) adds that the physical dimension plays a significant part in service delivery and further enhances customer satisfaction and influences repurchasing intentions. Service industries that emphasise the importance of physical evidence in their strategic moves encompass services in which clients physically get into the organisation to obtain the service like restaurants and hotels, hospitals, banks, airlines, leisure firms, and retail stores (Barber & Scacelli, 2010:75). This was also confirmed by a study by Prentice (2013) where certain groups of customers were found to have positive perceptions about tangibles in casinos. These findings have resulted in the acquisition of state of the art designs, layout, and interior decorations by such organisations to achieve their organisational goals. Tangibles are commonly utilised by service firms to augment their image, act as quality signals to clients, and enable continuity (Zeithaml *et al.*, 2009:115). Most firms mix tangibility with other dimensions to come up with the firm's service quality strategy. A good strategy can be marred through failure to give importance to the physical elements of a company.

Yet, the physical environment has normally been allocated very little significance in business (Brady & Cronin, 2001:44). Furthermore, despite the importance of carefully planning the physical environment in the running of the business, the effect of a design change or physical design on customers is not well comprehended and few studies have been done on this (Barber & Scacelli, 2010:71). This could be attributed to the problems associated with comprehending all the elements of

customer expectations and perceptions of the physical environment and the absence of instruments to absolutely measure them (Raajpoot, 2002:110).

In a study by Barber and Scacelli (2010:70–88) on “the assessment of tangible service quality through the creation of a cleanliness measurement scale”, it was found that customers are prepared to choose, stay in, and make repeat purchases from an organisation on the basis of cleanliness. However, this research was carried out in the restaurant industry in the United States and different findings can be obtained in the health insurance industry and in other countries, since different service quality characteristics have different effects on customer quality perceptions and satisfaction (Liang, Wang & Farquhar, 2009:145).

In a study to analyse “the role and importance of the tangible elements of purchase processes in business to customer (b2c) electronic commerce”, design was found to be a critical element of overall perceived quality and willingness to pass a positive word-of-mouth message to others (Melian-Alzola & Padron-Robaina, 2006:320). Four attributes were discovered to explain the tangible dimension (design), namely navigation, signposting, tools, and explanation. Design was further taken to refer to aesthetic aspects of the website, speed of page download and usability or ease of navigation. The results of this study proved the earlier views wrong regarding reliability as the most significant dimension of service quality, with tangibility regarded as the least important characteristic (Parasuraman *et al.*, 1988:12).

Chowdary and Prakash (2007:493–509) conducted research to find if any generalisation in the significance of service quality characteristics is feasible. This study was necessary since managers are usually not certain of the level of tangibles to incorporate and the right combination of other service quality characteristics to include in their businesses. The study found that generalisation of quality characteristics was not feasible among all types of services taken collectively. However, tangibility was found to be more significant with more tangible actions and it was concluded that tangible cues buttress tangible actions in people processing and possession-processing activities. Tangibility was therefore found to be a more critical aspect in cinema halls and universities than in accounting firms and insurance companies. These results confirmed Bitner’s (1992:57) findings that service-scape has greater significance for customers who stay longer on the business premises (e.g. sporting events, theatres and restaurants) when compared to services that involve fast transactions (e.g. banks and dry cleaners).

The above findings were confirmed by El Saghier and Nathan (2013:4–5) who found the dimension of tangibility not having any significant effect on client satisfaction in the Egyptian banking services, whilst the same service was significantly affected by reliability, empathy, assurance, and responsiveness. In a study by Yesilada and Direktor (2010:962–971) in public hospitals, tangibility was also found to have insignificant influence on satisfaction. Again, the studies mentioned were conducted on services offered in hospitals and clinics and insurance companies. As health insurance companies’ services were not included in such studies, it is difficult to generalise the results obtained to this industry.

In a study by Lee *et al.* (2000:217–231), it was concluded that tangibility would be a more significant element in an equipment/facility-based rather than in a people-based service industry. The health insurance industry can be classified as a people-based service industry. Thus, since clients do not spend a long time in the facilities of health insurance companies and since the service can be classified as more people-based, it can be postulated that tangibility has an insignificant effect on customer satisfaction in health insurance companies.

Reimer and Kuehn (2005:785–808) investigated the association between service-scape and other aspects of quality measured by the SERVQUAL scale. The study revealed tangibility (service-scape) as more significant to restaurant and bank patrons than the other four dimensions in determining quality. These results contradict the findings of Parasuraman *et al.* (1988:12) which indicated that “intangible factors were more important than the tangible factor”.

Baloglu, Mao and Busser (2010:209–220) also investigated the effect of tangible quality constructs on restaurant customers and their behavioural intentions. It was found that tangibility had a positive effect on restaurants and influenced the re-patronage intention. Restaurant operators were thus recommended to direct their focus towards providing an exciting range of food and drinks offered in a distinctive and attention-grabbing manner. This research went a long way in guiding restaurant managers in choosing the most important physical restaurant features and channelling their resources in ways that meet customers’ expectations.

Various studies in service quality confirm the findings by Seth, Deshmukh and Vrat (2005:913–949) in their study that reviewed the various service quality models. They found that time, needs, situation, and the nature of the service setting, among other factors, have a bearing on the service quality measurement and outcome. They also found that customers’ expectations of certain services are ever-changing in relation to the volume of encounters with a given service, time, competitive environment, and many others. This, therefore, calls for the current research to be conducted, since results obtained from other studies cannot be generalised to this particular industry.

Kang and James (2004:266–277) undertook a study aimed at extending their comprehension of service quality through a pragmatic investigation of the conceptualisation of service quality proposed in the European context (Gronroos’s model). The authors initially critiqued the SERVQUAL model on the basis that it focuses on the service delivery process (functional dimension) only, whilst overlooking the service encounter outcomes (technical dimension). They further argued that customers’ perceived service quality is made up of three aspects, namely image, outcome (or technical) dimension, and process (or functional) dimension. However, they later concluded that the process dimension had a bigger effect on overall service quality and image in comparison to the technical aspect of quality, thereby confirming the credibility of the SERVQUAL model. Furthermore, they also concluded that in some services, like the health sector, it is difficult to measure the technical aspect (output). This was

due to the fact that it was very difficult for patients to assess the technical proficiency of service providers as well as the instantaneous results from treatments.

3.7 Service encounters

Service encounter is defined as “a period of time during which a consumer directly interacts with a service” (Shostack, 1985:243). Service encounters are very important in developing customers’ perceptions about services provided. For example, the service encounters experienced by a client at a hotel include the checking in process, being accompanied to the room, taking meals in the hotel dining room, and checking out. According to Zeithaml *et al.* (2009:120), these encounters give the customer a general impression of the firm’s service quality, and every encounter determines the client’s contentment on the whole, as well as the incentive to do repeat purchases in the same establishment. The number of service encounters also determines customer perceptions of the service.

Despite the volume of encounters a client may have with a service provider, each encounter is believed to be significant in building an image of the company in the customer’s mind. Therefore, favourable (or positive) experiences will assist in building high quality images, whereas the opposite is true for many negative experiences. A mixture of negative and positive experiences will result in the client having mixed feelings concerning the business entity’s quality, uncertain of its service delivery reliability, and susceptible to the offers from rivals (Zeithaml *et al.*, 2009:120).

3.7.1 Types of service encounters

In his interactions with a service provider, a customer may experience any one of the three different forms of service encounters, namely telephone encounters, remote encounters and face-to-face encounters (Shostack, 1985:248). Face-to-face encounters are experienced when employees of an organisation have direct contact with customers. Such encounters are usually experienced in hospitals, food outlets, pharmacies, and many others. It is believed that it is very complex to understand and determine service quality aspects in face-to-face encounters, compared to the other encounters mentioned above. This is because of the plethora of variables used to determine service quality, which include both non-verbal and verbal behaviour, tangible variables, and the behaviour of customers during the encounters (Zeithaml *et al.*, 2009:123).

In remote encounters there is no direct human contact, but each encounter is significant in establishing and reinforcing quality perceptions in the customer’s mind. Such encounters are experienced during customer interactions with the service provider’s internet website, emails, and ATM systems, as in the case of banks. All services delivered through internet technologies, for example repair and maintenance troubleshooting, airline ticketing, and retail purchases, are also classified under remote encounters. In these encounters, quality is judged mainly through the tangibles and the quality of the technical systems and processes (Zeithaml *et al.*, 2009:122).

In telephone encounters, the interactions between the firm and the end customer take place over the telephone. Although many organisations, like telecommunications, utilities, and insurance companies frequently experience these encounters, it has been found that almost all manufacturing and service firms to some extent rely on telephone encounters for order taking, general enquiries, and customer service. Variables used in judging quality in these encounters include tone of voice, the knowledge of employees, and the ability to handle customers' issues, which are likely to produce greater variability in different encounters (Shostack, 1985:248).

In the medical insurance industry, each of the three service encounters is likely to be experienced. For instance, with the prevalence of internet capabilities, remote encounters are likely to be experienced as the companies interact with the customers through the internet. Telephone encounters are also experienced as clients make general enquiries about their medical insurance plans. Furthermore, with the prevalence of the managed care system mentioned in Chapter two, face-to-face encounters are also on the increase as customers interact with employees and medical practitioners in the various health service providers owned by the medical insurance companies. This makes the prediction of customer perceptions among the various service quality characteristics very difficult, and this becomes one of the key objectives of this study.

3.8 Customer expectations of service

The most important step in service quality delivery at any level of operation is to understand what customers expect (Ramseook-Munhurrin, Lukea-Bhiwajee & Naidoo, 2010). Customer expectations are defined as the "beliefs about service delivery that serve as standards or reference points against which performance is judged" (Pizam, 2010; Yuen & Thai, 2015; William, Appiah & Botchway, 2016; Zeithaml *et al.*, 2009:75). Banerjee and Sah (2012) define customer expectations as customer predictions about their possible experiences in a service encounter. It is generally believed that customers exhibit different expectation levels about services. The two types of expectations discussed by Zeithaml *et al.* (2009:77) are "desired service" and "adequate service". "Desired services" are a mixture of the customer beliefs about what 'can be' and 'should be' (Gronroos, 2004:102) provided in the service. It is therefore a reflection of the wishes, hopes and beliefs the customer wants to be fulfilled. These wishes, beliefs and hopes are the drivers for customers' intended purchases.

Adequate service refers to levels of service customers will agree to in the face of some constraints in the environment, like economic challenges (Cadotte, Woodruff & Jenkins, 1987:306; Zeithaml *et al.*, 2009:77). Debates in service expectations are mainly centred on whether customers hold different or similar expectation levels for companies which belong to the same industry (Zeithaml *et al.*, 2009:78). This will also form a major hypothesis to be tested in this study.

3.8.1 The zone of tolerance

The tolerance zone refers to the difference between adequate service and desired service. Desired service is described as the service performance level that is wished for by a customer and is a combination of the desired service and the adequate service. It reflects the extent of customers' willingness to accept and recognise the differences of service performance across various service providers, across personnel in one organisation, or by the same employee in the same organisation. The fall of service below adequate service results in customer dissatisfaction, whereas the rise of service performance above the zone of tolerance results in customer satisfaction (Zeithaml *et al.*, 2009:80).

It is generally held that customers have different tolerance zones, whereby some customers could be busy and are generally impatient and require shorter waiting times. The tolerance zone can also be determined by internal factors like price, in which customers seem to be less tolerant to compromised service in the face of price increases (Zeithaml *et al.*, 2009:81). Zones of tolerance also vary among the service quality variables, where customers are believed to have high expectations in critical variables like reliability and are thus less tolerant to unreliable services. In the same vein, customers are also believed to have lower expectations in less important dimensions like empathy, thus becoming more tolerant to poor service quality in this variable (Berry, Parasuraman & Zeithaml, 1993:98; Parasuraman, Berry & Zeithaml, 1991:447). However, this needs to be confirmed by research on medical insurance in Zimbabwe.

3.8.2 Determinants of customer service expectations

The two levels of expectations discussed above have different determinants, which will be explored in this section.

3.8.2.1 Factors that determine desired service expectations

Two key aspects that determine desired service are individual desires of customers and lasting service intensifiers. These two factors are believed to increase the magnitude of desired service (Zeithaml *et al.*, 2009:82). Personal needs are defined as the physical, psychological, social, and functional factors that are pivotal and essential to the psychological and physical welfare of a client that nurture what customers want in a service. For instance, a business with limited staff but lots of work, expects more services of an insurance broker than a business which is adequately staffed. Lasting service intensifiers are aspects that increase the client's sensitivity to service and are further classified as "derived service expectations" and "personal service philosophy".

Derived service expectations are experienced when a client's expectations are determined by a certain group of people or another person. For instance, the desire of a medical insurance customer to have his services paid up by the insurance company is driven by health care providers who need payment for the services that they provide. On the other hand, personal service philosophy refers to the underlying

knowledge, beliefs, and attitudes that a customer has about the service and appropriate behaviour of service providers. Customers who either once worked in service businesses in the past or are currently working there, tend to have service philosophies that are strong and they tend to have high derived service expectations (Zeithaml *et al.*, 2009:83).

3.8.2.2 Determinants of adequate service expectations

Aspects that determine adequate service expectations are temporary and are more likely to vary when compared to those that determine desired service expectations. Among such aspects are perceived service alternatives, short term service intensifiers, situational factors, the predicted service and customer self-perceived service role (Zeithaml *et al.*, 2009:84–85), which will be further explained below.

- *Perceived service alternatives* refer to other providers from whom the client can get the service. Generally, levels of adequate service expectations tend to be high in situations where clients have wider choice of service providers to deal with, or if they are able to provide the service on their own. However, levels of adequate service expectations tend to be low when there are no perceived service alternatives.
- *Temporary service intensifiers* refer to short-range situations that compel customers to have an awareness of the need for the service. For example, the need for an emergency operation by a patient raises the need for a plan from a medical insurance company that is readily acceptable by health care service providers who are to perform the operation.
- *Situational factors* refer to “service performance conditions that customers view as beyond the control of the service provider” (Zeithaml *et al.*, 2009:85). For instance, in the case of catastrophes like earthquakes, that affect large numbers of people, levels of adequate service expectations (for insurance services) tend to be low as customers realise that insurance companies are overwhelmed with the demand for their services.
- *Customer’s self-perceived service role* refers to the “customer’s perceptions of the degree to which customers exert an influence on the level of service they receive” (Zeithaml *et al.*, 2009:85). For instance, a customer who gives specifications as to how he needs his order to be prepared in a restaurant is more likely to be more dissatisfied if his order is not properly prepared, than a customer who does not give specifications.
- *Predicted service* is the level of service clients believe they are likely to obtain. In other words, it refers to situations in which customers can estimate the levels of service performance that they anticipate. For instance, customers can estimate the time they are likely to spend in the waiting room before seeing a doctor, using their past experiences. Predicted services expectations tend to be more specific and concrete than in desired and adequate services. For

instance, the time to be spent in the waiting room can be expressed in number of hours or minutes. This prediction is usually for a single transaction rather than for the overall relationship with the service provider as is the case in adequate and desired service expectations.

3.8.2.3 Factors that influence predicted and desired expectations of services

When customers are considering buying services, they normally gather information from various sources which include asking friends, calling a store, or tracking media advertisements. Information can also be obtained through surfing the internet, watching television, or from unsolicited comments from colleagues. Thus, according to Zeithaml *et al.* (2009:88–90), aspects that influence both predicted and desired service expectations can be classified into past experiences, explicit service promises, implicit service promises and word of mouth communications.

- *Explicit service promises* are influences on expectations which are entirely under the jurisdiction of the service provider and include both personal and impersonal statements made by the company to clients about their services. Personal statements refer to statements made by organisational personnel like salespeople, whereas non-personal statements are those obtained from brochures, publications, and web pages. Therefore, organisations need to make accurate promises to ensure that what they promise matches with what they deliver. This helps them to manage clients' expectations. However, sometimes the nature of services (for instance heterogeneity), together with the activities of the companies, cause them to overpromise customers about their service delivery, thereby raising the desired service levels and predicted service expectations in clients which may be difficult to fulfil.
- *Implicit service promises* refer to quality cues like price and other physical aspects of the service resulting in deductions concerning the nature of service likely to be obtained (Zeithaml *et al.*, 2009:89). Generally, higher prices and more exciting tangibles cause customers to expect more from the service. It is thus common for a customer shopping for insurance to think that the company which charges higher prices provides better service quality and coverage.
- *Word-of-mouth communications* refer to individual and impersonal declarations from persons, excluding those associated with the organisation, that have an influence on both desired and predicted service expectations. Word-of-mouth communications are generally professed as unbiased and are very significant in services that cannot be assessed prior to purchase (Zeithaml *et al.*, 2009:89–90). Other sources of word of mouth that are influential on levels of predicted and desired services are internet forums, customer reports, friends, and family.
- *Past experience* refers to the prior experiences of the customer to service that is pertinent to the current service. Thus, past experience helps in shaping desires and predictions to a great extent (William *et al.*, 2016; Urban 2010; Zeithaml *et al.*, 2009). Hess, Ganesan and Klein (2007:129)

are of the view that past experiences also include experience with last purchased service, experiences with comparable service offerings, and earlier experiences with the current service provider. In a study by Urban (2010), customers' expectations of reliability, assurance, and responsiveness were found to be greatly influenced by past experiences. However, tangibles and empathy were found to be independent of past experiences. In another study by Yamaguchi, Akiyosh, Yamaguchi and Nogawa (2015), past experiences were found to have a positive effect on behavioural intentions and destination image. Since mixed results have been obtained on the effect of past experiences on customers' expectations, this needs to be further investigated to formulate appropriate service quality strategies for the sustainability of the Zimbabwean medical insurance industry. This led to the formulation of the following null hypothesis:

H2.3: There are no statistically significant differences in medical insurance customers' expectations of the service quality along all the dimensions amongst customers with different periods of membership.

3.8.3 Commonly asked questions about customer service expectations

According to Zeithaml *et al.* (2009:90), the questions most frequently asked about customer service are:

- What should a service provider do with unrealistic customer expectations?
- Is it proper for a business concern to attempt to delight customers?
- How can a company surpass the expectations of customers about service?
- Do the expectations of customers about service continue to rise?
- How can a business entity out-compete rivals in meeting customer expectations?

3.8.3.1 What should a service provider do with unrealistic customer expectations?

It is generally believed that companies fail to learn about customer expectations due to the fear that this will raise the levels of expectations. Companies are afraid that customers' expectations will be so unrealistic that they will have problems in fulfilling them. However, Parasuraman *et al.* (1985:48–49) are of the opinion that customers' expectations are simple, and they expect business organisations to do what they are supposed to do and not to give false promises. They also found that, contrary to the belief that learning about customer expectations will raise the levels of expectations, it rather gives customers the conviction that the organisation will do something with the information they get.

However, the worst thing companies can do is showing an interest in understanding customers' expectations and failing to do anything about the information obtained (Zeithaml *et al.*, 2009:91–93). It is believed that companies should acknowledge their knowledge of customers' expectations and try to address those issues. Alternatively, a company can try to explain why it is failing to deliver the services up to the expectations of customers or launch a promotion to inform customers on how to use and improve the service they are currently receiving.

Davidow and Uttal (1989:77–85) recommend making under promises about the service to raise the probability of meeting or surpassing customer expectations. Making under-promises is believed to make service expectations more pragmatic, thus reducing the gap between perceptions and expectations. However, it is also believed to reduce the competitiveness of the offer. Boulding, Kalra, Staelin and Zeithaml (1993:7) argue that under-promising lowers customers' perceptions of the service.

3.8.3.2 Is it proper for a company to attempt to delight customers?

A “delight” refers to a “profoundly positive emotional state that results from having one’s expectations exceeded to a surprising degree” (Rust & Oliver, 2000:86). Gross (2016:6) expresses it as a “positively outrageous service”, which is extraordinary, arbitrary, unanticipated, and excessively affirmative. In education a delight could be a free text book for students enrolling for the first time in a course. Delights are believed to lead to repeat purchases and customer loyalty (Keiningham & Vavra, 2001), though it is quite involving and costly to the organisation. Companies are therefore recommended to do a cost and benefit analysis of delighting customers.

Companies are also expected to consider the period of time that the delight is able to maintain customers' attention and the implications of the delight on competition. Thus, if the delight is short-lived and is easily forgotten by customers, it is not worth undertaking (Zeithaml *et al.*, 2009:294). Companies should also consider the impact that a delight has on the expectations of other companies in the same industry. Failure by other competitors to imitate a delight strategy will cause customers' expectations to increase, thus disadvantaging the company using a delight strategy. However, a delight that is not easily copied by competitors is a basis of long term competitive advantage over competitors (Zeithaml, *et al.*, 2009:94).

3.8.3.3 How do companies surpass the expectations of customers?

Surpassing customer expectations is achieved through delighting and surprising customers by exceeding their expectations (Choudhuri, 2014). It is important to note that surpassing customer expectations of the fundamentals is difficult, and companies should first strive to honour their promises (Zeithaml *et al.*, 2009:95). Parasuraman *et al.* (1991:420) concur with the above and argue that companies need to be dependable and accurate and provide the service to customers as promised. Building customer relationships through information technologies has been suggested as one way of delighting and surpassing customers' expectations (Chawla & Singh, 2008; Choudhuri, 2014; Saad, Yusoff & Islam, 2014). This helps companies to provide highly personalised services to their customers. This strategy has been used successfully by companies in the tourism industry, which have used guests' information history to design their services in a way that surpasses their expectations (Zeithaml *et al.*, 2009:96).

Under-promising and over-delivering service is another strategy suggested for surpassing customers' expectations. However, this should be done with careful consideration, since regular customers tend to

easily discern under-promising and consequently alter their expectations. Furthermore, such a strategy is not suitable when competitive pressures are so high that customers will opt for the competitors' offers. Positioning a service as unique rather than as standard is another way in which expectations can be exceeded (Zeithaml *et al.*, 2009:97).

3.8.3.4 Do service expectations of customers continually rise?

Customers' expectations of services are very dynamic (Zeithaml *et al.*, 2009:75). Thus, in a turbulent environment characterised by rapidly changing and highly competitive industry conditions, adequate service expectations are expected to rise quickly. This calls for adequate service expectations to be monitored continuously. However, desired service expectations are regarded as being invariable, since they are prompted by more lasting aspects like individual desires and lasting service intensifiers (Zeithaml *et al.*, 2009:96).

3.8.3.5 How does a company outcompete rivals in meeting customer expectations?

The organisation's overall objective is to satisfy the expectations of customers better than rivals. Given that in a turbulent environment, adequate service expectations also rapidly change, companies should not only aim to surpass adequate service levels, but should also aim at attaining the desired service level. It is believed that outstanding service can strengthen customer loyalty to an extent that customers are unyielding to competitive options (Zeithaml *et al.*, 2009:97).

3.9 Comparison of service quality in publicly and privately owned institutions

A number of studies have been done to compare service quality perceptions and expectations for customers in different sectors of the economy, and the results obtained suggest that customer perceptions and expectations of service quality tend to vary across different service sectors (Selvakumar, 2016). For instance, in a study conducted by Gautam (2011), customers perceived public sector insurance companies as offering better service quality than private insurance companies. A study conducted by Bhardwaj and Chawla (2013) also portrayed almost similar results, as public hospitals were found to provide better service in terms of reliability, promptness, security, and accuracy when compared to private hospitals. This was despite the high prices charged by private hospitals.

However, a study conducted by Banerjee and Sah (2012) indicated that customer expectations were higher in private banks than in public banks, for all the service quality dimensions and service quality gap scores (P-E) were found to be lower for privately owned banks than public sector banks. Similar results were obtained in a study by Selvakumar (2016), where higher service quality gap scores were obtained in banks in the public sector than those in the private banks. Thus, banks in the private sector were perceived as providing better service quality than public sector banks. In a study conducted by Rao (2012), it was also found that quality of care in the public sector was poor and weak, which led to the growth of the private sector health care. Thus, a rule of thumb cannot be established when comparing

service quality between government and non-government owned organisations. The different results obtained in these studies warrant further investigations on the issue, which led to the formulation of the fourth research objective of this study which intended to compare service quality gaps between government-owned and privately owned medical insurance companies. This led to the formulation of the following null hypotheses:

H4.1: There are no significant differences in the customer perceptions of service quality between government owned and privately owned medical insurance companies.

H4.2: There are no significant differences in the customer expectations of service quality between government owned and privately owned medical insurance companies.

H4.3: There are no significant differences in service quality gaps experienced by customers in government owned and privately owned medical insurance companies.

3.10 Models of Service Quality

According to Crosby (1979:18), quality is regarded as “an elusive and indistinct construct” and is “often mistaken for imprecise adjectives like goodness, luxury, shininess, or weight”. Scholars have tried to explain what quality is in the form of models. Initially, research on service quality models considered the perception of service quality as based on multiple components and recent studies have also concurred with this notion. Different scholars have come up with different service quality models. A few of these will be discussed briefly below. This discussion is very important, since the researcher has based this study on some of the most reputable models discussed here, namely the SERVQUAL model and the Gaps model.

3.10.1 Lehtinen’s service model (1982)

The basic premise of the model was that service quality emanates from the interaction between the customer and elements in the service organisation. Two distinct approaches to service quality were used, namely the two dimensional and three dimensional approaches. In the three dimensional approach, Lehtinen and Lehtinen (1982) suggested three different types of quality, that is image (corporate) quality, physical quality, and interactive quality. According to Lehtinen and Lehtinen (1991:288), “physical quality is the tangible” part of the service, whilst interactive quality is the two-way dealings between the customer and the service provider, or between the customer and the representatives of the service provider. They also include evaluations of the service delivery process. He defined corporate quality as the perceived “image of the service provider” by the current as well as future clients. The way image is regarded in this model is similar to how it is viewed by Gronroos (1984:36), who defines it as “the result of how the consumers perceived the firm”.

The two dimensional approach is regarded as a higher level perspective in which customers are taken to perceive quality as consisting of process quality and outcome quality. This classification was very

similar to Gronroos's (1984) classification of service quality into functional quality (how service is provided) and technical quality (what is perceived by the customer). Although the model forms a solid basis for understanding service quality which was later adopted by other service quality researchers like Gronroos (1984; 1988), it has faced some criticisms which makes its adoption in this study difficult. For instance, it does not provide any means for measuring the service quality elements suggested by the model. Furthermore, Glaitis and Minis (2007:173) argue that the model is not valid in the manufacturing industry. Jain and Aggarwal (2015:131) also note that the model is inappropriate in this technological period in which self-service technologies, coupled with new internet capabilities, have greatly changed the operations of the retail sector.

3.10.2 Gronroos's 1982 model

According to Gronroos (1982:36), service quality is defined in terms of three dimensions: technical, functional, and image quality. Gronroos (1982:43) argues that the technical quality is actually the by-product of customer and service provider relations; functional quality is the method employed to provide technical quality; and image is made up of both functional and technical quality, including other aspects like pricing, word of mouth, customs, beliefs, and public associations. This shows that the three dimensions that were suggested by Gronroos are interrelated. According to Gronroos (1982), service quality management entails aligning perceived quality with expected quality and minimising the discrepancy between the two as much as possible. Customer perceptions of service quality are therefore the key component of Gronroos's (1982) service quality model, and this depends on the comparison of the actual service perceived by the customer and expected service from customers (Gronroos, 1984:36). According to Gronroos (1984:36), "the outcome of this comparison process will then be the perceived quality of the service". Therefore, the model measures service quality using performance scores only, since it considers measuring customer expectations as difficult. Thus, according to Gronroos (1988:11), the evaluation of performance comprises two dimensions, which are the technical (outcomes) dimension and the functional (process related) dimension. This model is shown in Figure 3.3 below.

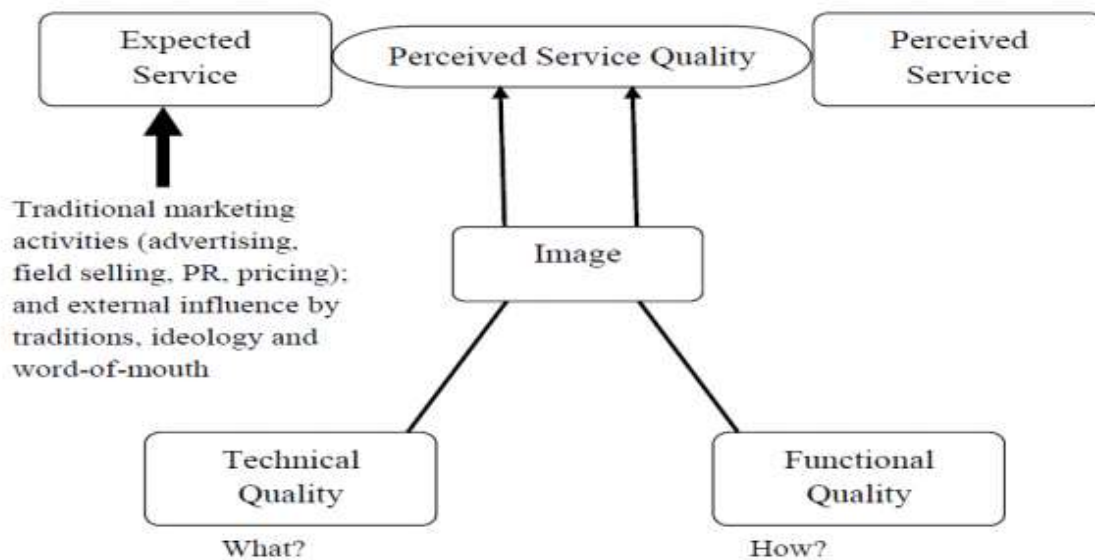


Figure 3.2: The Gronroos's model

Source: Gronroos (1984:40)

As shown in Figure 3.2 above, image imposes an influence on perceived service quality and is built up by the functional quality and the technical quality and refers to the customers' view of the corporate or brand (Gronroos, 1984). Therefore, according to Gronroos, customer expectations are influenced by their perception of the firm and it is also an outcome of how they perceive its services.

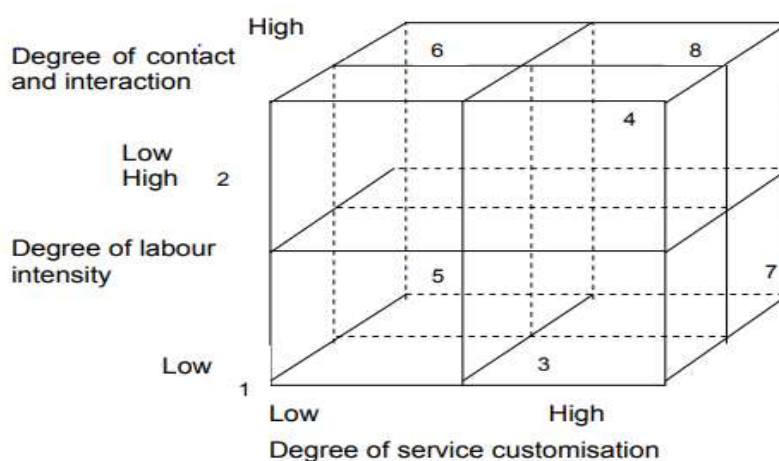
Gronroos modified his model in 1988 by incorporating six sigma criteria of how service quality is perceived. These criteria are recovery, reliability and trustworthiness, reputation and credibility, accessibility and flexibility, attitudes and behaviour and professionalism and skills. Since recovery, reliability and trustworthiness, accessibility and flexibility and attitudes and behaviour are process related, he classified them under the functional quality dimension. He considered reputation and credibility as image related, while professionalism and skills were classified under the technical quality dimension, since they were outcomes related (Gronroos, 1988).

Although several aspects suggested by Gronroos (1984; 1988) have been accepted and the models have been applied in service quality studies (Kang & James, 2004; Lassar, Manolis & Winsor, 2000), the model has not gone without its own criticisms. These criticisms also led to the non-adoption of the model in this study. Firstly, the model has been criticised for the failure of the functional and technical quality to adequately describe all the components of service quality (George & Gibson, 1988:4). Secondly, it has been argued that, since the model is mainly

centred on services which involve human interaction, services in which technological and physical aspects play a significant role cannot be adequately accommodated (George & Gibson, 1988). Furthermore, although the model is credited for being the first attempt to introduce a real model that measures perceived service quality, it is criticised for its failure to explain how functional quality and technical quality can be measured (Ghotbabadi, Feiz & Baharun, 2015). In agreement with the above, Jain and Aggarwal (2015:131) contend that the model identified the elements of service quality as image, functional, and technical, without pointing out anything about the tools or techniques to quantify these elements.

3.10.3 The Haywood-Farmer service quality model

Haywood-Farmer (1988:19–29) advocates for a service quality model comprising three equally important aspects of service quality: people’s behaviour, physical facilities and processes, and professional judgment. According to Haywood-Farmer, the selection of elements from each of the above aspects of service quality forms the basis of any strategic managerial decision. He, however, argues that this selection should be done in a more careful manner that ensures a balance between the three aspects. The appropriate mix of the three aspects is determined by the degree of interaction and contact between the customer and the service process, the degree of service process customisation and degree of labour intensity (Haywood-Farmer, 1988:28). Haywood-Farmer came up with a three dimensional classification scheme that will assist managers to classify each service correctly. This scheme is shown in Figure 3.3 below.



Some examples of services in each octant:

- | | |
|--|--|
| 1. Utilities, transportation of goods | 5. Computerised teaching, public transit goods |
| 2. Lecture teaching, postal services | 6. Fast food, live entertainment |
| 3. Stock broking, courier services | 7. Charter services, hospitals |
| 4. Repair services, wholesaling, and retailing | 8. Design-, advisory- and healing services |

Figure 3.3: Haywood-Farmer’s three dimensional classification scheme

Source: Haywood-Farmer (1988:26)

Using the classification suggested by the scheme, medical insurance services can be described as low labour intensive, since members do not require services from the employees of such institutions, unless they are sick and have queries regarding the settling of their medical claims. They can also be classified as having a high degree of service customisation due to different medical insurance plans of which membership is determined by income levels (section 2.5). Therefore, medical insurance services can be classified in octant 3, together with stock broking and courier services, as shown in Figure 3.3.

According to Haywood-Farmer (1988:26), in services that are less labour intensive, customers give great importance to physical facilities, procedures, and processes. Thus, the higher the service contact, the more labour intensive the service becomes and the more the effort that has to be made to ensure that staff members behave appropriately. However, this needs to be empirically investigated in medical insurance services.

Haywood-Farmer (1988:28) suggests that it is not feasible to plot the service quality model onto a triangular model of the three elements, since the elements are not scales ranging from low to high. However, Seth *et al.* (2005:913–949) used Haywood-Farmer’s (1988) model to plot some of the different types of services onto the model as shown in Figure 3.4 below.

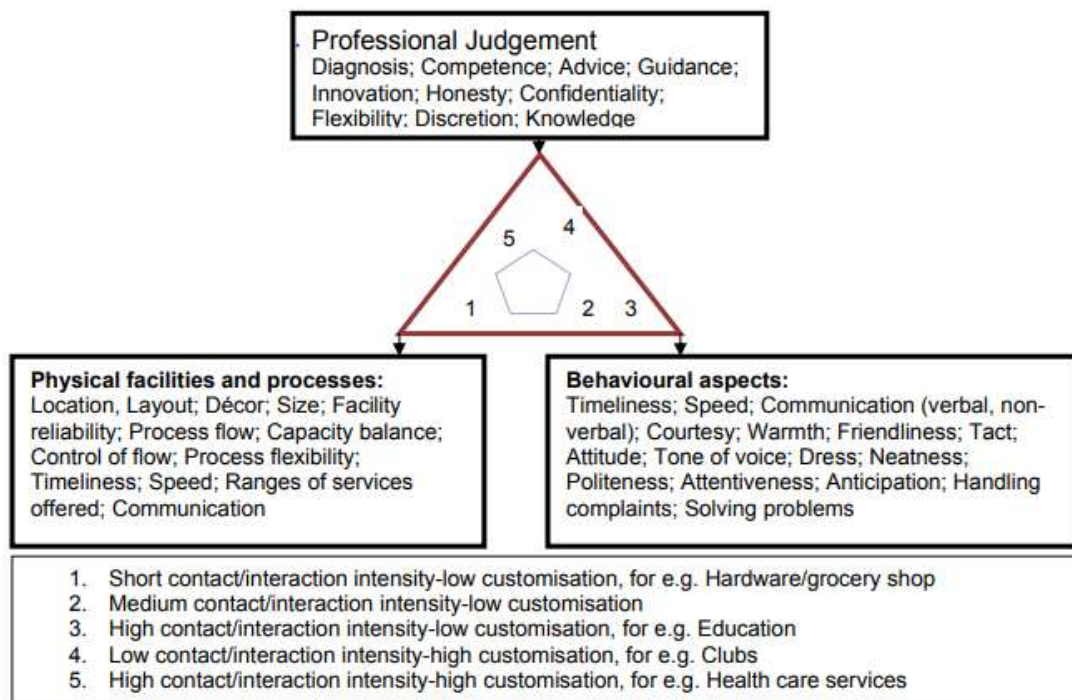


Figure 3.4: Seth *et al.*'s (2005) Attribute service quality model

Source: Seth *et al.* (2005:919) as adapted from Haywood-Farmer (1988)

Therefore, using Seth *et al.*'s (2005) adapted model, medical insurances services fall into the same category as clubs. However, these models were not used in this study, due to their failure to provide

means to measure service quality in quantitative terms. Furthermore, Haywood-Farmer's (1988) model does not provide management with guidance in terms of procedures and methods that can be used to enumerate service quality problems and to control such problems.

3.10.4 The gaps model

The gaps model, based on the expectation–disconfirmation theory (Oliver, 1980:460), shows how customers evaluate quality and it incorporates the aspects that are significant in determining quality in its diverse spheres. Service quality gap is defined as the discrepancy between customer perceptions and expectations of service: if expectations exceed service delivered, then quality perceived is less than acceptable and customer discontentment is experienced (Parasuraman *et al.*, 1985:48). This model originally comprised 10 dimensions which were established as a result of interviews and focus groups (Jain & Aggarwal, 2015:126). These 10 dimensions, according to Parasuraman *et al.* (1985:47), are responsiveness, reliability, trustworthiness, communication, courteousness, access, competence, tangibles that clients utilise in building perceptions of and expectations about services, understanding and knowing the customer and safety. These ten elements were simplified and broken down into five dimensions. These five dimensions are restated as follows (Shahin, 2006:4; Van Iwaarden, Van Der Wiele, Ball & Millen 2003:922):

- Tangibles: physical facilities, equipment and appearance of personnel
- Reliability: ability to carry out the promised service in a dependable and accurate manner
- Responsiveness: keenness to assist clients and offer timely service
- Assurance (including competence, courtesy, credibility and security): knowledge and courtesy of personnel and their capability to instigate confidence and trust
- Empathy (including access, communication, understanding the customer): caring and individualised attention that the company offers its clients

According to Parasuraman *et al.* (1985:46), service quality refers to the variance between expectations and perceptions of services, commonly referred to as GAP 5. A larger gap entails the greater need to enhance service quality by the organisation. This is shown in the diagram below (Figure 3.5).

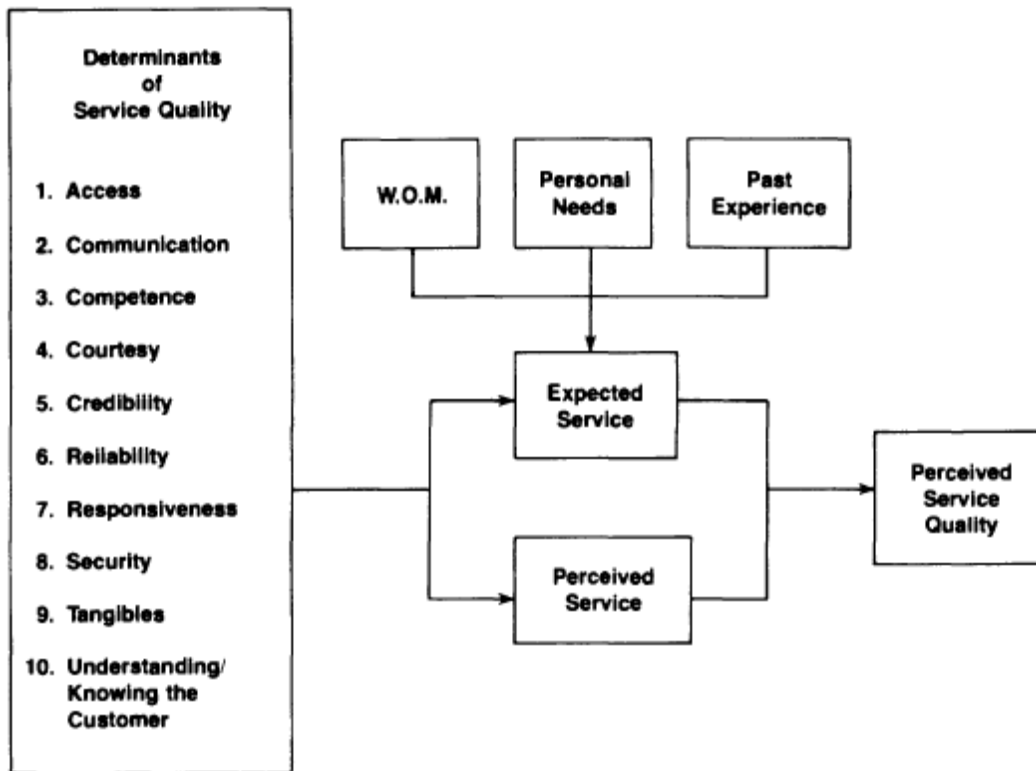


Figure 3. 5: Original gaps model

Source: Parasuraman *et al.* (1985:48)

Besides identifying the gap between perceived service and expected service, Parasuraman *et al.* (1985:44–46) also established other four branching gaps that commence from the provider’s side, which were explained as follows:

Table 3.1 The four provider gaps

| Service quality gap | Description |
|---------------------|--|
| Gap 1 | This gap exists when the expectations of clients are different from what management assume clients expect. |
| Gap 2 | This occurs when clients’ standards of service do not match with management’s findings of the customers’ expectations. |
| Gap 3 | This gap results when the service performed does not match the standards of performance already set. |
| Gap 4 | This gap occurs when the firm’s communiqué to the outside world concerning its service quality is not in sync with the service actually performed. |

Source Parasuraman *et al.* (1985:44–46)

Parasuraman *et al.* (1985:44) also came up with a diagram (Figure 3.6) to show how these four gaps work together with each other and with the customer gap.

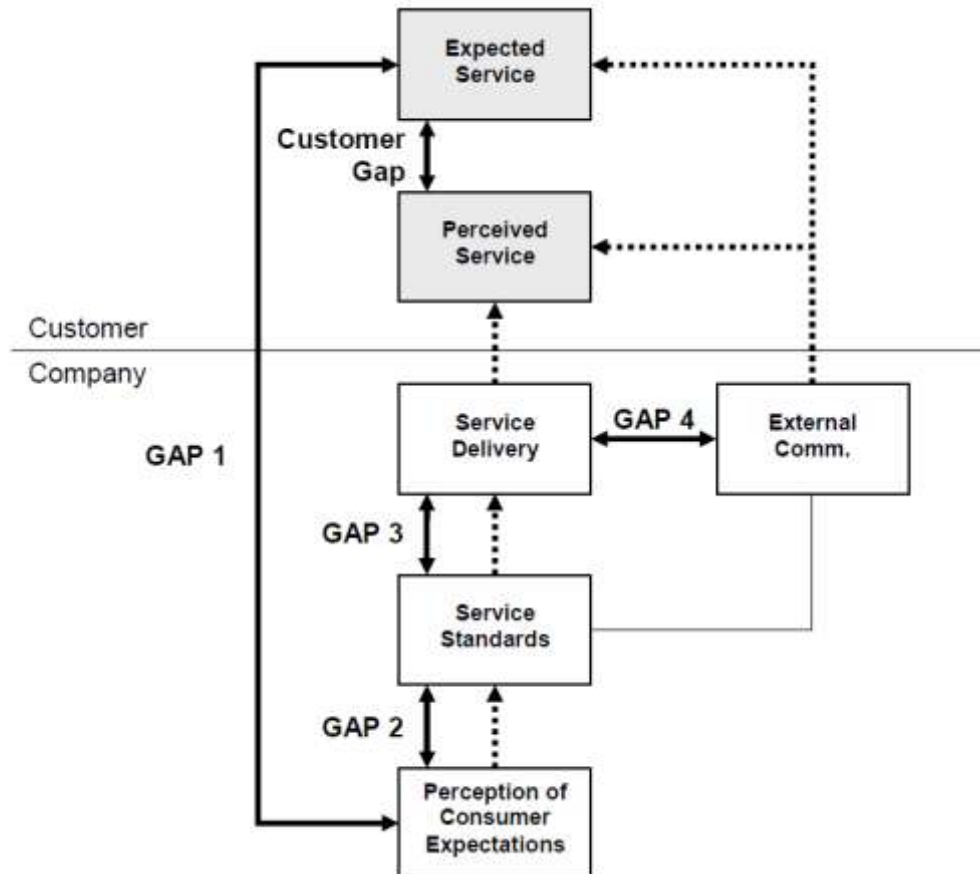


Figure 3.6: Gaps model of service quality

Source: Parasuraman *et al.* (1985:44)

Gaps 1–4 are the four major reasons behind service quality gaps customers experience (Zeithaml, Parasuraman & Berry 1990:47). Gaps 1–4 represent the difference between the firm’s service shortfalls, or alternatively, areas in the organisation where positive service adjustments could be made between the organisation and the client. The major factors that determine the nature of service expected by clients include: service provider external communications, past experiences, personal needs, and word-of-mouth communications (Zeithaml *et al.*, 2009:88–90).

Gap 1 is also known as the listening gap and is believed to be caused by insufficient marketing research orientation; poor communication among customers, employees and management; many layers between top management and contact personnel; poor customer relationship management; and poor service recovery (Zeithaml *et al.*, 2009:34). Candido and Morris (2000:466) attribute this gap to lack of efforts to listen to customers or failure to correctly understand customers.

Gap 2, which is also described as the “service design and standards gap” and is attributed to service design deficiencies, lack of clients, based standards, poor servicescape design or inadequate maintenance and updating of the service-scape (Zethaml *et al.*, 2009:36–37). It can also be attributed to

lack of proper analysis, design, and clarification of service quality specifications or poor alignment between strategy content and service quality specifications (Candido & Morris, 2000:467).

The service performance gap (gap 3) is attributed to poor human resources strategies, inability to align demand and supply, lack of awareness of duties and responsibilities by clients, as well as problems caused by service intermediaries (Zeithaml *et al.*, 2009:38–39). Gap 4 (communication gap) is also attributed to deficiencies in co-ordinated services marketing communications, overpromising, poor administration of customer expectations, and inappropriate pricing, among others (Zeithaml *et al.*, 2009:42).

3.10.4.1 Limitations of the model

Ladhari (2008:65) argues that the gap model has promoted lack of clarity between the two concepts, i.e. customer satisfaction and service quality. Furthermore, Oliver and Bearden (1985:253) are not in agreement with the notion of measuring service quality as the variance between expectations and perceptions of customers. However, despite these critiques, the gaps model has been highly recommended because of its usefulness in identifying areas of weakness and strength of a firm's services and where improvements can be targeted (Ladhari, 2008:75). This is also the major reason for its adoption in this study.

3.10.5 The SERVQUAL model

Having been unequivocally influenced by the European stance, Parasuraman *et al.* (1985:42–43) proposed that quality assessments cannot be entirely done at the end result of the service, but also on the process by which the service is produced (Kang & James, 2004:266). The SERVQUAL method is regarded as an important exodus from the conventional mode of employing a perception-based assessment as a prediction of client gratification. As an alternative to using perception, SERVQUAL suggests using expectation/perception – the service quality gap – as a lasting perception that determines customer satisfaction with a service provider (Babakus & Mangold, 1992:769; Parasuraman *et al.*, 1991:422). Although the characteristics are highly correlated, the main centre for the distinction is based on the point where the assessments take place. In the case of process quality, assessment happens during the process of performing the service. However, in the case of outcome quality, assessment occurs after the service has been performed. However, their quantification of service quality (i.e. SERVQUAL) does not clearly show both aspects, but the functional aspect only. Parasuraman *et al.* (1988:15) define service quality as the client's assessment of the superiority of the service on the whole, or the discrepancy between a person's expectation and the service actually produced. Parasuraman *et al.* (1988:30–36) recognise several possible purposes of the SERVQUAL model, which include:

- being used for tracking customer perceptions of service quality of a particular business in comparison to its rivals;

- providing the prospects for a business to evaluate its service quality performance based on each aspect separately, as well as the overall aspect;
- allowing the business to categorise its clients into different classes based on their personal SERVQUAL scores; and
- allowing multi-segment retail companies to evaluate the level of service quality offered by individual stores and to classify them into various segments with varying quality images.

However, the major objective of the model is to be used as a common tool for measuring service quality across various service sectors.

After collecting and analysing the data of four service sectors, namely long-distance telephone, appliance repair and maintenance, banking and credit card, Parasuraman *et al.* (1988:23) established the underpinnings of an acknowledged 22 item scale called SERVQUAL, which comprises the 5 dimensions that have been referred to continuously. Table 3.2 below provides further explanations of these dimensions.

Table 3. 2: The five determinants and their definitions

| Determinant | Definition |
|-----------------------|--|
| TANGIBLES | The appearance of physical facilities, equipment, personnel and communication materials. |
| RELIABILITY | The capability to carry out the promised service in a dependable and accurate manner. |
| RESPONSIVENESS | Readiness to assist clients and to offer timely service. |
| ASSURANCE | The knowledge and courteousness of the personnel and their ability to instil confidence and trust. |
| EMPATHY | Caring, personalised consideration the business offers its clients. |

Source: Adapted from Parasuraman *et al.* (1988:23)

SERVQUAL offers a broad variety of application through its perceptions/expectations design, and it is extensively employed in the service sector to comprehend the perceptions of targeted customers concerning their service requirements; and to allow the measurement of service quality in organisations (Punnakitkashem, Buavaraporn, Maluesri & Leelartapin; 2012:2).

Although the SERVQUAL tool has been extensively employed in various service sectors, it has been heavily criticised (Ladhari, 2009:172) based on conceptual, theoretical, and operational deficiencies. For instance, the validity of the model has been criticised in terms of the independence or dependence of the five dimensions, applicability, dimensionality, and use of variance scores (Babakus & Boller, 1992:253). Kang and James (2004:266) are also of the view that although the initial developers of the SERVQUAL tool proposed that the model consisted of both the functional (process) aspect and the technical (outcome) aspect (Parasuraman *et al.*, 1985:42–43), the technical quality aspect is not measured in the model and has been neglected in measuring service quality.

Gilmore and McMullan (2009:640–651) also critiqued the model based on its employment of scales to measure service quality. They argued that although scales are likely to provide answers in relation to the detail and finer points of customer perceptions, the information obtained will fail to explain reasons behind the existence of these perceptions. They recommended qualitative research as an appropriate research approach to solve this problem. However, qualitative methods were not opted for in this study because of their reliance on detailed data collected from small samples which were feared to lead to false conclusions about the perceptions and expectations of service quality in the Zimbabwean medical insurance sector (Bhattacharjee, 2012:103–104). Furthermore, an increase of sample size using qualitative methods was also feared to produce too much data, which could not be effectively processed (Bhattacharjee, 2012:103–104). Gilmore and McMullan (2009:646) also point out that although alternative models have been proposed as a result of the critique of the SERVQUAL model, these models never matched the SERVQUAL model in terms of degree of usage and adaptation since it is easy to use and apply. This is another reason why the SERVQUAL model was adopted in this study.

Jain and Jain (2015) point out the lack of consensus among researchers about the conceptualisation and measurement of service quality. They indicate that, although the SERVQUAL and SERVPERF are the two major scales that have been employed in the past researches, there is no consensus on the best model to be employed in future studies. The authors also propose the employment of more sophisticated techniques like the structural equation model as a way to reach into a more reliable and valid conclusion about the relationships of service quality with other constructs like behavioural intentions and customer satisfaction. However, since this study sought only to establish the perceptions and expectations of customers and any service quality gaps in an area little researched, the proposals of employing structural equation modelling techniques were reserved for future studies on private health insurance.

Ladhari (2009) also carried out a 20 years review of research on the SERVQUAL model in which he analysed the various empirical and theoretical criticisms that have been levelled against the model. Criticisms included the use of difference scores, the reliability of the model, the emphasis on process rather than outcome, and the applicability of a universal scale for evaluating service quality in all service situations among others. In his analysis he found that, although some instruments like the SERVPERV have shown “to possess impressive convergent and predictive validity”, the SERVQUAL model proved to have better diagnostic capabilities (Ladhari, 2009:184). He concluded that, despite the criticisms levelled against the model, it remains a useful instrument for managing and measuring service quality in organisations. He further recommended the model to be adapted to suit different contexts and qualitative studies to find service quality dimensions suitable for different industries. However, due to time and financial constraints, this was postponed to future studies and since some studies on service quality had been conducted on general insurance and another one on health insurance (Asghari & Babu, 2017), the model was adapted to suit the Zimbabwean health insurance sector by measuring the dimensions in the context of health insurance.

Whyte and Bytheway (2017:923–945) came up with a new multistage model, built upon the existing service quality theory (SERVQUAL) and the information systems development practice called the V model. This was a move towards improving the existing models for measuring service quality. The model was developed in a developing country setup (with weak service management) and it was grounded in “psychological theory and methodological symmetry” (Whyte & Bytheway, 2017:923). The model had a strong background in the management of information systems development (Bytheway, 2015) and was developed to measure service quality at three different levels. These levels were the ‘service level’ (which focuses on deciding the scope of an intervention and the identification of the participant); the ‘attribute level’ (which focuses on the choice of the attribute to be used for different service groups), and the ‘item level’ (where analysis of statistical data is to be based on the attributes appropriate to the context of the intervention). According to Whyte and Bytheway (2017), the model is regarded as a ‘V’ in which the analysis starts with a drill ‘down’ into detail and then come back ‘up’ to provide an understanding of the situation that allows suitable management actions. Although the model was a milestone from the SERVQUAL and other service quality management techniques, it was not adopted in this study, due its heavy reliance on technical expertise and resources which were not readily available. Furthermore, the authors also point out that its application still needs further investigation (Whyte & Bytheway, 2017:941).

The SERVQUAL model was adopted in this study since it has been tested and tried and has stood the test of time. Moreover, it was designed to suit a variety of service sectors (Parasuraman *et al.*, 1988:30; Tsoukatos & Rand 2006:503). Parasuraman *et al* (1988:30–31) argue:

It provides a basic skeleton through its expectations/perceptions format encompassing statements for each of the five service quality dimensions. The skeleton, when necessary can be adopted or supplemented to fit the characteristics or specific research needs of a particular organisation.

Since the researcher sought to comprehend the nature of service quality in the little researched and controversial area of private health insurance (particularly in the Zimbabwean context), an extensively used model that has been tried and tested and has been successfully employed in different service settings around the world was adopted (Tsoukatos & Rand, 2006:503). Banerjee and Sah (2012) employed the model in a comparative study of customers’ perceptions of service quality between private and public banks in India. The SERVQUAL scale was also used in a study by Meesala and Paul (2018:265) to identify factors significant in determining service quality, customer satisfaction, and loyalty in hospitals. Asghari and Babu (2017) also used the SERVQUAL scale in their study to understand customers’ expectations and perceptions of Indian health insurance companies. Several recent studies have also successfully employed the SERVQUAL tool, and have proved it as a very reliable and consistent tool for measuring service quality (Al-Neyadi, Abdallah & Malik, 2018; Nyandwe, Mapatano, Lussamba, Kandala & Kayembe, 2017; Saini & Singh, 2018). Based on these

more recent studies and other earlier studies, the SERVQUAL model was considered as ideal for understanding customer perceptions and expectations of service quality and uncovering areas of strengths and weaknesses in the service quality of the Zimbabwean medical insurance industry. These would enable the crafting of service quality strategies that will result in superior service quality, profitability, and sustainability of the Zimbabwean medical insurance sector. Furthermore, despite the above criticisms launched against the model, the model was adopted in this study because it continues to be the major instrument employed in service quality studies and is mostly preferred because it is flexible and easy to apply (Asubonteng, McCleary & Swan 1996:80; Lo, Wu & Tsai 2015:169; Punnakitikashem *et al.* 2012:2; Purcarea *et al.*, 2013:576).

3.10.6 The Cronin and Taylor SERVPERF model

This model emerged as a critique to the SERVQUAL model by Cronin and Taylor (1992:55–68). These authors condemned the GAP and SERVQUAL models on the grounds of their conceptuality. Cronin and Taylor (1992:58) contended “that performance-based” service quality measurement is a better technique to measure service quality than a ‘performance-expectations’ approach. Although Cronin and Taylor agree with the definition of service quality as the discrepancy between customer perceptions and expectations, they disagree on the manner in which the perception of such services is measured. They argued that service quality is determined by performance rather than performance and expectation. According to Kotler and Keller (2010:424), they regarded customer expectations as being built into performance such that it should not be measured separately. In this model a new tool called SERVPERF was suggested to replace the SERVQUAL (Cronin & Taylor, 1992:58–59). They argue that the performance-based scale (SERVPERF) developed was more proficient when compared to the SERVQUAL scale. This scale was less tedious than SERVQUAL as it consists of only 22 items instead of 44 items.

Although there is an ongoing debate on the superiority of the two models, it has been argued that both the SERVPERF and SERVQUAL instruments have received an equal amount of citations in the past years (Carrillat, Jaramillo & Mulki 2007:473). It is also argued that the growing popularity of the SERVPERF has not diminished the usage of the SERVQUAL among researchers and that the SERVQUAL and SERVPERF are equally valid and adequate predictors, although the SERVQUAL scale is highly favoured by practitioners. Yet, some scholars regard SERVPERF as empirically and theoretically superior to SERVQUAL (Andronikidis & Bellou, 2010; Jain & Gupta, 2004). Nevertheless, Jain and Gupta (2004:34) concur with Carrillat *et al.* (2007:485) that the SERVQUAL instrument has superior diagnostic power to highlight areas that need managerial intervention.

One of the limitations of the model is that it does not give an explanation on how physical and human resources can effectively be pooled together to attain expected levels of functional and technical quality. Moreover, the model is not generally applicable to different services and therefore needs to be tailored

to suit various types of service settings (Cronin & Taylor, 1994). The model has also been criticised for its poor goodness of fit index, not suitable for people with different cultural backgrounds, with different scripts and expectations to bring to the service encounter (Lee, 2007).

3.10.7 Theoretical models adopted for the study

In the context of the foregoing discussion, this empirical study adopted the gaps and the SERVQUAL models. The gaps model was adopted mainly for its usefulness in identifying areas of weakness and strength of a firm's services and in identifying areas where improvements should be targeted in the health insurance sector (Ladhari, 2008:75; Saini & Singh, 2018:702). The SERVQUAL model was adopted because it has been designed and applied to various service segments which comprise banking, education, healthcare, and insurance, among others (Madan, 2012). Furthermore, regardless of the criticisms that have been levelled against the SERVQUAL tool, it has stood the test of time and it remains the key instrument most used in service quality studies due to its ease of application and flexibility (Asubonteng *et al.*, 1996:80; Lo *et al.*, 2015:169; Punnakitikashem *et al.*, 2012:2). This is evidenced by current studies that are continuously employing the model (Al-Neyadi *et al.*, 2018; Asghari & Babu, 2017; Banerjee & Sah, 2012; Meesala & Paul, 2018; Nyandwe *et al.*, 2017; Saini & Singh, 2018).

3.11 Strategies to improve service quality

According to Gokilavani and Durgarani (2016:2413), "excellent service is a profit strategy because it results in more new customers, more business with existing customers, fewer lost customers, more insulation from price competition, and fewer mistakes requiring the re-performance of services". Asubonteng *et al.* (1996:62) argue that, with the heightened competitive pressures and hostile environmental conditions, service quality becomes the basis of organisations' marketing strategies to survive and grow. Van Looy, Gemmel and Dierdonck (2003) affirm that quality plays a key role in competing in today's world through the creation of strong brand names and developing marketing strategies.

Research has shown the importance of understanding the intended customer group as the basis for service delivery (Kotler & Keller, 2012; Lo *et al.*, 2015; Ramseool-Munhurrun *et al.*, 2010), and the knowledge about service quality gaps has been regarded as the basis for setting clear standards that enhance the quality of service in any sector (Chikwendu, Ejem & Ezenwa 2012; Naidoo & Mutinta, 2014). Strategies that can be employed by medical insurance companies are therefore explained in this section.

3.11.1 Proper selection and training of employees

Employees have been regarded as the most valuable resource that should have a central position in the strategy of any organisation (Boxall & Purcell, 2011; Kasper, Van Helsdingen, Gabbott & Fuxiang,

2008). According to Kasper *et al.* (2008), without the full involvement of employees in quality initiatives, even the most carefully planned and specified services are bound to fail. Organisations are therefore expected to have skilled employees who are motivated to execute organisational service quality strategies (Weber, 2013). Thus, to enhance service quality, organisations must work on building their capacity to attract, employ, and retain satisfactory numbers of high quality employees that will enable them to cope with ever changing circumstances (Gatoto, Wachira & Mwenda, 2015:84). According to a study by Ofori-Okyere and Aboagye (2015:20), personnel require enough instruction in the essential knowledge, technical skills, and interactive skills to provide high quality service. Interactive skills help company personal to be more empathetic, responsive, caring, and courteous. High performing companies have been known of investing heavily in training and ensuring that the training aligns well with their business strategies and goals strategies (Gatoto *et al.*, 2015:84). This is supported by a study conducted by Dhar (2015) in which a strong relationship was found between service quality offered by hotel employees and employee training.

3.11.2 Employee empowerment

In addition to employee training, service quality strategies can also be enhanced through employee empowerment. Employee empowerment entails giving employees unreserved power and trust to appraise and implement innovative ideas efficiently (Craig, 2015:299). Kar (2017:15) defines employee empowerment as “getting workers to do what needs to be done rather than doing what they’re told”. Employee empowerment has also been regarded as a strategic business tool for companies to gain sustainable competitive advantage through enabling faster decision and unified work cultures (Kar, 2017). Employee training and empowerment have been regarded as key tools that enable service organisations to meet customer expectations of service quality (Karatepe & Vatankhah, 2014; Yavas, Karatepe & Babakus, 2011). This is because they equip employees with skills that help them to deal with customers effectively and their heavy reliance on peer networks and horizontal structures results in employee satisfaction that boosts work performance (Kar, 2017).

3.11.3 Building strong customer relationships

Strong relationships with customers can be built through customer relationship management (CRM) strategies. CRM refers to the establishment of durable relationships with customers that enable customers to do business easily and allow businesses to deliver personalised services to customers (Kotler & Keller, 2012; Nikolova, 2005). CRM has been associated with several benefits which include increased profitability, reduced marketing costs, and customer loyalty (De Meyer & Mostert, 2011; Kotler & Keller, 2012). The importance of CRM in the delivery of service quality was also brought up by Sigala (2008), who emphasised significance of delivering and evaluating service quality from a relationship and culturally sensitive approach. In building strong relationships with customers, communication with customers has been found necessary in establishing and sustaining a service

quality base and managers were encouraged to formulate strategies that improve communication with customers as well as acquiring information about customer needs (Valmohammadi & Beladpas, 2014).

3.11.4 Use of information technologies

Customer relationships discussed above can also be enhanced through the use of various information technologies, like mobile communication systems, e-commerce applications, and the internet (Ojiako, 2012). According to Zeithaml *et al.* (2009), building customer relationships through information technologies helps in delighting customers and surpassing their expectations, and it also enables organisations to provide their clients with highly personalised services. Moreover, information technologies have been found a significant factor that facilitates the provision of better service quality in a health care setting. Organisations in such settings have been encouraged to relieve the overloaded manual processes through the use of technologies (Itumalla, 2012).

3.11.5 Coming up with proper systems and structures that enhance the delivery of service quality

Koufteros, Vonderembse and Jay Aram (2005:97–133) provided empirical evidence on the relationship between organisational structure and internal communication, since organisational structure facilitates the processing and flow of information. Some interfaces in the service delivery process (employee–customer, manager–employee, and employee–role) were investigated by Hartline and Ferrell (1996:52–70), who found that job satisfaction, increased self-efficacy, reduction in employee’s role ambiguity and conflict had a positive effect on customers’ perceptions of service quality. Research has also revealed that practices and policies earmarked for service quality enhancement are required on top of an environment favourable for service (Schneider, White & Paul, 1998:150). From this literature it is clear that structure of a company is a significant aspect in improving service quality.

According to Goldstein, Johnston, Duffy and Rao (2002:121), service refers to an outcome which results in the client being either contented or discontented with the service encounter. They further add that it is of great significance that service firms focus on crafting systems through which service concepts are created and delivered to clients. According to Hoffman and Bateson (2016:335), “reliably delivering the basic service customers expect depends, in part, on how well various elements function together in a service system”. These elements comprise the physical environment in which services are produced, the equipment that facilitates the performance of services, and the workforce that perform particular services in the service chain (Hoffman & Bateson, 2016:335). According to Weber (2013), without proper systems and ample organisational resources including willing and motivated personnel, promises made to customers are hard to fulfil. For instance, in a study by Nsiah Boateng *et al.* (2016), it was found that systems (in the form of excessive paper work and government involvement in the distribution of health insurance funds) were a key factor for delays in settling medical claims for the insured in Ghana.

Thus, the above strategies can be used by organisations in the medical insurance sector to understand customer needs and close any service quality gaps identified to enhance service quality in the sector. Poor knowledge of service quality in an organisation causes managers to focus on things less important to the customer. A good service quality strategy enables an organisation to chart its competitive scope through proper selection and positioning itself along the fundamental service quality dimensions that are likely to give it some competitive advantage (Storey & Larbig, 2017). It thus enables an organisation to come up with specifications of quality dimensions to compete with.

3.12 Proposed research framework for the role of service quality in the Zimbabwean medical insurance sector

The proposed research framework for this study is based on the SERVQUAL model (Parasuraman *et al.*, 1985; 1988) and the various ideas generated from the literature reviewed. Companies in the Zimbabwean medical insurance sector can use the proposed research framework to appreciate the role of service quality in the sector and to implement service quality strategies suggested in the study to enhance the quality of service in the industry. The design of the research framework is based on the premise that service quality has been confirmed as a significant element of customer satisfaction (Banerjee & Sah, 2012; Jain & Jain, 2015; Lakshmi & Santhi, 2015; Zeithaml *et al.*, 2009) and that customer satisfaction with the service offerings of their current health insurer has been established as a significant factor to remain insured with that insurer (Amo-Adjei *et al.*, 2016; Reitsma-Van Rooijen *et al.*, 2011; Wendel *et al.*, 2011). The model is shown in Figure 3.7 below.

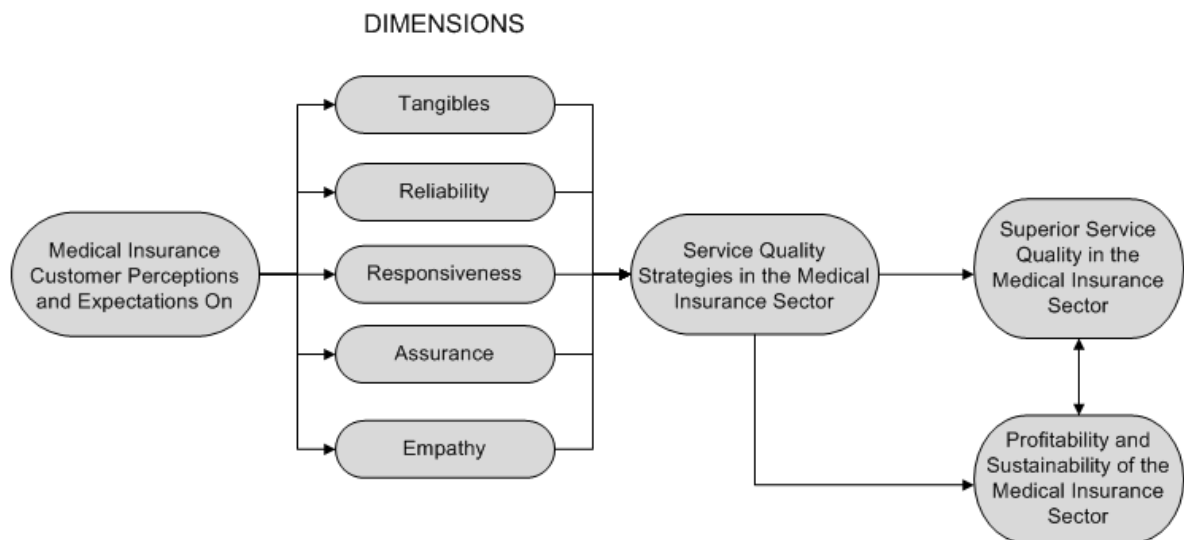


Figure 3.7: Proposed research framework

Source: Researcher's own compilation

The five SERVQUAL dimensions from the SERVQUAL model have been adapted to design the above proposed research framework. Since literature has shown that knowledge of service quality gaps forms the basis for setting clear standards that enhance quality of service in an industry (Chikwendu *et al.*, 2012, Naidoo & Mutinta, 2014), the proposed model starts with understanding customer perceptions and expectations along all five service quality dimensions as the basis for formulating service quality strategies in the medical insurance sector. Furthermore, since excellent service has been regarded as a profit strategy that results in more business with existing and new customers (Gokilavani & Durgarani, 2016:2413), the model asserts that service quality strategies will result in superior service quality, profitability, and sustainability of the Zimbabwean medical insurance sector.

Since current strategies to improve the quality of service in the Zimbabwean medical insurance industry were mainly based on efforts to adopt health insurance systems in developed countries like America and some government regulations (section 2.10), it is believed that this study will generate new knowledge on enhancing efficiency in the industry through service quality strategies suggested by the study.

3.13 Conclusion

This chapter discussed the literature on service quality, spanning from definitions to models developed in trying to understand this abstract construct. Aspects discussed also included the literature on service quality characteristics, as well as customer perceptions and expectations in general. Although few researchers reflected on service quality in private health insurance, studies close to the discipline were consulted in an attempt to close this gap in the literature. Some of the models that have been developed to understand service quality have been discussed, and the adoption of the gaps model and the SERVQUAL model has been justified. In addition, literature on strategies that can be adopted to improve service quality has been reviewed. Lastly, a research framework, based on the SERVQUAL model and some ideas generated from the literature reviewed, was designed. The next chapter will discuss the methodology used in conducting the study.

CHAPTER FOUR

RESEARCH METHODOLOGY

4.1 Introduction

Research methodology refers to the philosophy and science behind all research. It tries to probe further “how we know what we know” and allows us to understand the various ways of creating knowledge (Adams, Khan, Raeside & White, 2007:25). Adams *et al.* (2007) highlight that the concepts that make up the subject matter of methodology allow us to be analytical and critical when faced with information that is presented as facts. This chapter is therefore a blueprint of how the research was conducted, providing the methodological and philosophical foundations of the study. Thus, an exposition of the research design, philosophy, approach and strategy used in this research is presented in this chapter. The chapter will start by looking at the research problem, objectives, research questions and the hypotheses to be tested.

4.2 Research problem

Even though Zimbabwe is listed amongst few African developing countries that adopted private health insurance successfully (Sekhri & Savedoff, 2005:132), customer perceptions and expectations of these services remain unknown since limited research on service quality is recorded in this area. Furthermore, it remains uncertain whether these services are meeting or exceeding the expectations of medical insurance clients, as there have been extensive calls to improve quality standards in the medical insurance industry in Zimbabwe (AHFoZ, 2014). The magnitude of the gaps also remains unknown.

Measuring service quality within medical insurance companies in Zimbabwe is an indicator of whether medical insurance clients are satisfied or dissatisfied with the service offering. This study will therefore make an empirical assessment of the perceptions and expectations of medical insurance customers on the well-established service quality variables, namely reliability, tangibles, responsiveness, empathy, and assurance. This will assist in identifying individual and overall service quality gaps that exist, together with customer satisfaction and dissatisfaction levels experienced, and in determining how service quality can be improved in the medical insurance industry.

4.3 Research objectives

The objectives of the study were to:

- ascertain medical insurance customers’ perceptions of service quality with respect to reliability, tangibles, responsiveness, empathy and assurance;
- establish medical insurance customers’ expectations of service quality offerings provided by medical insurers with respect to reliability, tangibles, responsiveness, empathy and assurance;

- measure the service quality gaps experienced by medical insurance clients in Zimbabwe;
- compare service quality gaps experienced by customers in government owned and privately owned medical insurance companies; and
- suggest strategies that medical insurance companies in Zimbabwe can employ to improve service quality in the industry.

4.4 Research questions

The study set out to provide some answers to the following research questions:

- What are the medical insurance customers' perceptions of service quality with respect to reliability, tangibles, responsiveness, empathy and assurance?
- What are the medical insurance customers' expectations of service quality offerings provided by medical insurers with respect to reliability, tangibles, responsiveness, empathy and assurance?
- To what extent are service quality gaps experienced by medical insurance clients in Zimbabwe?
- How do service quality gaps experienced by customers in government owned medical insurance companies differ from those experienced by customers in privately owned companies?
- How can medical insurance companies in Zimbabwe enhance service quality using the information obtained from the study?

4.5 Research hypotheses

In an effort to answer the above research questions, the following hypotheses were tested:

H1.1: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers in different age groups.

H1.2: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers.

H1.3: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy.

H1.4: There are no statistically significant differences in the perceptions of medical insurance service quality along all the dimensions amongst customers with different periods of membership to their medical insurance companies.

H1.5: There are no statistically significant differences in the perceptions of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies.

H2.1: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups.

H2.2: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers.

H2.3: There are no statistically significant differences in the customer expectations of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy.

H2.4: There are no statistically significant differences in medical insurance customers' expectations of the service quality along all the dimensions amongst customers with different periods of membership.

H2.5: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies.

H3.1: There are no statistically significant differences in service quality gaps experienced by medical insurance customers in different age groups.

H3.2: There are no statistically significant differences in service quality gaps experienced between male and female medical insurance customers.

H3.3: There are no statistically significant differences in service quality gaps experienced by medical insurance customers employed in different sectors of the economy

H3.4: There are no statistically significant differences in service quality gaps experienced by medical insurance customers with different periods of membership to the medical insurance companies.

H3.5: There are no statistically significant differences in service quality gaps experienced by medical insurance customers who have either switched or not switched between medical insurance companies.

H4.1: There are no statistically significant differences in customers' perceptions of service quality between government owned and privately owned medical insurance companies.

H4.2: There are no statistically significant differences in customers' expectations of service quality between government owned and privately owned medical insurance companies.

H4.3: There are no statistically significant differences in service quality gaps experienced by customers in government owned and privately owned medical insurance companies.

Please note, the results obtained from the customers' perceptions, expectations and gap scores as well as those obtained in section D of the questionnaire together with those from the hypothesis tested were

used to come up with service quality strategies to enhance efficiency and sustainability of the Zimbabwean medical insurance sector.

4.6 Research philosophy

Research philosophy is a broad term that focuses on the nature of knowledge as well as on how that knowledge is developed and it contains key postulations concerning the way the world is viewed by the researcher (Saunders, Lewis & Thornhill, 2007:101). These postulations form the basis of the research methods and strategies. The adopted research philosophy is largely determined by the views of the researcher concerning the association between knowledge and its development process (Saunders *et al.*, 2007:101–102).

Epistemologically, there are two basic belief systems that guide how research is conducted: positivism and interpretivism (Potrac, Jones & Nelson, 2014:31). These two belief systems describe what constitutes acceptable knowledge in a particular field of study (Saunders *et al.*, 2007:102). The major distinction between positivism and interpretivism lies in how each paradigm examines and explains human behaviour. These two approaches will be briefly explained in this section and the researcher will justify why each approach was found more suitable or unsuitable for the study.

4.6.1 The positivist philosophical paradigm

This is a natural scientist philosophical standpoint, which “holds that all genuine knowledge is based on experience and can only be advanced through observation and experiment” (Cohen, Manion & Morrison, 2007:9). Thus, under positivism, the researcher is regarded as an observer of social reality and the resultant analysis is expressed in terms of laws generated in relation to the natural phenomena (Cohen *et al.*, 2007:10).

In an attempt to comprehend the clients’ perceptions and expectations of service quality offered by health insurance companies in Zimbabwe and to find ways to improve it, the researcher adopted the objectivist stance. In this perspective, service quality in health insurance companies was taken to have “a reality that” was “separate from the customers that perceive that reality” (Saunders *et al.*, 2007:108). Thus, the positivist research philosophy was adopted in which the researcher was regarded as being independent of the research and not affected by the matter of the research (the social actors). Service quality was thus regarded as an observable social reality which could be reduced to simplest elements in the form of the five service quality variables proposed by Parasuraman *et al.* (1988:12–40). In this regard, it was assumed that generalisations about the service quality dimensions most significant to the health insurance sector in Zimbabwe could be made and therefore used to improve service delivery in this industry. This assumption was based upon successful previous researches in service quality undertaken in various disciplines, namely tourism, the banking sector, health sector and many others, and there being very little research, or none done in the health insurance sector, most particularly in the

Zimbabwean context. Thus, the motivation to adopt the positivism philosophy was based on the fact that the service quality dimensions most significant to the health insurance sector, particularly in Zimbabwe, remain unknown, yet they are the cornerstones for the improvement of service quality in many service sectors as proved by research. The positivist research philosophy uses theories that exist to formulate some hypotheses, which are tested and verified, partly or in whole, or refuted (Saunders *et al.*, 2009:113). In this research, the SERVQUAL model formulated by Parasuraman *et al.* (1988:12–40) was used to develop hypothesis along all the service quality dimensions which were to be tested in the health insurance companies in Zimbabwe. The research was carried out in a value-free manner where the researcher did not have any interference to the data and maintained an objective position, thus contributing to the credibility of the data and facts generated from this study. Highly structured questionnaires were used to collect quantitative data from a sizeable sample, from which generalisations about service quality dimensions very important to the health insurance sector could be made. These generalisations can be used as the basis for improving service delivery in the industry.

4.6.2 The interpretivism philosophical paradigm

The interpretivism paradigm provides a radical option to positivism, which rejects the assumption that the social world can be investigated using natural scientist methods or through a set of value-neutral research procedures (Potrac *et al.*, 2014:33). This philosophical paradigm is based on the assumption that social reality is complex and is largely influenced by social contexts and human experiences and is best investigated “in its socio-historic contexts by reconciling the subjective interpretation of its various participants” (Potrac *et al.*, 2014:36). This paradigm was considered unsuitable for this study, because it focuses on the depth and detail of data collected from small populations using a wide array of qualitative methods. Such small populations could result in too little data being collected, leading to false conclusions being made about the perceptions and expectations of service quality in the medical insurance sector in Zimbabwe (Battacherjee, 2012:103–104). Using this method with an increased sample size could also result in too much data, which could not be effectively processed employing qualitative methods. Furthermore, the interpretation of the social reality using this paradigm results in heavily contextualised inferences, which cannot be generalised. All these considerations influenced the researcher to adopt the positivist stance.

4.7 Research design

Research design refers to the conceptual framework in which a study is conducted (Kothari, 2004). In other words, it is a detailed plan designed to fulfil research objectives and answer research questions, which clearly specifies the sequence of research tasks and activities (Adams, Khan, Raeside & White, 2007:81; Shukla, 2008:29). It therefore constitutes the outline of the entire research course of action, from making broad assumptions to the gathering, measurement, and analysis of data (Creswell, 2013:107; Kothari, 2004). From these definitions, it can be concluded that a research design is a master

plan that shows a series of all the activities and tasks that are undertaken in a research study to fulfil the research objectives and answer the research questions.

Although different authors classify research designs differently, it should be pointed out that these differences add up to the same thing. For instance, Adams *et al.* (2007:82) categorise research designs into three categories, namely observational (or non-experimental) design, quasi-experimental design, and experimental design. Battacherjee (2012:35), however, loosely defines research design as the data collection process and therefore groups research designs into two categories, namely positivist and interpretive. Saunders *et al.* (2007:133) and Shukla (2008:29) identify three types of research designs, which are causal (or explanatory), descriptive, and exploratory designs. Creswell (2013:107) also identifies three types of research designs, namely qualitative, quantitative, and mixed methods. According to Shukla (2008:29), the exploratory research design involves exploring the phenomenon and it is qualitative in nature. It uses projective techniques, focus groups, and in-depth interviews to collect the required data. This design resembles the non-experimental or observational design identified by Adams *et al.* (2007:82), the interpretive design of Battacherjee (2012:103), and the qualitative method of Creswell (2013:183). The descriptive research design, on the other hand, is quantitative in nature and involves the determination of frequencies associated with events occurring or in the correlation between variables (Shukla, 2008:99). According to Shukla, this design is commonly used to make predictions of consumer and market behaviour in the marketing field. This research design shares some similarities with the quasi-experimental design by Adams *et al.* (2007:82), the positivist design of Bhattacharjee (2012:101), and the quantitative design of Creswell (2013:155). The causal or explanatory design is generally used to denote the cause and effect association between variables and experimentation is a method commonly used in causal designs (Shukla, 2008:45). Thus, this design has common features with the experimental design of Adams *et al.* (2007:82) and also partly the positivist approach of Bhattacharjee (2012:101).

Using the above classification, this study was descriptive, and the quantitative research design was employed, which involves the testing of objective theories by investigating the association among variables that can be calculated and evaluated using statistical procedures. According to Cooper and Schindler (2011), quantitative methodologies in business researches are generally used to estimate levels of consumer attitudes, opinions, knowledge, and behaviour. Therefore, in the present study, this design was most suitable for measuring clients' perceptions and expectations of service quality in health insurance firms, using the SERVQUAL model suggested by Parasuraman *et al.* (1988:12–40). The research design was also appropriate for testing the above hypotheses.

4.8 Research approach

Since this research involved the testing of the SERVQUAL model and the establishment of service quality characteristics that mostly influence service quality in the health insurance sector in Zimbabwe,

the deduction approach was used. This approach is scientific in nature and it entails the formulation of a theory that should be rigorously tested. The deduction method was adopted in this study on the premise that the service quality problems in the health insurance sector could be better understood and solved if they are simplified into smallest possible elements (in the form of service quality dimensions), as suggested by Parasuraman *et al.* (1988:12–40). Hypotheses for this study were deduced from the SERVQUAL model developed by Parasuraman *et al.* (1988:12–40) and literature reviewed from several articles written around this model. Hypotheses were expressed in operational terms of service delivery activities that enabled facts about services expected and perceived by customers in the health insurance sector in Zimbabwe to be measured quantitatively. These hypotheses were then tested on a selected sample of health insurance clients from the five largest health insurance companies.

4.9 Research strategy

The research strategy used was a cross-sectional survey since it involved the collection of data at a particular point in time (Creswell, 2013:157). This was due to time and financial constraints, which could not allow this study to measure changes of customers' perceptions and expectations and service quality gaps over time. A survey design gives a numeric or quantitative justification of patterns, views, or attitudes of people by investigating a section of that population (Creswell, 2013:157). A survey thus allows quantitative information to be gathered, which can be examined through descriptive and inferential statistics. Such an approach enables the compilation of a substantial quantity of data from a considerable population in an economic way (Saunders *et al.*, 2009:138). The population of this study was very large, comprising 1 000 000 health insurance members from the five largest health insurance companies in Zimbabwe. A census was not possible for this population, due to accessibility and financial constraints. Therefore, from a financial point of view, a survey was the best strategy to gather information from such a large population.

A cross-sectional survey allowed a snapshot of the expectations and perceptions of customers about service quality in the health insurance sector to be taken at a particular point in time. This would provide some insights into the phenomenon and provide some general guidelines regarding customer perceptions and expectations, which can be used by health insurance providers to improve service delivery in the sector. Thus, questionnaires were administered to a sample comprising 384 participants. A survey was also suitable in this study as there was a need to establish the association between the various service quality dimensions and satisfaction as perceived by clients in the health insurance sector. Data collected from this sample was therefore used to explain particular correlations between the service quality dimensions and levels of client satisfaction in the health insurance sector. This data could further be used as the basis to enhance service offerings in the health insurance sector.

4.10 Study population

Population refers to “totality of cases” (Shukla, 2008:56) from which a sample is drawn. In Zimbabwe, there are 30 health insurance companies, which cover about 1.5 million of the 13 million people in the country (AHFoZ, 2014). According to AHFoZ, the five largest insurance companies in Zimbabwe, namely PSMAS, CIMAS, First Mutual Life, Fidelity, and Altfin account for the approximately 1 000 000 membership in health insurance companies, while the rest constitutes small firms and in-house health insurance facilities for specific industries and companies. The population of this study is the 1 000 000 members of the five largest insurance members in Zimbabwe.

PSMAS accounts for 50 per cent of the 1 000 000 membership, since its beneficiaries were mostly government employees, whereas CIMAS accounts for 30 per cent of the total membership, followed by First Mutual Life, which has 10 per cent, and Altfin and Fidelity with both 5 per cent each (AHFoZ, 2014; Shamu *et al.*, 2010:5). Since the five chosen health insurance companies are the ones whose activities are significant in the industry and the others are in-house schemes for specific industries, a study of customers in these five health insurance companies was sufficient to give a good reflection of clients’ perceptions and expectations about service quality in the industry. These big health insurance companies also have high chances of experiencing serious service delivery issues, since they deal with many customers (Chinyadza, 2014). These five medical insurance companies represented three (out of five) forms of ownership of medical insurance companies in Zimbabwe. These three forms of ownership are the Government (PSMAS), Corporate General Insurance Companies (Fidelity, First Mutual Medical Savings Fund and Altfin), and private not for profit health insurance schemes (CIMAS). However, these three forms of ownership can further be reduced to government owned and non-government (private) owned companies. Thus, the study intended to test if there are significant differences in perceptions and expectations among medical insurance companies differently owned. The other two forms of ownership of medical insurance companies (urban councils and provided initiated ownership) were not included in the population. This is because membership to urban councils’ medical insurance is closed and service quality is likely to be good, since it is done as a motivational strategy for employees.

4.11 Sample size

As it was not possible to gather information from all 1 000 000 members of the five medical insurance companies studied, because of money, accessibility and time constrains (Saunders *et al.*, 2007:204), a sample was chosen to collect the data required for the study. According to Cohen *et al.* (2007:101), there is no specific response that can be given about the acceptable size of sample to use, but this is largely determined by the research purpose together with the nature of the population being studied. They add that the magnitude of the sample is also dependent on the style of the research and they give an example of a survey style, which generally needs a large sample to enable the calculation of inferential statistics. Cohen *et al.* (2007:102) are also of the view that size of the sample might be

restricted “by cost in” the form of “time, money, stress, administrative support, the number of researchers and resources”. However, they recommend larger samples for greater reliability and use of sophisticated statistics. Cohen *et al.* (2007) further recommend thirty cases as a minimum that allows some meaningful statistical analysis to be done.

Cohen *et al.* (2007:102) are also of the view that the “size of a sample can be determined in two ways, either by the researcher exercising prudence and ensuring that the sample represents the wider features of the population with the minimum number of cases, or by using a table which from a mathematical formula, indicates the appropriate size of a sample for a given number of the wider population”. A good example of such a table is the one provided by Krejcie and Morgan (1970:607–610). The Krejcie and Morgan table is based on the idea “that the smaller the number of cases in the wider population, the larger the proportion of that population” which should appear “in the sample” and vice versa (Cohen *et al.*, 2007:103). However, Krejcie and Morgan do not merely consider the size of the population, but the confidence interval and level as well. The confidence level “(95 per cent or 99 per cent) is an index of how sure we can be that the responses lie within a variation range” and it “is that degree of variation that one wishes to ensure” (Cohen *et al.*, 2007:102).

All the above facts were considered in determining the sample size for this study. Since the researcher intended to use some inferential statistics in analysing the data, she used the Krejcie and Morgan (1970:607–610) table to decide on the appropriate sample size of medical insurance subscribers to include in the study. From the computations of Krejcie and Morgan (1970:607–610), a population size of 1000 000 requires a sample of 384 elements at a 5 per cent margin of error and 95 per cent confidence level. The sample size for this study was therefore 384. Elements to be included in this sample were chosen in proportion to the percentage of membership in each of the five medical insurance companies studied, as shown in Table 3.1 below.

4.12 Sampling strategy

The researcher used non-probability sampling techniques (quota sampling and convenience sampling) to select a sample of 384 participants who could be conveniently selected from the five major health institutions in Harare, namely Parirenyatwa Group of Hospitals, Harare Central hospital, West End Medicare, Baines Imaging Group, and Dr Mazvuru and Partners Dental Surgeons. Health institutions were chosen as points to collect data. As such, clients had fresh experiences with their respective health insurance companies and were likely to give accurate and useful insights about service quality due to their immediate encounters from the health insurance companies responsible for settling their medical bills. The five major health institutions in Harare were also chosen on the premise that Harare is the capital city of Zimbabwe and it is these hospitals that all medical cases are referred to in Zimbabwe. Thus, to a certain extent, the sample will be a reliable presentation of people who consume health insurance services in Zimbabwe.

The adoption of a non-probability sampling technique in this quantitative study is justified on the grounds of several studies on service quality reviewed by the researcher, who employed this technique. For instance, the convenience sampling method was used for collecting data in a study by Kassim and Abdullah (2010:351–371) to examine the association between loyalty, trust, satisfaction, and perceived service quality in e-commerce settings in Qatar and Malaysia. Convenient sampling was also employed by El Saghier and Nathan (2013:4–5) in a questionnaire survey in a study on service quality dimensions and customer satisfaction on banks in Egypt. In addition, Sweeny *et al.* (2008:344–364) used convenience sampling “to study the impact of service quality dimensions on satisfaction and the effect of satisfaction on repurchase and word-of-mouth communication for outpatients in Turkey”. Here convenience sampling was adopted to accommodate time and budget restrictions. In this particular study, two SERVQUAL dimensions (Empathy and Assurance) were suggested as significant determinants of satisfaction. A study on “Expectations, perceptions and satisfaction about service quality at destination Gotland” by Kabir and Carlsson (2010) is another example where convenience sampling was used.

4.13 Quota sampling

According to Bailey (1978:82), “quota sampling” is commonly known as “the non-probability equivalent of stratified sampling”, and it endeavours to symbolise major features (strata) of the broader population (Cohen *et al.*, 2007:114; Saunders *et al.*, 2007:227). With this sampling method, “the population is segmented into mutually exclusive subgroups, and then a non-random” group of participants “is chosen from each subgroup to meet a predefined quota” (Kothari, 2004:59). According to Kothari, quota sampling can be either proportional or non-proportional. In the present study, the researcher used proportional quota sampling in which the percentage of participants in each subgroup matched that of the population.

The population for the present study comprised one million (1 000 000) subscribers of the five biggest medical insurance companies in Zimbabwe, namely PSMAS, CIMAS, First Mutual, Fidelity, and Altfin. The five medical insurance companies were the strata identified, so that members chosen for the sample could be proportional to the overall membership in the health insurance companies studied. Clients from these five medical insurance companies (which have different forms of ownership) are most likely to experience different service delivery from their service providers and the researcher intended to capture this from the study.

The proportions of the five subgroups (medical insurance companies), as presented in section 4.10 above, were used to determine the number of respondents from each medical insurance company. Quota sampling was used to determine the number of respondents to select from each medical insurance company. Medical insurance members were then conveniently selected from the five medical

institutions in Harare and questionnaires were distributed to those patients in the five medical institutions visited (or selected) who showed willingness and interest to take part in the survey.

4.14 Convenience sampling

This is a sampling method whereby subjects of the sample are taken from that section of the population that is readily available, close at hand, or convenient. It is also referred to as opportunity or accidental sampling (Bhattacharjee, 2012:69). In the present study, only medical insurance customers who had visited the five health institutions selected and who were ready and willing to participate were included in the sample. This implies that all medical insurance customers in other health institutions and who had not visited health institutions at all were excluded from the sample. Thus, the opinions obtained were likely to reflect the unique characteristics of clients who visit these health institutions. However, these opinions were likely not to accurately represent the views of medical insurance customers in general (Bhattacharjee, 2012:69). Yet, since the medical institutions selected normally handle referral cases from several hospitals in Zimbabwe, diverse opinions of customers from different backgrounds were likely to be obtained. Furthermore, although the opinions obtained were not representative, they were very useful in giving some insights into this least researched area of service quality in private health insurance.

The following table was used to determine the number of members to select from each of the five health insurance companies.

Table 4.1 Sample size determination

| INSURANCE COMPANY | PROPORTION OF THE SUBGROUPS IN THE POPULATION (%) | SAMPLE SIZE |
|-------------------|---|-------------|
| PSMAS | 50 | 192 |
| CIMAS | 30 | 115.2 |
| FIRST MUTUAL LIFE | 10 | 38.4 |
| ALTFIN | 5 | 19.2 |
| FIDELITY | 5 | 19.2 |
| TOTAL | 100 | 384 |

The researcher rounded the above figures to the nearest decimal. Thus, for the 384 conveniently selected participants, 192 were PSMAS members, 115 were from CIMAS, 38 were from FIRST MUTUAL LIFE, 19 were from ALTFIN and 19 were from Fidelity.

4.15 Data collection methods

Primary data collection techniques were employed for collecting data. Since the research strategy adopted was a survey, questionnaires were regarded as the most appropriate research instruments for

collecting a large quantity of information from a substantial population in an economic manner (Saunders *et al.*, 2009:139). Questionnaires would also allow the collection of data in a way that permits the quantitative description of attitudes, opinions, or patterns from the large sample of medical insurance customers (Creswell, 2013:157).

4.16 Research instruments

This section focuses on the tools or instruments employed in collecting data. The research instruments used were questionnaires.

4.16.1 Questionnaire

Since the study was descriptive in nature, questionnaires were the most suitable research instruments (Saunders *et al.*, 2007:366). A questionnaire is a research tool comprised of a number of questions (items) designed to obtain information from the target population in a standardised method (Ross, 2005:3). DeVaus (2002, cited in Saunders *et al.*, 2007:354–355) also concurs with the above definition and defines a “questionnaire as a technique of data collection in which each person is asked to respond to the same set of questions in a predetermined order”. Saunders *et al.* (2007:355) further recommend “a questionnaire” as an effective “way of collecting responses from a large sample prior to quantitative analysis”.

When coming up with a questionnaire, the researcher needs to consider the type and wording of the questions, which can be either open-ended or closed-ended (Saunders *et al.*, 2007:368). Open-ended questions give participants room to provide their own opinions, whereas closed-ended questions give the respondent some limited choice of answers from which to choose. Closed-ended questions were used in this study, since they were considered to be easier and quicker to answer. They were also chosen because it was easier to compare responses, since answers were predetermined (Saunders *et al.*, 2007:368).

A structured questionnaire was used in which respondents were asked to choose a response from a set of choices provided. The response format was the interval-level response where participants were asked to show their levels of agreement or disagreement about their expectations and perceptions around the five dimensions of service quality in the health insurance sector. This was done using a 5-point Likert-type scale, which ranged from ‘strongly disagree’ (1) to ‘strongly agree’ (5).

A questionnaire made up of the 22 questions on expectations and perceptions of the health insurance customers in terms of the five service quality dimensions was utilised. The questionnaire was modified to suit service delivery aspects in the health insurance industry. Furthermore, a 5-point Likert-type scale was used instead of the 7-point Likert-type scale originally suggested by Parasuraman *et al.* (1988:12–40).

The 5-point Likert-type scale was used due to its advantages, which include its expansiveness, ability to show the degree of the respondent's views or opinions towards what is being asked, easy collection of data from respondents, and easy analysis of data. It was also used due to its compatibility with the research design of the self-administered survey employed in the study (Hair, Wolfinbarger, Ortinau and Bush, 2008:155).

The construction of the questionnaire was mainly guided by the objectives of the study and hypotheses. The questionnaire comprised the following four sections:

- Section A: Demographic data (Questions 1–7)
- Section B: Customer expectations of the services offered by medical insurance companies
- Section C: Customer perceptions of the services offered by medical insurance companies
- Section D: Customer views on medical insurance companies in Zimbabwe and how service quality can be improved

Section A required medical insurance clients to give their demographic data which included their age, sex, the medical insurance they subscribe to, the sector of the economy in which they are employed, the period of membership of their medical insurance company, whether or not they have switched between medical insurance companies, and the reasons for switching. This information allowed for the in-depth analysis of the customers' perceptions and expectations around the service quality dimensions. It would also allow for hypotheses to be formulated and tested, which will assist in building the body of knowledge on service quality in the context of the medical insurance industry.

Section B comprised 22 questions on customer expectations of the services offered by medical insurance companies, while section C comprised 22 questions on customer perceptions of the services offered by medical insurance companies. These two sections allowed service quality gaps to be calculated or estimated among the various service quality dimensions in the medical insurance industry.

Section D was made up of general questions about medical insurance customers' views on medical insurance companies in Zimbabwe and how service quality in the industry can be improved. This gave a basis for the formulation of strategies to improve service quality in the medical insurance companies in Zimbabwe.

Each questionnaire had a covering letter, which clearly justified the intention of the survey and informed that it was conducted towards the completion of a PhD programme. The letter also highlighted that the study had been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee and contained the names and contact details of the researcher and her supervisor. The researcher also stated that the details of the respondent would not be disclosed in the study and that there were no risks or discomforts involved in participation in the study. She also highlighted that there were no monetary gains to be obtained by participating in the study and that the information obtained will help towards building the body of knowledge on service quality in the medical

insurance industry in Zimbabwe. According to Dillman (2000, cited in Saunders *et al.*, 2007:372–398), all the above information is necessary for the attainment of a high response rate with questionnaires.

4.17 Data collection process

The researcher, with the assistance of some field workers, personally delivered the questionnaires to medical insurance clients in the nominated five medical institutions in Harare. Permission to collect data from these centres was sought earlier by the researcher before the commencement of data collection, as evidenced by the gatekeepers' letters attached as appendices. Questionnaires were distributed to patients at their points of admission to the medical institutions. The respondents were given enough time to complete the questionnaires and they were asked to leave them at the reception after completion. However, in some cases respondents preferred to arrange a time with the researchers and the field workers to come and collect the completed questionnaires. The researcher also asked for the contact numbers of the respondents so that a follow up could be done to check whether the respondents had managed to leave the completed questionnaires or not. Out of the 384 questionnaires distributed, 286 were completed and returned, resulting in a 74 per cent response rate. These were used for the data analysis process.

4.16 Ethical considerations

Research ethics “refers to the appropriateness of the researcher’s behaviour in relation to the rights of those who become the subject of his or her work or are affected by it” (Saunders *et al.*, 2009:183). This research was designed in a manner that was ethically justifiable to all those concerned through the guidance of the University Research Ethics Policy. The researcher obtained a clearance letter from the University to conduct the research and consent to collect info was also obtained from the selected sources of data. Gatekeepers' letters from the five medical institutions where data was to be collected were also acquired. Furthermore, the approval of the respondents was also obtained before they completed the questionnaires. As mentioned earlier, the researcher also assured the respondents that their details would not be disclosed in the study.

4.17 Validity and reliability

This section explains how the aspects of validity and reliability were dealt with in the study.

4.17.1 Validity

Validity “refers to the extent to which a measure adequately represents the underlying construct that it is supposed to measure” (Bhattacharjee, 2012:58). In the context of questionnaires, internal validity “refers to the ability of a questionnaire to measure what it is intended to measure” (Saunders *et al.*, 2007:394). According to Blumberg, Cooper and Schindler (2005, cited in Saunders *et al.*, 2007:366), when researchers are examining the validity of a questionnaire, they normally refer to construct validity,

criterion validity, and content validity. Content validity refers to the effectiveness of a questionnaire to provide sufficient coverage of the investigative questions, while adequate coverage is ensured through literature review and prior discussion with other knowledgeable people. Criterion-related validity (predictive validity) measures the extent to which questions can create precise forecast. Construct reliability is concerned with the ability of measurement questions to accurately determine the existence of those constructs intended to be measured.

In the present study, content validity was ensured through a literature review on service quality in general as well as on medical insurance and other related areas since literature on service quality in medical insurance is limited. The SERVQUAL instrument, designed by Parasuraman *et al.* (1985:420–450), was adapted to suit the service quality variables in the medical insurance industry and other related services. The questionnaire was peer-reviewed by a professional statistician, the researcher’s supervisor and senior academics with good knowledge of research methodology. Their invaluable input was used to correct and rephrase some questions.

A pilot study was conducted to determine the time required to complete the questionnaire, to verify clarity of instructions, and to check if any questions were unclear or ambiguous. The pilot questionnaires were checked to verify if the participants did not have problems in comprehending or answering questions and had correctly adhered to instructions. It helped to further refine the questionnaire and to make sure that the questionnaire was understood by respondents. The pilot study on medical insurance schemes was conducted in January 2015, involving 20 Chinhoyi University of Technology staff, before obtaining the ethical clearance from the UKZN Humanities and Social Sciences Research Ethics Committee. Areas that needed corrections were identified and subsequently corrected. The questionnaire was thus refined to minimise problems in answering the questions and to reduce problems in data capturing.

4.17.2 Reliability

Saunders *et al.* (2007:395) state that reliability “is concerned with the robustness of the questionnaire, and in particular, whether or not it will produce consistent findings at different times and under different conditions, such as with different samples or in the case of an interviewer-administered questionnaire, with different interviewers”. Cohen *et al.* (2007:146) concur with the above and add that reliability in quantitative research is a “synonym of dependability, consistency and replicability over time, over instruments and over groups of respondents”.

Shukla (2008:82) highlights three ways in which reliability can be tested, which are “test-retest reliability, alternative forms reliability and internal consistency reliability”. In a test-retest reliability measurement, a few respondents are given a similar set of scale items at two different periods. The extent of resemblance between the measurements (correlation) denotes reliability. For alternative forms of reliability, two sets of equivalent scales are made, and the same participants are assessed at different

intervals. Internal consistency reliability is employed to measure the reliability of a summated scale where a number of items are added together to form a total score. In this case, “techniques such as ‘split-half reliability’ or ‘coefficient alpha’ (Cronbach’s alpha) are used” for measuring “internal consistency reliability” (Shukla, 2008:84). In the case of the Cronbach’s alpha, a value above 0.7 denotes acceptable internal reliability (Shukla, 2008:84).

In the present study, the Cronbach’s alpha was used, since it suited very well with the nature of the data collected. The Cronbach’s alpha value for the overall data was 0.897, which shows that the data was reliable since the value was above 0.7.

4.18 Data analysis

The Statistical Package for the Social Sciences (SPSS) version 20 was used for analysing data. This was done with the assistance of a professional statistician. Descriptive statistics and inferential statistics were employed in analysing the data. The analysed data were presented in the form of pie charts, bar charts, and frequency tables. In the case of inferential statistics, the data were initially tested for normality and it was found to be not normally distributed. Therefore, non-parametric tests were used for inferential statistics. The researcher will give a brief description of the descriptive and inferential statistics employed in the study.

Saunders *et al.* (2007:420) classify the initial analysis of quantitative data into two groups, namely the exploratory data analysis approach and the descriptive statistics approach. Both approaches were employed in the present study.

4.18.1 The exploratory data analysis approach

This approach uses diagrams to explore and understand the data and is very useful in exploring and presenting individual variables (Saunders *et al.*, 2007:420). It usually makes use of frequency tables or distribution, bar charts, histograms, pie charts, and line charts, among others. In this study, frequency distributions, bar charts, and pie charts were employed mainly in presenting demographic data.

4.18.1.1 Frequency distributions

Frequency distribution refers to “a summary of the frequency (or percentages) of individual values or ranges of values for that variable” (Bhattacharjee, 2012:121). This distribution can be presented as either tables or bar charts, which is explained below. In this study, frequency distributions are used in bar charts, where the vertical axis shows the frequency or percentage of observations in each grouping.

4.18.1.2 Bar charts

Bar charts were chosen because of their usefulness in providing more accurate representation of individual variables, where the height and length of each bar gave the frequency of occurrence. Bar charts were thus very useful in representing the distribution of the respondents by age, the distribution

of medical insurance companies subscribed to, the period of membership to medical insurance companies, and the summary of statements regarding the expectations and perceptions dimensions.

4.18.1.3 Pie charts

Pie charts were also employed due to their ability to put emphasis on the proportion or share of occurrences of variables (Saunders *et al.*, 2007). Thus, pie charts were very useful in the study to show the distribution of the respondents by gender, the sectors of the economy where respondents were employed, whether respondents had ever switched between medical insurance companies, and the reasons for switching.

4.18.2 Descriptive statistics

Descriptive statistics refer to the quantitative analysis techniques that made the numerical description (and comparison) of variables possible for the researcher (Saunders *et al.*, 2007:433–434). Descriptive statistics are divided into measures of central tendency and measures of dispersion.

4.18.2.1 Measures of central tendency

Central tendency refers to an estimation of the “centre of a distribution of the values” (Battacherjee, 2012:121). Basically, measures of central tendency are three in number, namely the mode, median, and mean. These measures are discussed below.

4.18.2.1.1 The mode

This refers to the “most frequently occurring value in a distribution of values” (Battacherjee, 2012:122) and it is also regarded as the “only measure of central tendency that can be” sensibly “interpreted” (Saunders *et al.*, 2007:437). A good example of the application of the mode is the most frequently sold colour of motor vehicles during a given month.

4.18.2.1.2 The median

The median is the value at the centre of a series of values in a distribution and it is calculated by arranging all values in a distribution in an ascending order and choosing the middle value. However, if there are two values in the middle, the “average of the two middle values” denotes the median (Battacherjee, 2012:122).

4.18.2.1.3 The mean

This refers to the “simple average of all values in a given distribution” (Battacherjee, 2012:121). The mean includes all data variables in its computation, and it is the most commonly used measure of central tendency, although it is unduly influenced by outlying variables and considered a less representative measure of central tendency (Saunders *et al.*, 2007:437). Despite these considerations, the mean is

regarded as an important element for various statistical tests used to investigate association and it was therefore widely employed in this study.

4.18.3 Measures of dispersion

These measures are important in describing how data variables are scattered or dispersed around the mean (or measures of central tendency in general) (Saunders *et al.*, 2007:437). In particular, they look at how closely or how sparsely the values are distributed around the mean. The standard deviation and the range are the most commonly used measures of dispersion.

4.18.3.1 The range

“The range is the difference between the highest and the lowest values in a distribution” (Bhattacharjee, 2012:122) and it is very sensitive to the presence of outliers. Although the range gives a quick picture of the distribution of data values, it is not commonly used in research reports, since it only represents extreme values. The most commonly used measure or statistic is the inter-quartile range, which is obtained after further dividing the range into four equal sections called quartiles. The inter-quartile range is therefore the difference between the upper and lower quartiles and is only concerned with the middle 50 per cent of the data variables. It therefore overlooks outlying variables (Saunders *et al.*, 2007).

4.18.3.2 The standard deviation

This is “a measure of dispersion” that looks “at the extent to which data values for a variable are spread around the mean” (Saunders *et al.*, 2007:439). Kothari (2009:135) defines the standard deviation as “the square root of the average of squares of deviations, when such deviations for the values of individual items in a series are obtained from the arithmetic average”. If data are distributed very closely to the mean, the mean is very representative and does not vary widely. The advantages of the standard deviation, which includes its ability to take into consideration the problem of outliers and being least affected by fluctuations of sampling, qualifies it to be popularly used in estimating and testing a hypothesis (Kothari, 2009:136). The present study used this measure of dispersion extensively in trying to answer the research questions and in testing the hypotheses.

4.18.4 Inferential statistics

These refer to the statistical procedures “used to reach conclusions about associations between variables and they differ from descriptive statistics in that they are explicitly designed to test hypotheses” (Bhattacharjee, 2012:129). The process is called significance or hypothesis testing and the researcher will be making a comparison of the collected data with what she “would theoretically expect to happen” (Saunders *et al.*, 2007:437–438). It thus eliminates the likelihood that the research outcome could have been due to random variation in the sample.

According to Lavrakas (2008), hypothesis testing serves “to ascertain whether an observed deference in the sample is statistically significant or whether it can instead be adequately explained by chance alone”. Dytham (2011:2) adds that a hypothesis is tested to ascertain the probability that it is correct, and if the probability is small (p-value), then the hypothesis is taken to be untrue and it is rejected in favour of the alternative. Dytham (2011:2) also highlights that a statistical test is done to ascertain the extent to which a null hypothesis is true. A null hypothesis is the hypothesis that nothing is going on (H_0). Thus, the present study also sought to understand whether there are significant differences in customers’ perceptions and expectations along some demographic variables and between government and non-government owned companies. This led to the postulation of the above mentioned null hypotheses aimed at ascertaining these differences.

Statistical significance tests are classified into either parametric or non-parametric tests. Non-parametric tests are used on data that are not normally distributed, whereas parametric tests are used on quantifiable data, which are normally distributed. Saunders *et al.* (2007:441) are of the view that both non-parametric and parametric tests are used for testing significance through answering any one of the following questions:

- Is the relationship or association statistically noteworthy?
- Are the variations statistically noteworthy?
- What is the strength of the association and is it statistically noteworthy?
- Are the projected values statistically noteworthy?

4.18.4.1 Tests for normality

According to Dytham (2011:10), the normality tests normally “calculate the probability that the sample was drawn from a normal population” and the hypotheses tested are:

- H_0 : The data from the sample are not significantly different from that of a normal population.
- H_a : The data from the sample are significantly different from that of a normal population.

Probabilities which are more than 0.05, mean that the data are normal, whereas probabilities of less than 0.05 mean that the data are not normal.

In this study, the mean scores for every statement on the five service quality dimensions were added together and tested for normality, using the Shapiro-Wilk and Kolmogorov–Smirnov tests. The results indicated that the data were not normally distributed and hence the choice of using non-parametric tests for hypothesis testing. The non-parametric tests used in this research were the Kruskal-Wallis test, the Mann–Whitney test, and the Spearman’s rho coefficient.

4.18.4.2 The Mann–Whitney test

This is a non-parametric test used for comparing the mean scores and in mathematical terms. It is similar to the independent t-test with ranked values (Saunders *et al.*, 2007:447). This test compares the median

scores of two samples instead of the mean scores, and thus it is not affected by outliers and heavy tail distributions (Pallant, 2010). It is thus regarded as the best test to compare mean scores when the dependent variable is of an ordinal scale and not normally distributed (Dytham, 2011; Lavrakas, 2008).

Pallant (2010) argues that in carrying out the Mann–Whitney Test, the main values that must be taken note of in the output are the Z-value and the significance level given as Asymp sig (2-tailed). If the significance level is less than or equal to 0.05, it means the result is not significant and thus there are significant differences in the continuous variable scores being measured between the two groups. However, if a statistically significant difference is found between the groups, there is need to describe the direction of the discrepancy (which group is higher?) and this is seen in the Ranks tables under the mean ranks column (Pallant, 2010). Since lower scores are associated with low ranks, lower mean ranks denote lower concentration levels of the variable being measured, while higher mean ranks denote higher concentration of the variable being measured (Pallant, 2010). Thus, in the present study, lower mean ranks denote weaker perception, expectations, or (dis)satisfaction, whereas higher mean ranks denote stronger perceptions, expectations, or (dis)satisfaction.

Although the Mann–Whitney test is considered less powerful than the t-test or one-way ANOVA, it is highly regarded, because it is usually unlikely to obtain “a significant result when there are no real differences” (Dytham, 2011:2). In this study, the Mann–Whitney test was used for testing if there were any significant differences in gap scores between male and female respondents and between members who had either switched or not switched between the medical insurance companies by comparing the mean scores of the different groups.

4.18.4.3 The Kruskal–Wallis test

The Kruskal–Wallis test is a rank-based non-parametric test used to test for significant differences between two or more groups of an independent variable on a continuous or ordinal dependent variable (Pallant, 2010). It is regarded as the extension of the Mann–Whitney U test, which allows for the comparison of more than two independent groups and it also considered as an alternative to the one-way ANOVA (Dytham, 2011; Pallant, 2010). Thus, as in the Mann–Whitney test, the Z-value and the significance level should be considered, and if a statistically significant difference is found, the direction of the difference should be described through comparing the mean rank scores in the Ranks tables (Pallant, 2010).

In this study, the Kruskal–Wallis test was used for testing whether there were significant differences in the perceptions, expectations, and gap scores among customers in different age groups, different medical insurance companies, employed in different sectors, and with regard to periods of membership to the medical insurance companies.

4.18.4.4 The Spearman's rho coefficient

A correlation coefficient enables the researcher to assess the strength of linear relationships between quantifiable or two-ranked data (Saunders *et al.*, 2007:450–451). In the case of quantifiable data, the Pearson's product moment correlation coefficient is used to evaluate the power of the association. However, in the case of ranked data, the Spearman's rank correlation coefficient (Spearman's rho) is used. Since the data in this study were ranked, the Spearman's rho was used.

The Spearman's rank correlation ranges from -1 through 0 to 1, showing perfect negative correlation, no relation, and perfect positive correlation respectively. Thus, with these ranges, the direction of the relationship is shown, whether it is negative or positive. The strength of the relationship is shown by the significance level which tells how confident we should be in the results obtained (Pallant, 2010).

4.19 Summary

This chapter was an account of the research methodology employed to carry out the study. It discussed the research approach, philosophy and strategy used in order to answer the research questions and accomplish the research objectives. The study thus adopted a descriptive quantitative design which was considered suitable for measuring customers' expectations and perceptions of service quality in Zimbabwean medical insurance companies, using the SERVQUAL model. A positivist research philosophy was adopted in which service quality in medical insurance was taken to have a reality that was separate from the clients perceiving that reality. This philosophy was regarded to be relevant in extending the body of knowledge of service quality in the least researched area of medical insurance, particularly in the Zimbabwean context. The chapter also discussed the population of the study, sample size and sampling techniques employed, the research instrument used, the data collection procedures, and how the data were analysed. It was further indicated that the study conformed to the UKZN ethical requirements and the chapter also explained how validity and reliability were ensured.

4.20 Conclusion

This chapter was a blueprint of how the research was conducted and it gave the methodological as well as the philosophical foundations of the study. It thus gave an exposition of the research design, approach, philosophy as well as the research strategy used in fulfilling the research objectives. The next chapter (Chapter 5) will give a detailed analysis of the data collected.

CHAPTER FIVE

PRESENTATION AND ANALYSIS OF RESULTS

5.1 Introduction

This chapter provides a presentation and an analytical interpretation of the data gathered through questionnaires from medical insurance customers. The data obtained from the study was analysed using the Statistical Package for the Social Sciences (SPSS) version 20 and was presented by way of descriptive statistics and inferential statistics. The tolerance level of error (p-value) was set at 5 per cent (0.05).

The target population for this study was 1 000 000 medical insurance customers from the five largest medical insurance companies in Zimbabwe. A sample size of 384 medical insurance customers was determined using the Krejcie and Morgan (1970) tables. A total of 286 questionnaires were completed and returned, giving a 74 per cent response rate. This response rate was adequate to provide meaningful conclusions about the targeted medical insurance population.

The chapter starts by discussing the demographic variables, using pie charts and bar charts. The medical insurance customers' expectations, perceptions and gap scores will also be presented, and inferential statistics will be used to highlight some relationships and patterns emanating from the study.

5.2 Reliability

The data were tested for reliability using the Cronbach's coefficient alpha. Reliability was tested for individual expectation and perception dimensions as well as for the overall data. The results are shown in Table 5.1 below.

Table 5.1: Results for reliability

| | | Reliability statistics | |
|-------------|----------------|------------------------|------------|
| | | Cronbach's alpha | N of items |
| | Overall | 0.897 | 44 |
| Expectation | Tangible | 0.875 | 4 |
| | Reliability | 0.826 | 5 |
| | Responsiveness | 0.872 | 4 |
| | Assurance | 0.859 | 4 |
| | Empathy | 0.903 | 5 |
| Perception | Tangible | 0.758 | 4 |
| | Reliability | 0.838 | 5 |
| | Responsiveness | 0.907 | 4 |
| | Assurance | 0.904 | 4 |
| | Empathy | 0.768 | 5 |

As shown in the table above, the results for reliability for both the expectation and perception dimensions are above 0.7, which shows that the data is reliable. Furthermore, the Cronbach Alpha for the overall data is 0.897, which is also good.

5.3 Presentation of demographic data

In this section, results on the demographic data will be presented, starting with the age groups of the respondents.

5.3.1 Age groups of respondents

The age groups for the medical insurance respondents are as shown in Figure 5.1 below.

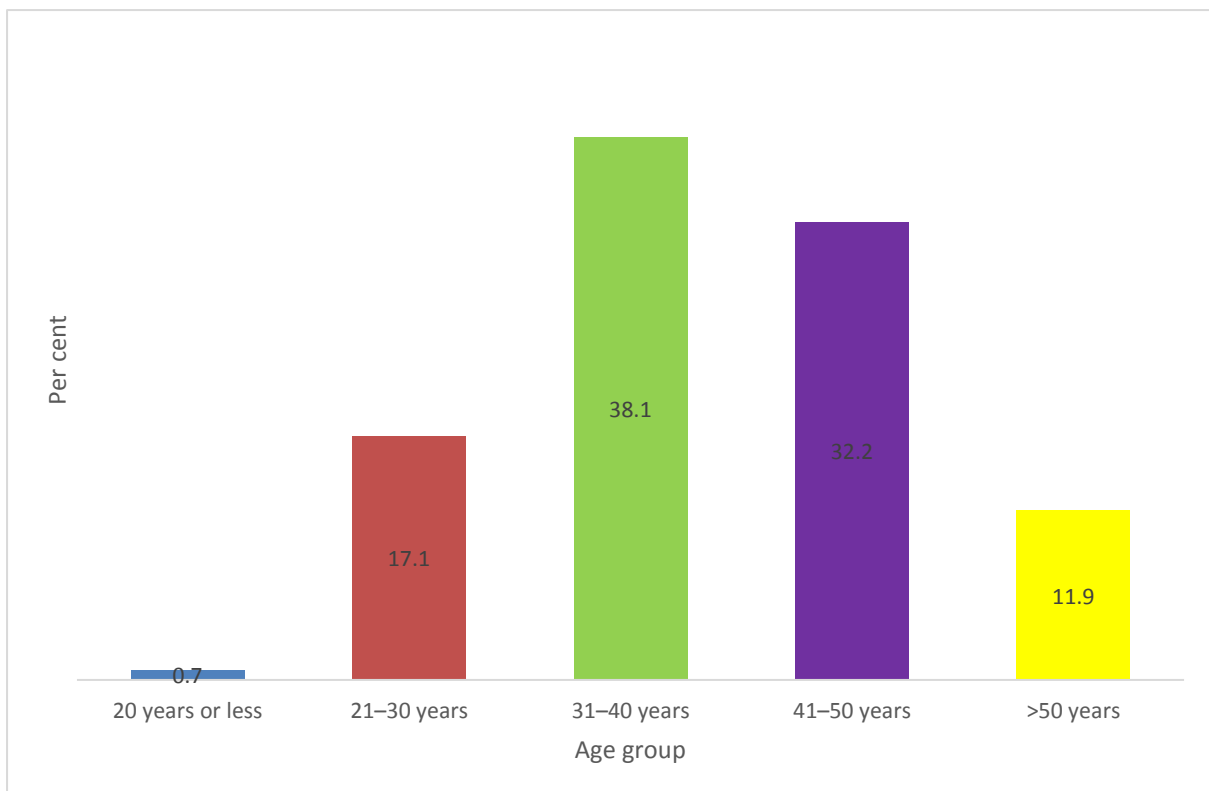


Figure 5.1: Distribution of age

A larger proportion of the respondents (38.1 per cent) were in the age group of 31–40 years. This was followed by respondents in the age groups 41–50 years (32.2 per cent), 21–30 years (17.1 per cent), above 50 years (11.9 per cent) and less than 20 years (0.7 per cent).

The results show that more than two thirds (70 per cent) of the participants were between the ages of 31 years and 50 years.

5.3.2 Gender

The distribution of the medical insurance respondents by gender is shown in Figure 5.2 below.

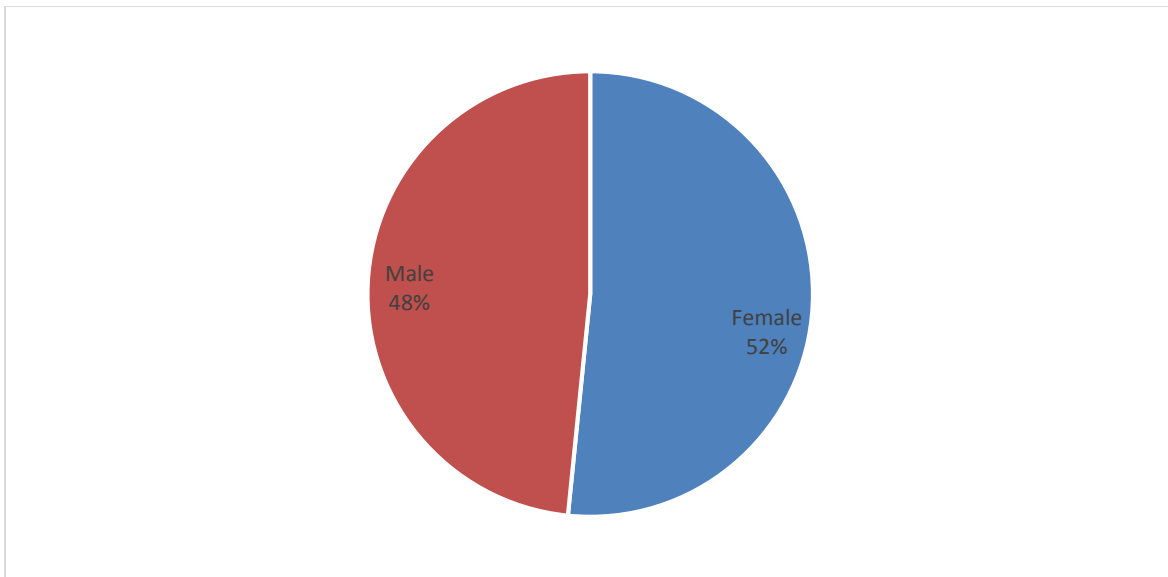


Figure 5.2: Distribution of age

With regard to participants' gender, just over half (52 per cent) of the participants were found to be female and male participants were 48 per cent.

5.3.3 Medical insurance company subscribed to

The medical insurance companies subscribed to by the participants are shown in Figure 5.3 below.

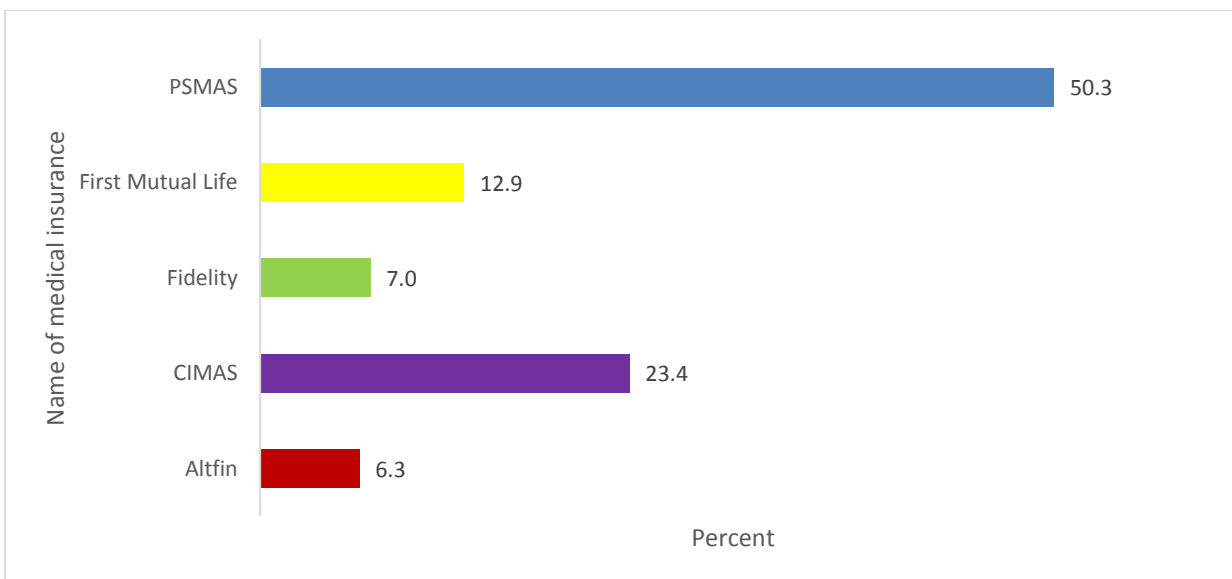


Figure 5.3: Distribution of participants by medical insurance company

The results showed that half of the participants belong to PSMAS medical insurance company, followed by CIMAS (50 per cent and 23 per cent respectively). This was followed by First Mutual Life, which had 12.9 per cent, Fidelity with 7 per cent and Altfin with 6.3 per cent.

5.3.4 Sector of the economy employed

The sectors of the economy in which the participants were employed are shown in Figure 5.4 below.

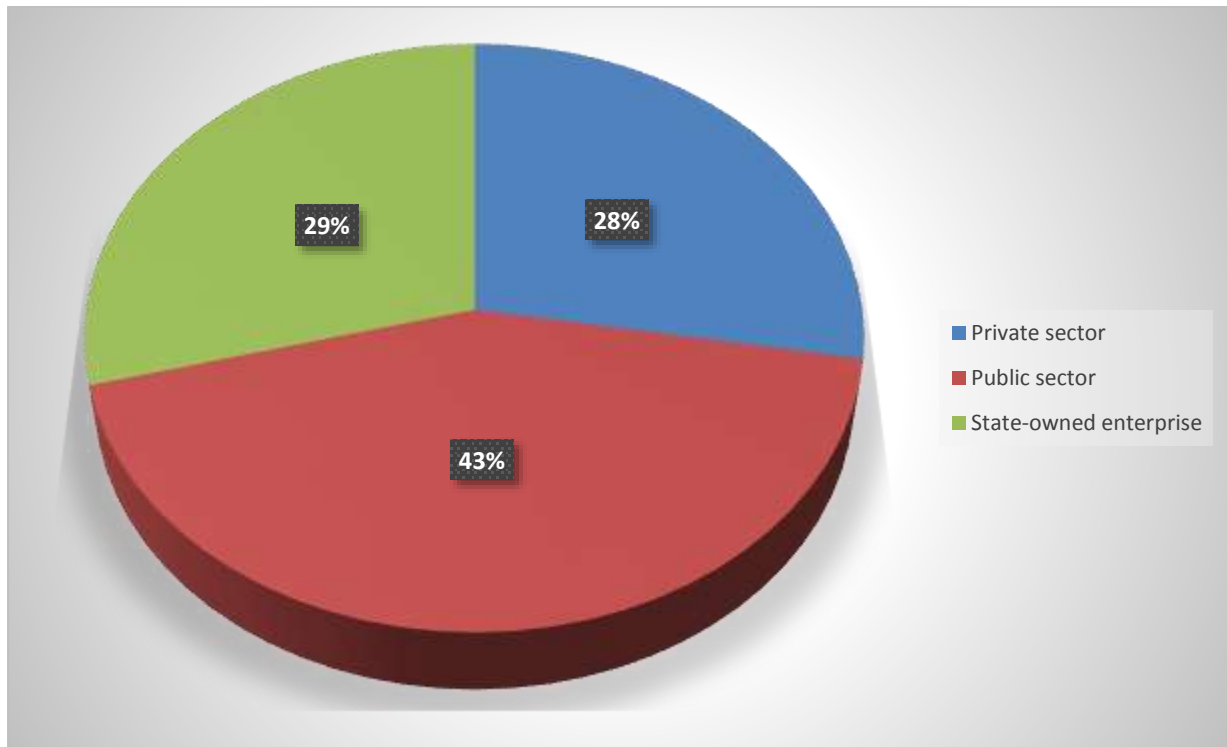


Figure 5.4: Sector of economy.

The results indicate that the biggest proportion of the participants (43 per cent) were economically engaged in the public sector. However, 29 per cent were employed in state-owned enterprises and 28 per cent were employed in the private sector.

5.3.5 Period of membership with a medical insurance company

The period of membership with medical insurance customers with their various medical insurance companies is shown in Figure 5.5 below.

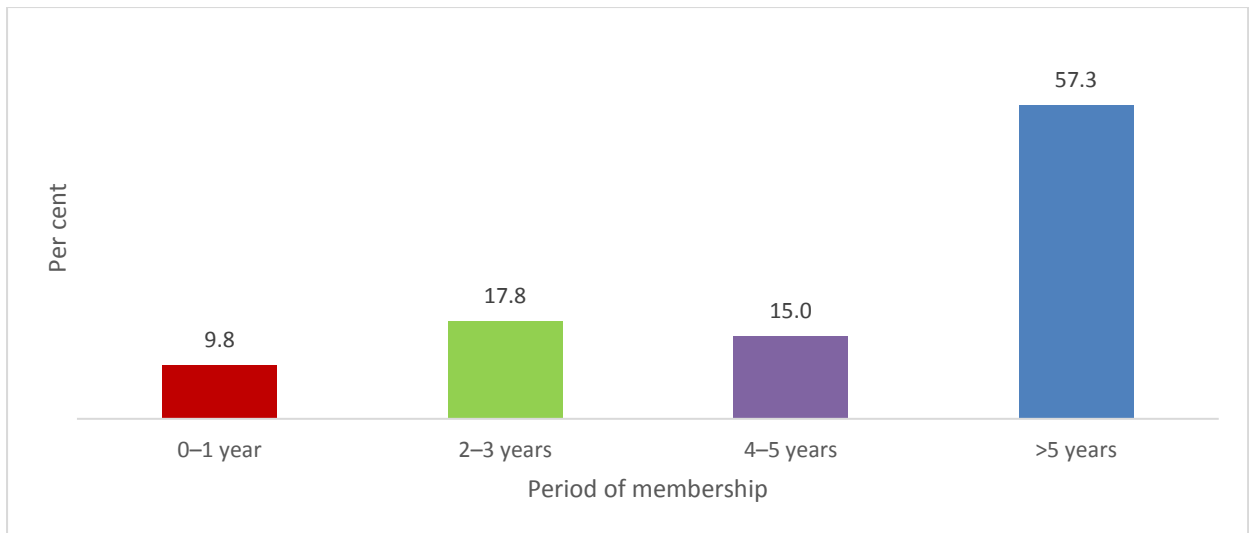


Figure 5.5: Period of membership.

The findings show that more than half of the respondents (57.3 per cent) were members of their medical insurance companies for more than 5 years. This was followed by 17.8 per cent who were members for a period of 2–3 years, 15 per cent who were members for a period of 4–5 years and 9.8 per cent who were members for a period of less than 1 year.

5.3.6 Switching between medical insurance companies

The results of whether medical insurance customers either have switched between medical insurance companies or have not switched are shown in Figure 5.6 below.

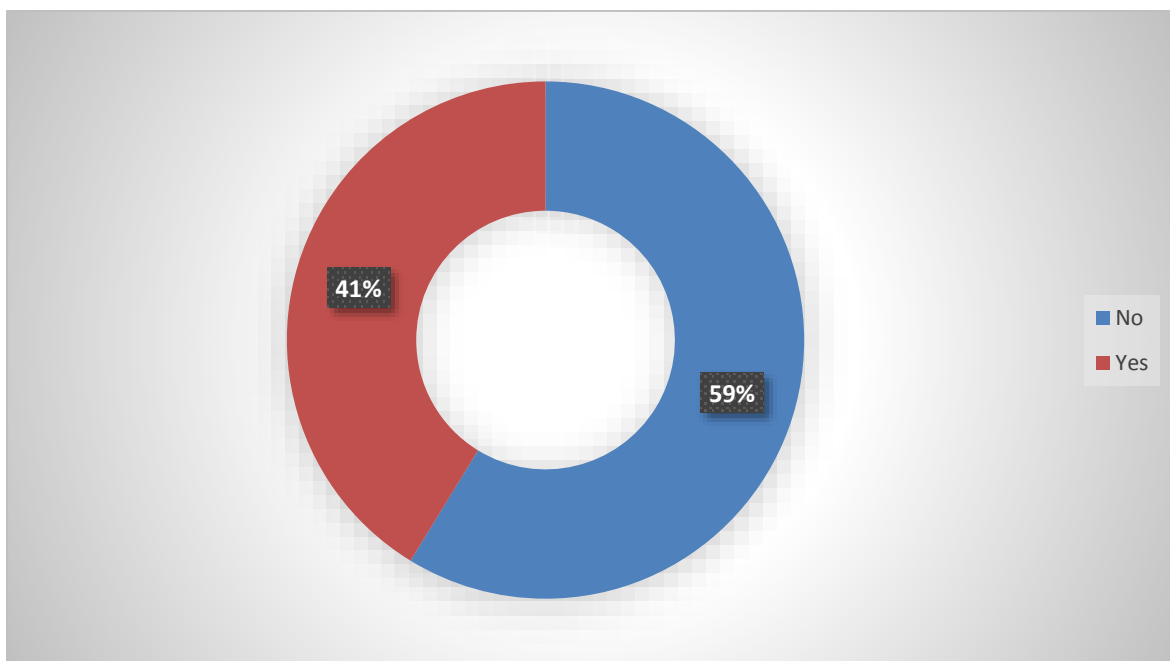


Figure 5.6: Clients who switched between medical insurance companies.

The results indicate that more than half of the participants (59 per cent) have never switched between medical insurance providers, whereas 41 per cent have switched between medical insurance companies.

5.3.7 Reasons for switching between medical insurance companies

Those who switched between medical insurance companies were asked to give reasons for their switching and the results are shown in Figure 5.7 below.

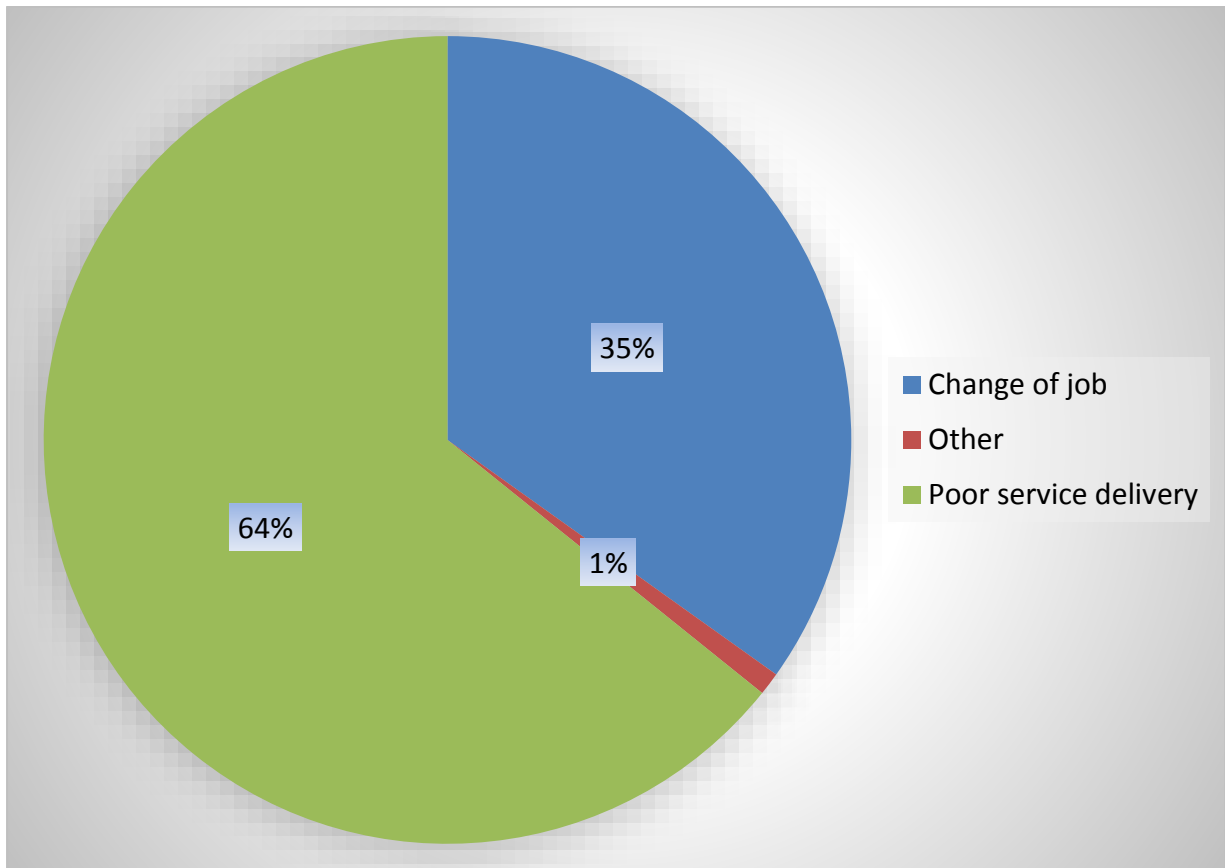


Figure 5.7: Reasons for switching.

It was found that the main reason for switching was poor service delivery (64 per cent), followed by change of jobs (35 per cent).

5.4 Presentation of results on customer expectations of service quality by medical insurance companies

Results on customer expectations of medical insurance service quality will be presented in this section along all the five service quality dimensions.

5.4.1 Tangible expectation

With regard to the tangible expectation, it was found that almost all the participants agreed or strongly agreed to all the four statements as shown in Figure 5.8 below. This indicated that most of the medical insurance customers had very high expectations with regard to the tangible dimension.

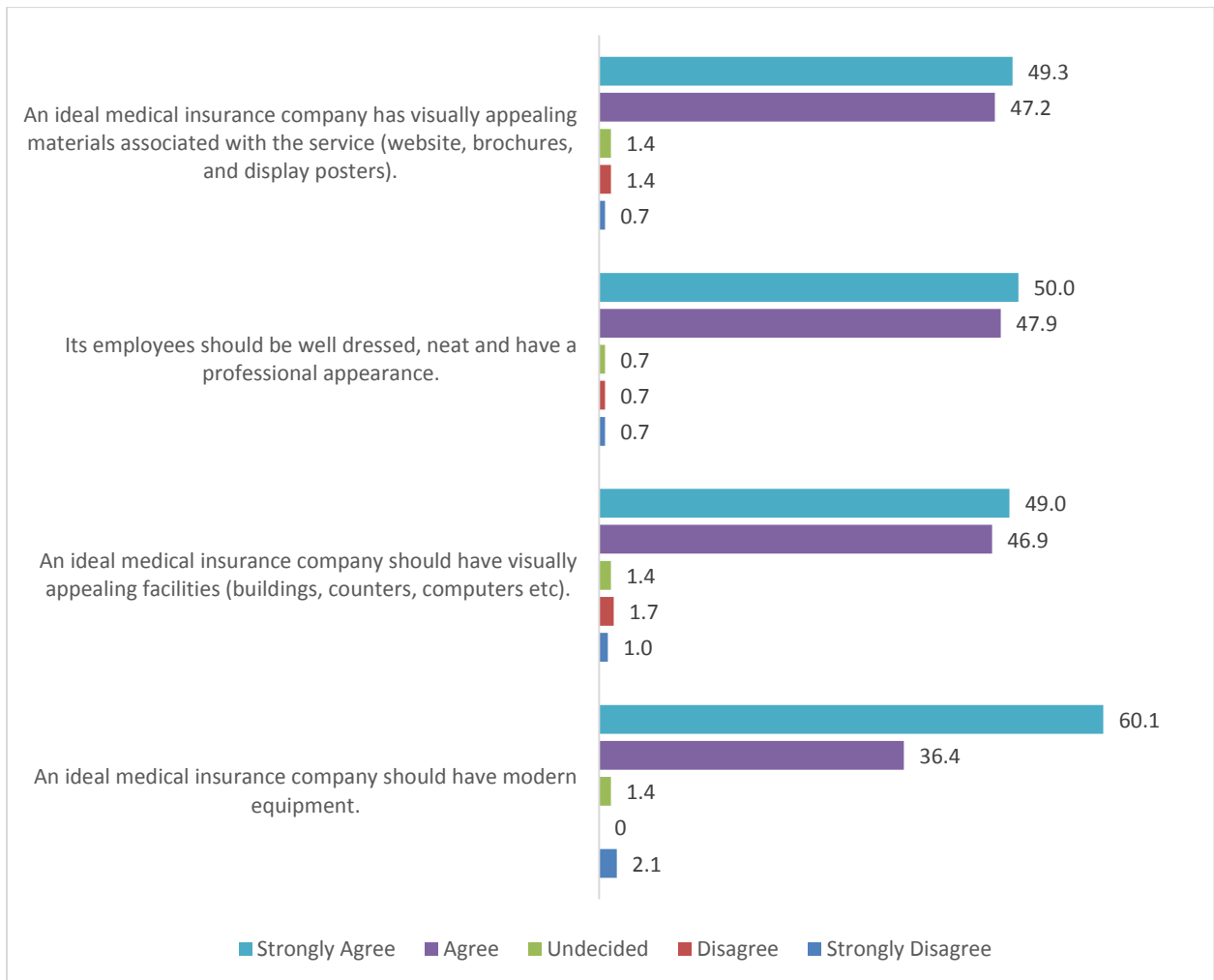


Figure 5.8: Summary of statement regarding tangible expectation

5.4.2 Reliability expectation

To determine the reliability expectation, bar charts were used and results indicated that most of the respondents strongly agreed or agreed to all the statements as is shown in Figure 5.9. This meant that medical insurance customers had very high expectations with regard to reliability.

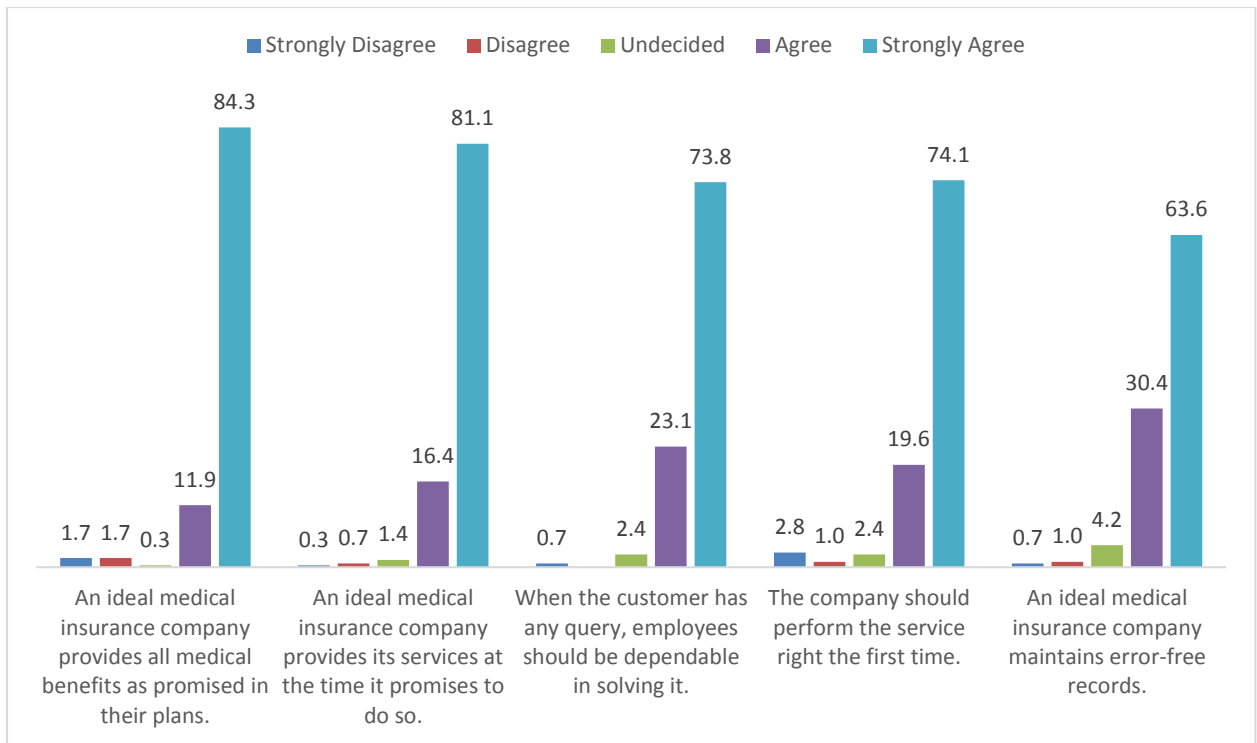


Figure 5.9: Distribution of statements regarding reliability expectation.

5.4.3 Responsiveness expectation

For responsiveness expectations, results indicated that the majority of the participants responded positively to all the statements (Figure 5.10). Therefore, it could be concluded that the participants' expectations for responsiveness were extremely high.

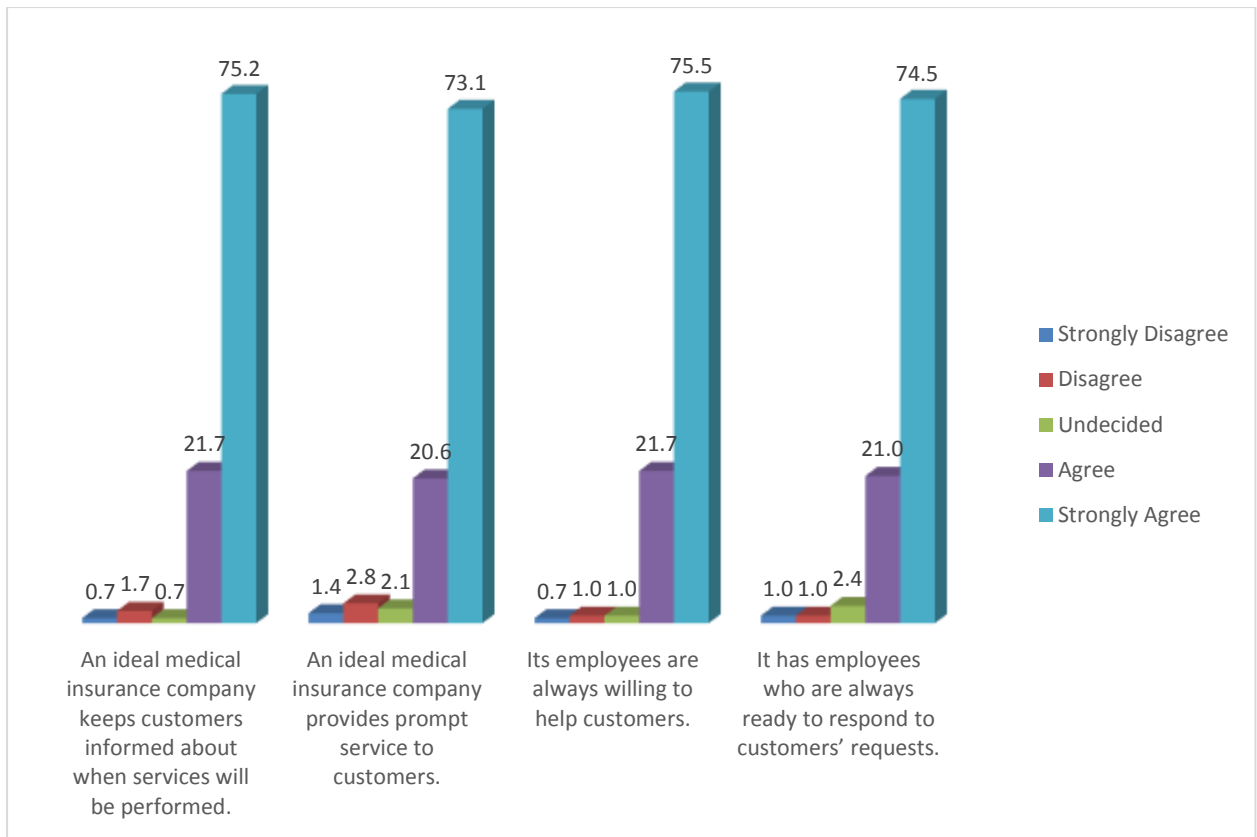


Figure 5.10: Distribution of statement regarding responsiveness expectation.

5.4.4 Assurance expectation

With regard to customer expectations for assurance, results showed that the greater number of the participants strongly agreed or agreed to all the statements (Figure 5.11). This meant that participants had very high expectations for assurance.

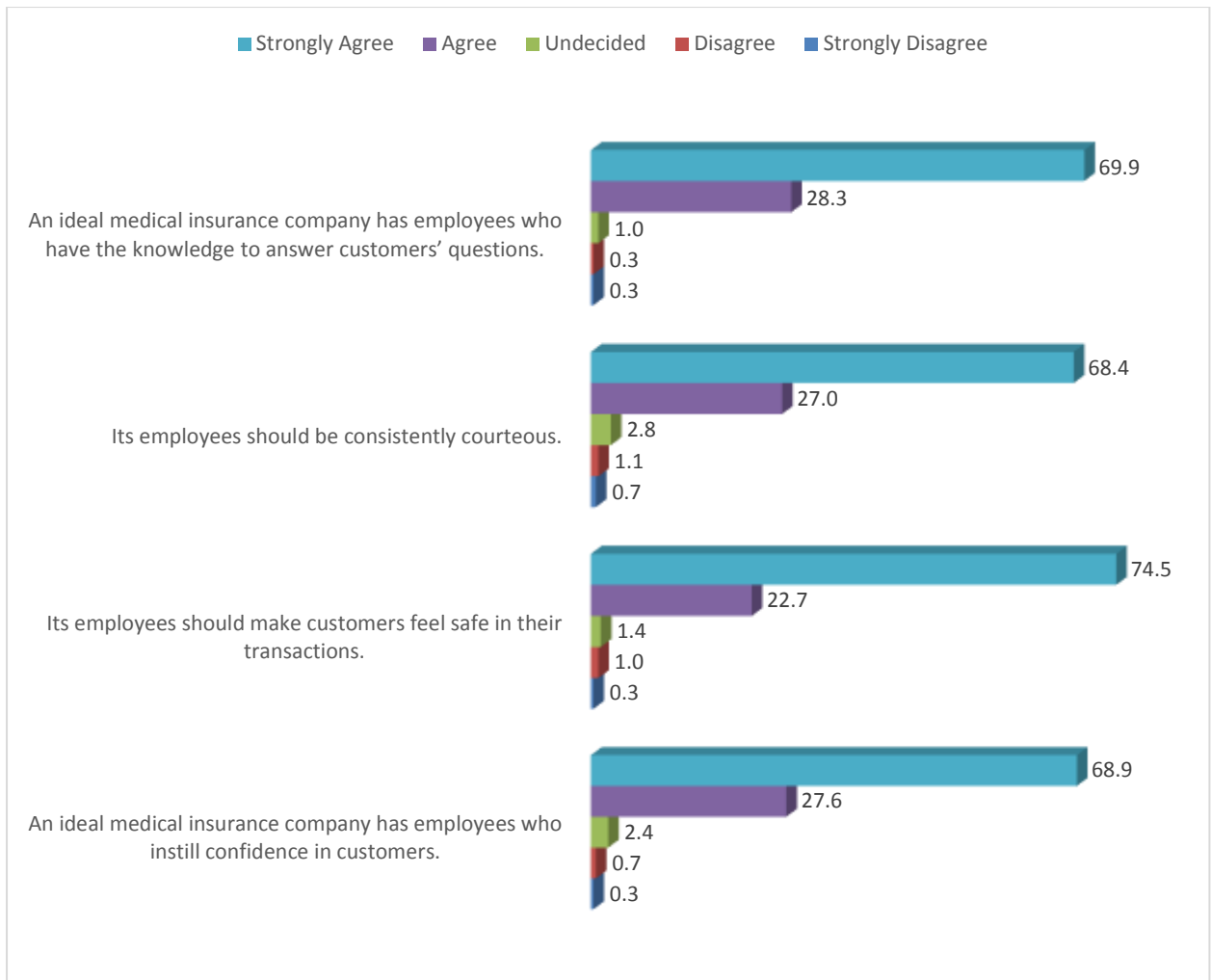


Figure 5.11: Summary of statements regarding assurance expectation.

5.4.5 Empathy expectation

The results indicated that the majority of the participants had very high expectations regarding empathy as they had strongly agreed or agreed to all the statements as shown in Figure 5.12 below.

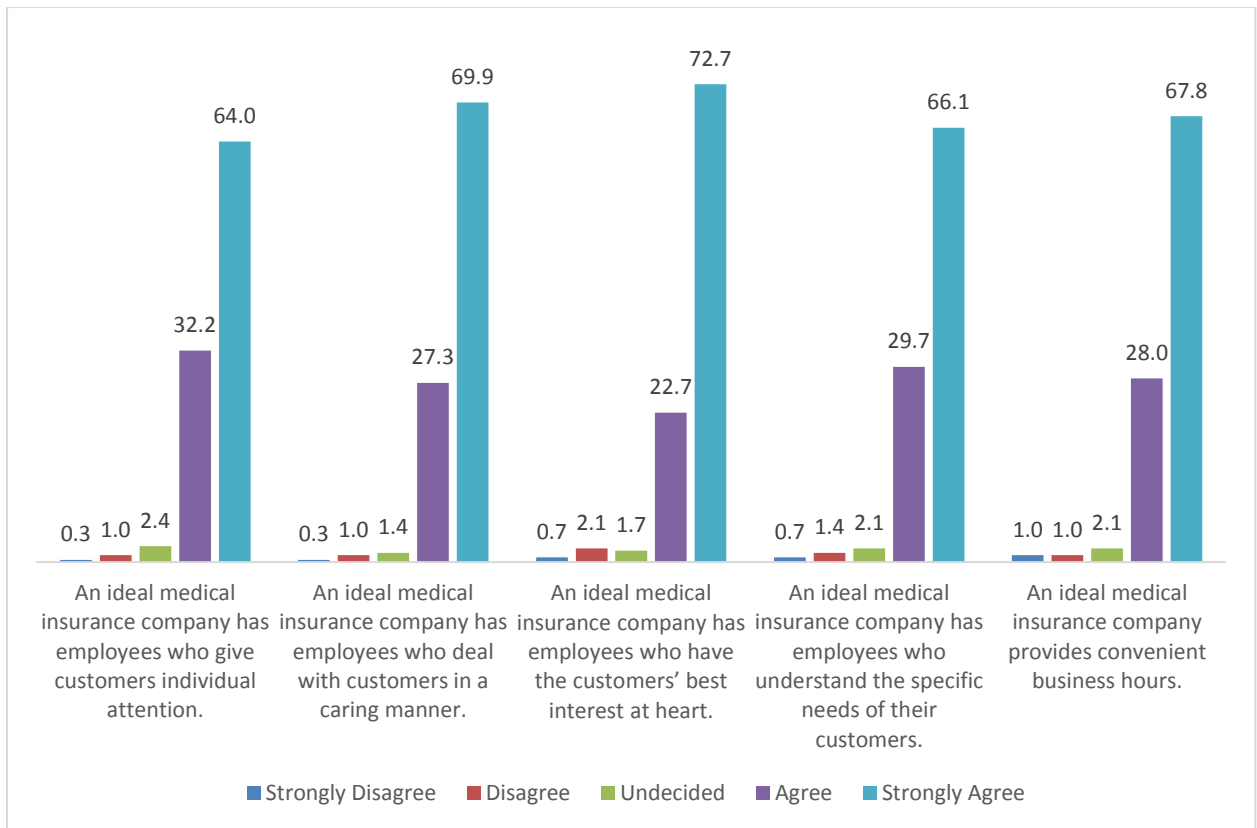


Figure 5.12: Distribution of statement regarding empathy expectation.

5.5 Presentation of results on customer perceptions of service quality by medical insurance companies

This section will present results on customer perceptions of service quality offered by medical insurance companies along all the five service quality dimensions.

5.5.1 Tangible perception

To determine customer perception with regard to the tangible aspect, four Likert type statements were tested. Results show that many respondents agreed or strongly agreed to all the statements (Figure 5.13). This shows that medical insurance customers had high perceptions of the tangibles of medical insurance companies.

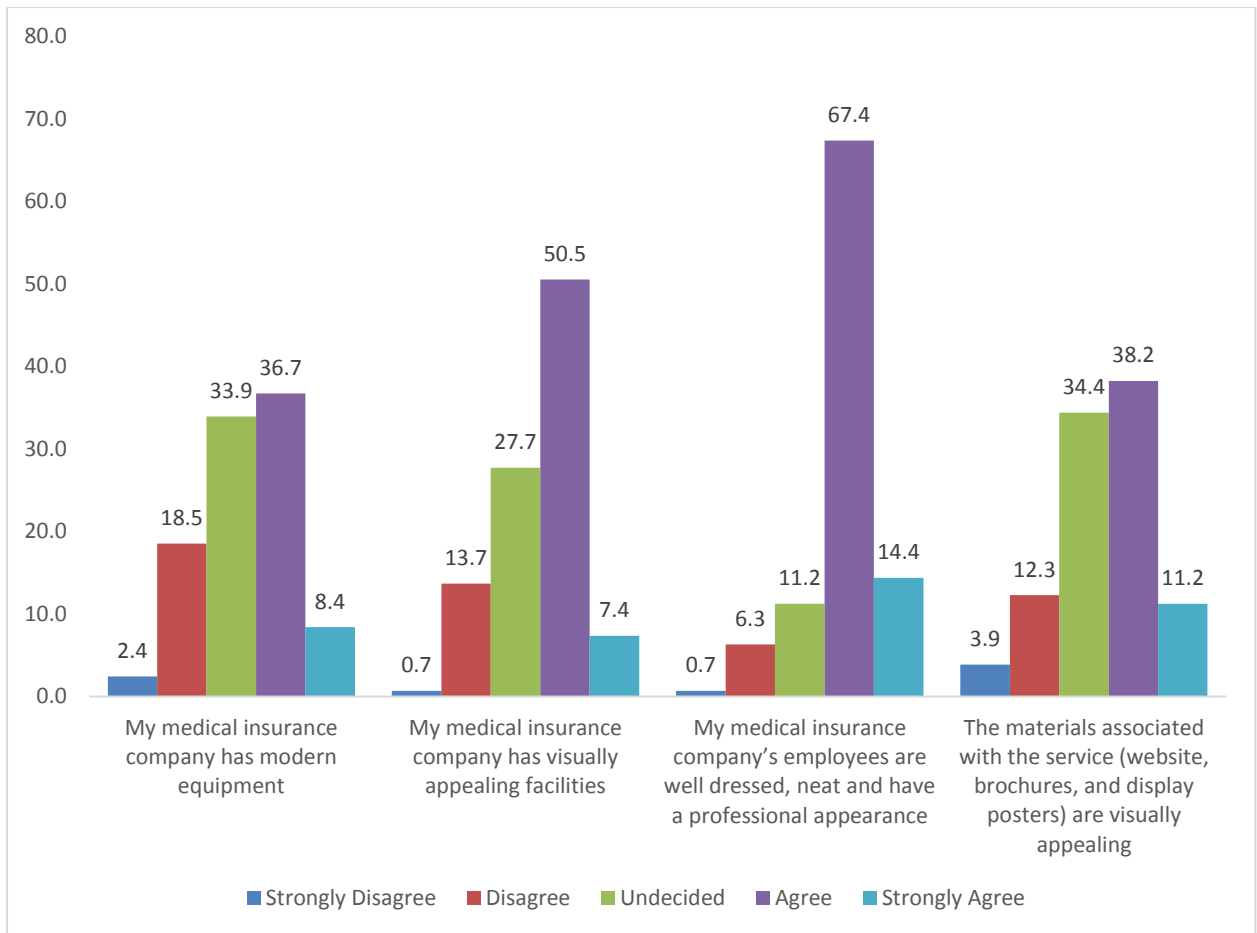


Figure 5.13: Distribution of statements regarding perception of tangible aspects.

5.5.2 Reliability perception

The present study found that many participants had negative perceptions regarding reliability. For instance, as shown in Figure 5.14, more than half of the participants responded negatively to the assertion that their medical insurance company provides all the medical benefits services as promised, and their medical insurance company provides services at the promised time.

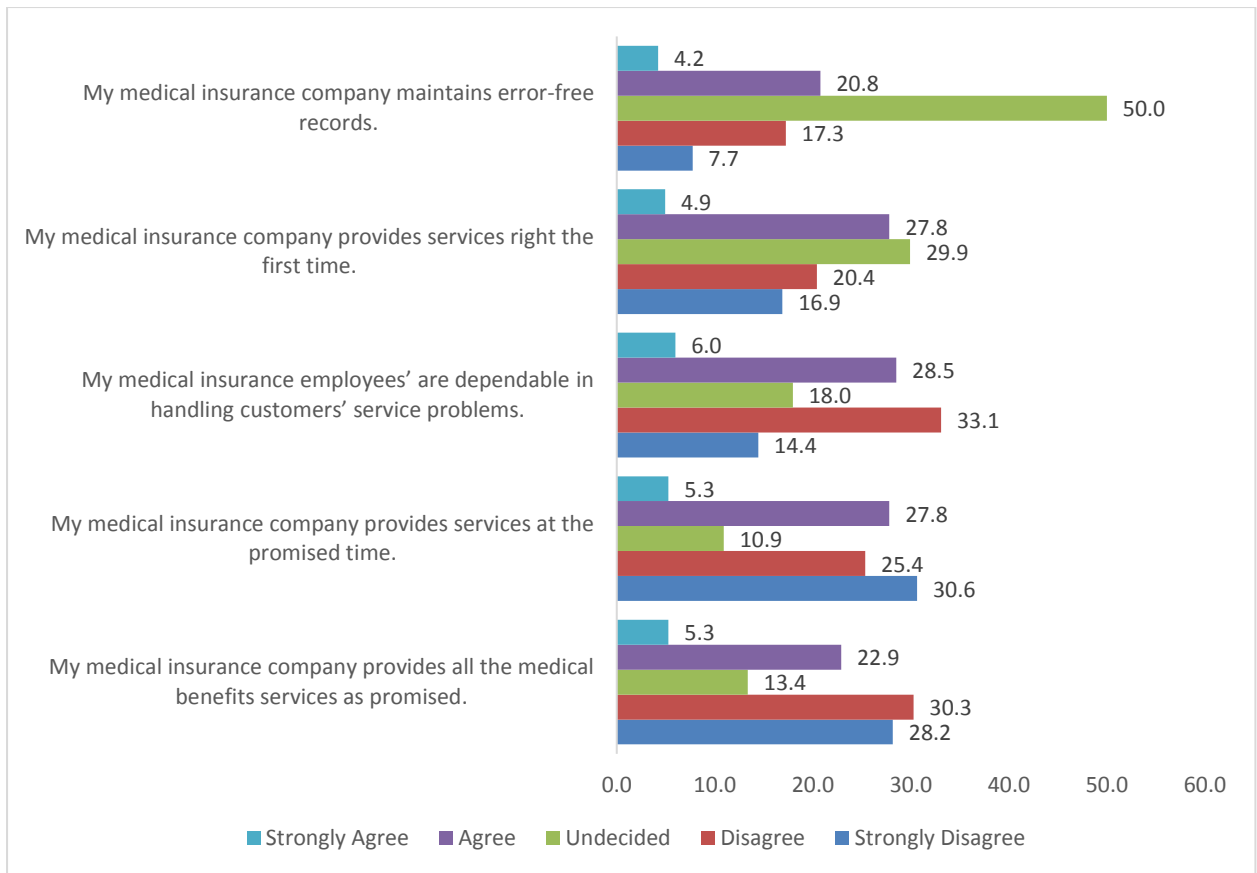


Figure 5.14: Distribution of statements for perception of reliability.

5.5.3 Responsiveness perception

It was found that many participants had negative perceptions regarding responsiveness. For instance, more than half of the participants responded negatively to the statements that their medical insurance company has personnel who keep customers updated about when services will be provided, and that their medical insurance company provides prompt service to customers (Figure 5.15).

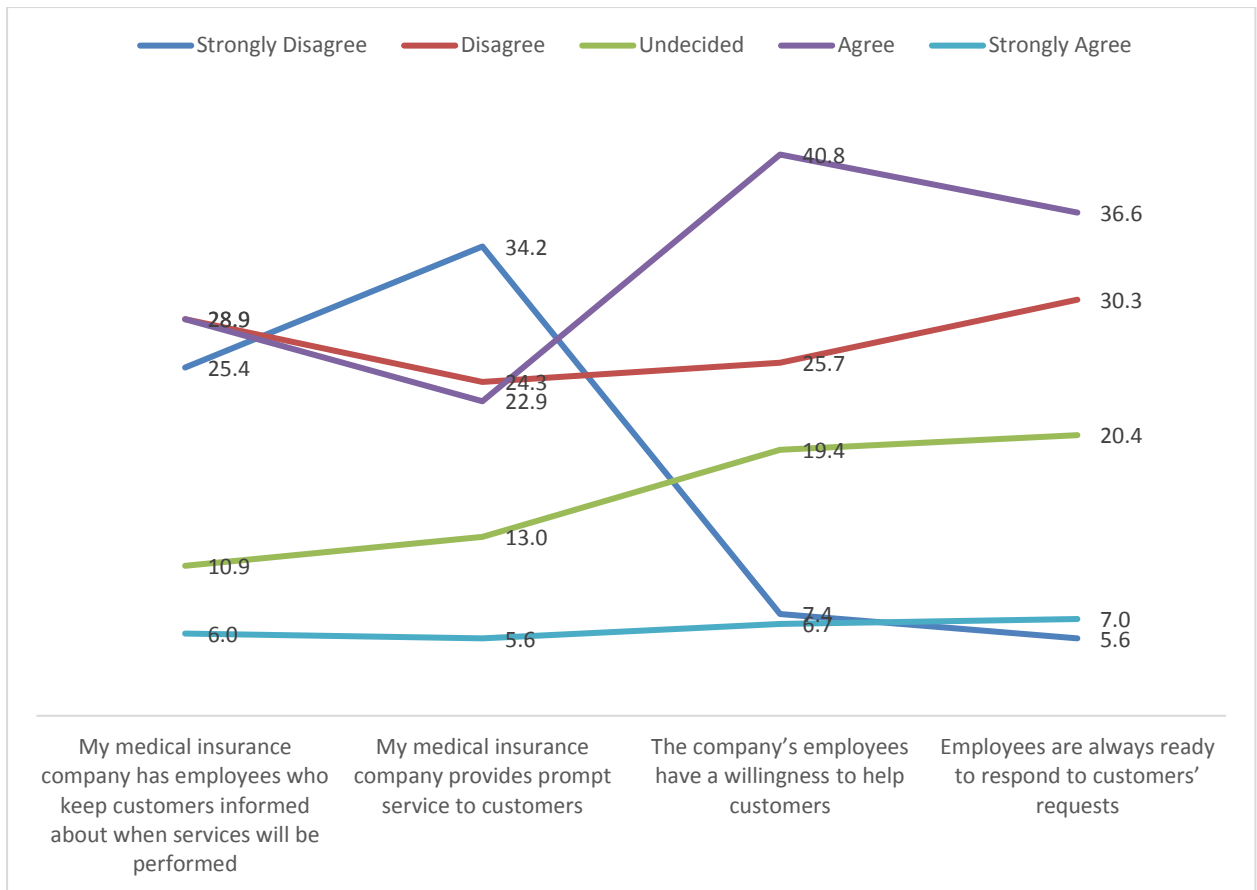


Figure 5.15: Distribution of statements regarding responsiveness perception.

5.5.4 Assurance perception

Results show that about half of the participants responded positively or negatively to all the statements (Figure 5.16). Therefore, it could be concluded that participants' perception towards assurance was not very good.

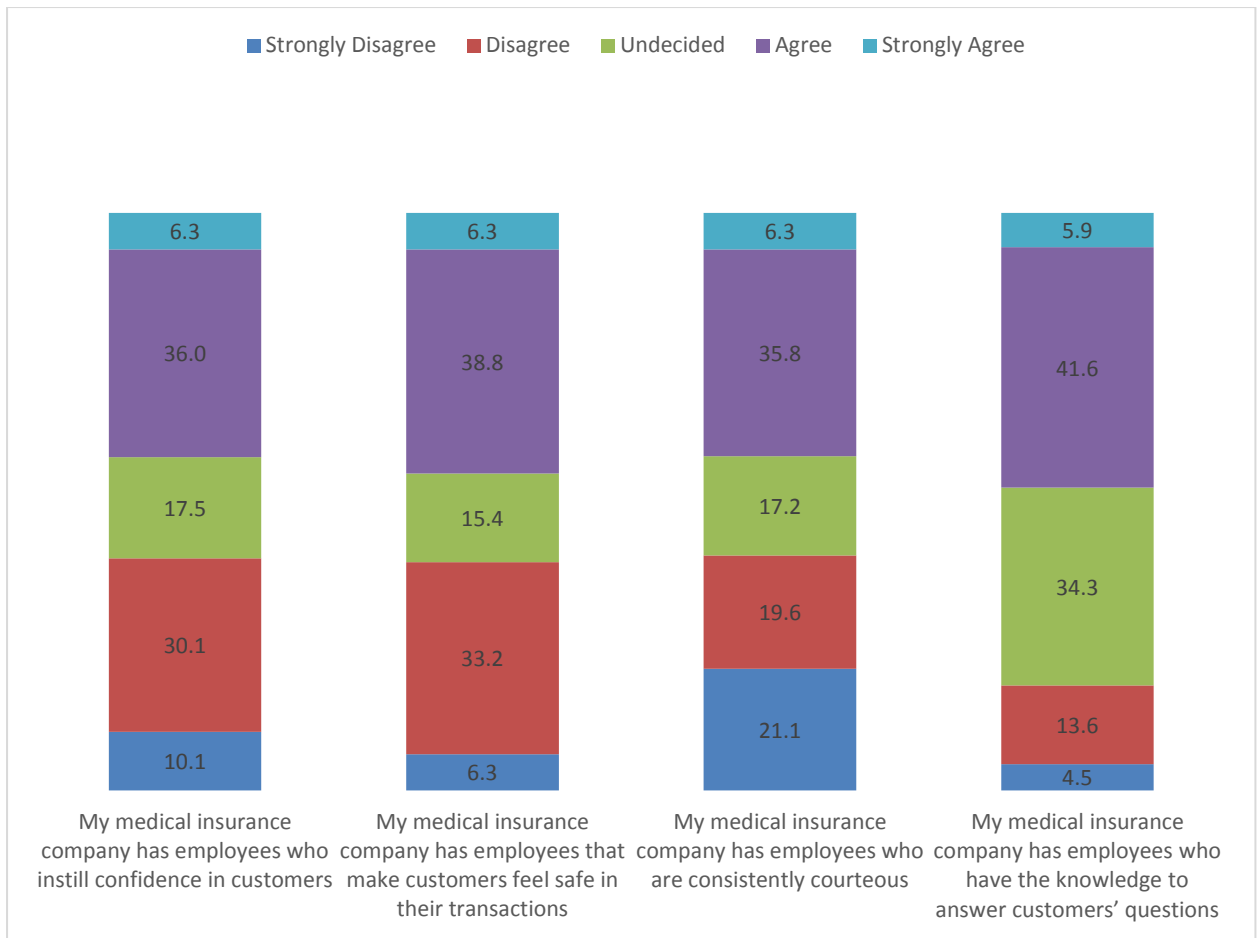


Figure 5.16: Distribution of statements regarding assurance perception.

5.5.5 Empathy perception

The study found that more participants responded positively to all the statements regarding perception related to empathy. For example, 68 per cent of the participants agreed or strongly agreed that their medical insurance company provides convenient business hours, and 58 per cent mentioned positively that their medical insurance company has employees who give customers individual attention (Figure 5.17).

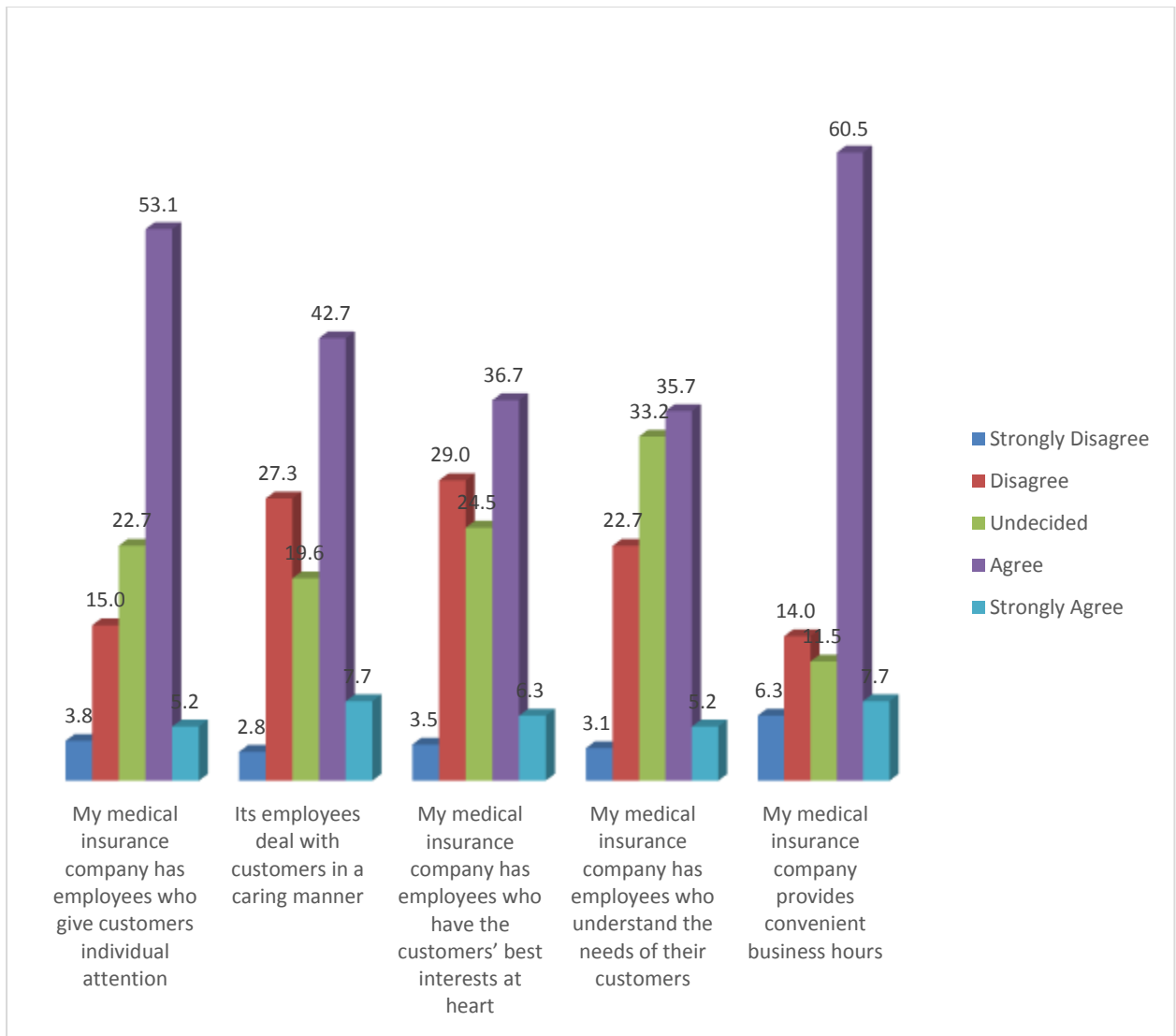


Figure 5.17: Distribution of statements regarding empathy perception.

5.5 Results of general questions about medical insurance companies in Zimbabwe and how service quality can be improved

Participants were asked to respond to 10 statements to determine customers' general knowledge about medical insurance companies. Results show that 95 per cent of the participants positively reported that there is need to improve service delivery in most medical insurance companies in Zimbabwe, while 58 per cent affirmed that medical insurance services are quite beneficial in Zimbabwe. Moreover, 73 per cent disagreed or strongly disagreed that the quality standards are uniform in all medical insurance companies in Zimbabwe, and that it seems that there are quality standards to which all companies adhere. Furthermore, there was a 50 per cent negative response to the statement that their medical insurance company has proactive and not reactive customer service and retention programmes. Figure 5.18 summarises all the statements regarding general knowledge.

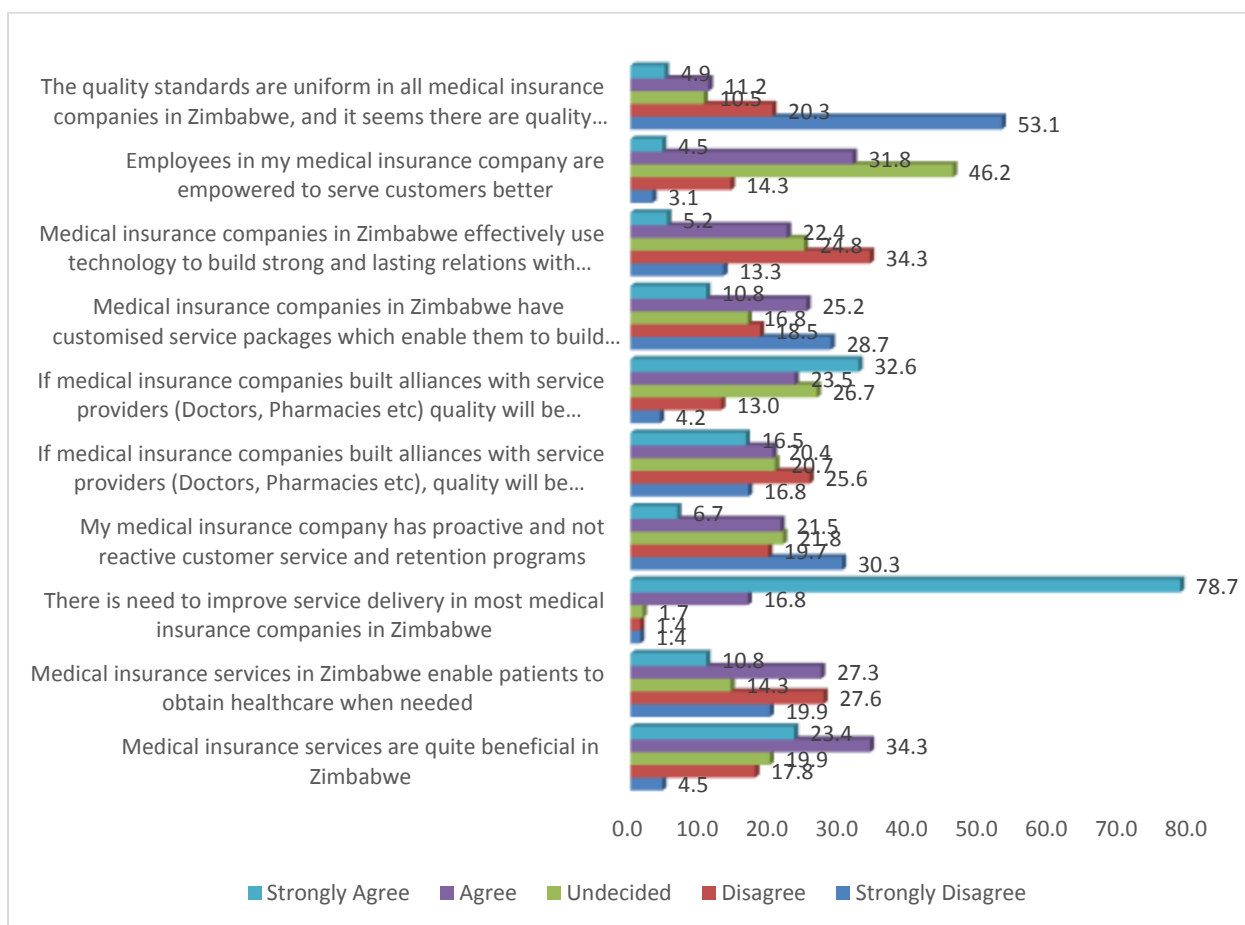


Figure 5.18: Distribution of statements regarding general knowledge.

5.6 Measures of central tendency and dispersions for the service quality dimensions

The results for the service quality dimensions above were further analysed using measures of central tendency and dispersion. These results are shown in Table 5.2 below.

Table 5. 2: Descriptive statistics

| Descriptive statistics | | | | | |
|------------------------------------|-----|--------|---------|---------|---------|
| | N | Mean | SD | Minimum | Maximum |
| Tangible expectation average | 286 | 4.4554 | 0.58263 | 1.00 | 5.00 |
| Reliability expectation average | 286 | 4.6762 | 0.52200 | 1.00 | 5.00 |
| Responsiveness expectation average | 286 | 4.6678 | 0.58172 | 1.00 | 5.00 |
| Assurance expectation average | 286 | 4.6562 | 0.50542 | 1.00 | 5.00 |
| Empathy expectation average | 286 | 4.6161 | 0.55733 | 1.00 | 5.00 |
| Tangible perception average | 286 | 3.5192 | 0.67673 | 1.50 | 5.00 |

| | | | | | |
|-----------------------------------|-----|--------|---------|------|------|
| Reliability perception average | 284 | 2.6514 | 1.03834 | 1.00 | 5.00 |
| Responsiveness perception average | 284 | 2.8444 | 0.93605 | 1.00 | 5.00 |
| Assurance perception average | 286 | 3.0545 | 0.99162 | 1.00 | 5.00 |
| Empathy perception average | 286 | 3.2916 | 0.71525 | 1.00 | 5.00 |

In relation to the perceptions of service quality dimensions, the mean scores can be used to show the dimensions where highest and lowest perceptions were recorded. Highest perceptions were recorded in the tangible dimension (m=3.5192), showing that medical insurance customers perceived their companies as offering pleasant and excellent facilities. This was followed by the empathy dimension (m=3.2479), showing that customers perceived medical insurance companies as showing empathy. The assurance dimension followed (m=3.0545), showing that medical insurance customers perceived their companies as offering slight assurance. Responsiveness (m=2.8444) was the next dimension, showing that medical insurance customers did not perceive their companies as being responsive, while reliability (m=2.6514) was the last dimension, showing that medical insurance customers did not perceive their companies as having reliability.

The analysis of the variations in responses indicated highest variations in the reliability dimension (SD [standard deviation]=1.03834), followed by assurance (SD=0.99162), responsiveness (SD=0.93605), empathy (SD=0.71525), and tangibles (SD=0.67673). Although the highest variation was recorded in reliability, minimum and maximum scores (1 and 5 respectively) indicated that some participants strongly disagreed that these dimensions were present, while others strongly agreed that they were present.

In terms of expectations, the highest mean scores were recorded in the reliability dimension (m=4.6762), indicating that medical insurance customers expected their companies to offer more reliability. This was followed by the responsiveness dimension (m=4.6678), indicating that participants expected their companies to be more responsive. They also expected their companies to offer more assurance (m=4.6562), to be more empathetic (m=4.6161), and to provide more appealing facilities (tangibles) (m=4.4554).

Highest variations in the expectation dimensions were recorded in the tangible dimension (SD=0.58263), followed by responsiveness (SD=0.58172), empathy (SD=0.55733), reliability (SD=0.52200) and, lastly, assurance (SD=0.50542).

5.7 Descriptive statistics for the gap scores of medical insurance customers

The descriptive analysis showed the gap score for each of the dimensions. The gap score was calculated as perception – expectation (Parasuraman *et al.*, 1988:19; Naidoo, 2015:43). If the mean gap score is

positive, it means their perception was higher than expectation. The results showed that for all the five dimensions based on SERVQUAL, participants had higher expectations than perceptions (Table 5.3).

Table 5.3: Descriptive statistics for gap score of SERVQUAL dimensions

| Descriptive statistics | | | | | |
|--------------------------------|-----|---------|----------------|---------|---------|
| | N | Mean | Std. deviation | Minimum | Maximum |
| Tangibles gap score (P-E) | 286 | -1.0420 | 0.94311 | -3.00 | 3.00 |
| Reliability gap score (P-E) | 286 | -2.0434 | 1.27503 | -5.00 | 4.00 |
| Responsiveness gap score (P-E) | 286 | -1.8434 | 1.23533 | -4.50 | 4.00 |
| Assurance gap score (P-E) | 286 | -1.6017 | 1.21214 | -4.00 | 1.50 |
| Empathy gap score (P-E) | 286 | -1.3245 | 0.94459 | -4.00 | 3.20 |
| Overall gap score (P-E) | 286 | -1.5498 | 0.90078 | -3.29 | 1.60 |

Table 5.3 above shows that all the gap scores for medical insurance customers are negative. This indicates that the medical insurance customers' expectations exceeded their perceptions; thus, the medical insurance customers were dissatisfied with the service offerings of medical insurance companies.

The highest gap score was recorded in the reliability dimension (-2.0434), followed by responsiveness (-1.8434), assurance (-1.6017), empathy (-1.3245) and tangibles (-1.0420).

5.8 Comparison of service quality gaps between customers in government-owned and privately owned medical insurance companies

Since PSMAS is government owned and the other four health insurance companies fall under private and corporate general insurance companies (section 2.9), the study was also set to compare service quality gaps experienced by customers in government-owned and non-government medical insurance companies (construed as privately owned medical insurance companies). Table 5.4 below shows the descriptive analysis of the constructs of the SERVQUAL model and the gaps between government and privately owned institutions.

Table 5.4: Descriptive statistics for government- and privately owned medical insurance companies

| Group statistics | | | | | |
|------------------------------------|------------------|-----|---------|----------------|-----------------|
| | Government-owned | N | Mean | Std. deviation | Std. error mean |
| Tangible expectation average | Yes | 144 | 4.4444 | 0.53988 | 0.04499 |
| | No | 142 | 4.4665 | 0.62472 | 0.05243 |
| Reliability expectation average | Yes | 144 | 4.7917 | 0.49040 | 0.04087 |
| | No | 142 | 4.5592 | 0.52863 | 0.04436 |
| Responsiveness expectation average | Yes | 144 | 4.8125 | 0.43200 | 0.03600 |
| | No | 142 | 4.5211 | 0.67207 | 0.05640 |
| Assurance expectation average | Yes | 144 | 4.7720 | 0.49649 | 0.04137 |
| | No | 142 | 4.5387 | 0.48861 | 0.04100 |
| Empathy expectation average | Yes | 144 | 4.7583 | 0.51161 | 0.04263 |
| | No | 142 | 4.4718 | 0.56636 | 0.04753 |
| Tangible perception average | Yes | 144 | 3.4219 | 0.57213 | 0.04768 |
| | No | 142 | 3.6180 | 0.75776 | 0.06359 |
| Reliability perception average | Yes | 143 | 2.0594 | 0.83495 | 0.06982 |
| | No | 141 | 3.2518 | 0.86680 | 0.07300 |
| Responsiveness perception average | Yes | 143 | 2.3091 | 0.77921 | 0.06516 |
| | No | 141 | 3.3872 | 0.75222 | 0.06335 |
| Assurance perception average | Yes | 144 | 2.5214 | 0.89670 | 0.07473 |
| | No | 142 | 3.5951 | 0.76650 | 0.06432 |
| Empathy perception average | Yes | 144 | 3.0042 | 0.62823 | 0.05235 |
| | No | 142 | 3.5831 | 0.68105 | 0.05715 |
| Tangibles gap | Yes | 144 | -1.1111 | 0.90925 | 0.07577 |
| | No | 142 | -0.9718 | 0.97445 | 0.08177 |
| Reliability gap | Yes | 144 | -2.7465 | 1.07706 | 0.08975 |
| | No | 142 | -1.3303 | 1.04520 | 0.08771 |
| Responsiveness gap | Yes | 144 | -2.5194 | 1.01518 | 0.08460 |
| | No | 142 | -1.1577 | 1.04839 | 0.08798 |
| Assurance gap | Yes | 144 | -2.2506 | 1.15405 | 0.09617 |
| | No | 142 | -0.9437 | 0.86776 | 0.07282 |
| Empathy gap | Yes | 144 | -1.7542 | 0.81514 | 0.06793 |
| | No | 142 | -0.8887 | 0.86591 | 0.07267 |
| Overall expectation | Yes | 144 | 4.7158 | 0.36688 | 0.03057 |
| | No | 142 | 4.5115 | 0.44597 | 0.03743 |
| Overall perceptions | Yes | 144 | 2.6571 | 0.58835 | 0.04903 |
| | No | 142 | 3.4777 | 0.62190 | 0.05219 |

| | | | | | |
|-------------|-----|-----|---------|---------|---------|
| Overall gap | Yes | 144 | -2.0587 | 0.76512 | 0.06376 |
| | No | 142 | -1.0338 | 0.71677 | 0.06015 |

NB: ‘Yes’ denotes government-owned institutions and ‘No’ denotes non-government (private) institutions.

As shown in Table 5.4 above, it was found that government-owned institutions had the higher mean values for reliability expectation, responsiveness expectation, assurance expectation, and empathy expectation. For perceptions, government-owned institutions had the lower mean value for all the constructs. The mean gap scores were found to be higher in government-owned institutions for all the constructs than in non-government institutions. This shows that service quality deficiencies were higher in government-owned medical insurance companies than in privately owned companies. As shown in Table 5.4 above, highest gaps were also experienced in reliability, followed by responsiveness, assurance, empathy and, lastly, tangibles.

A t-test was used to compare the mean scores for all the constructs, including the gap scores (Table 5.5). Results indicated that government-owned institutions had significantly higher mean scores for responsiveness expectation, assurance expectation, and empathy expectation ($p < 0.05$), as shown in Table 5.5 below. Furthermore, government-owned institutions had significantly lower mean scores for tangible perception, reliability perception, responsiveness perception, assurance perception, and empathy perception ($p < 0.05$). It was also found that government-owned institutions had higher mean gaps for reliability gap, responsiveness gap, assurance gap, empathy gap, overall perception, and overall gap ($p < 0.05$). However, the overall expectations gap was significantly higher in private institutions ($p < 0.05$).

Table 5.5: t-test for equality of means between government-owned and privately owned medical insurance companies

| | t | df | Sig. (2-tailed) | Mean difference |
|------------------------------------|---------|-----|-----------------|-----------------|
| Tangible expectation average | -0.320 | 284 | 0.749 | -0.02210 |
| Reliability expectation average | 3.857 | 284 | 0.000 | 0.23251 |
| Responsiveness expectation average | 4.367 | 284 | 0.000 | 0.29137 |
| Assurance expectation average | 4.004 | 284 | 0.000 | 0.23326 |
| Empathy expectation average | 4.490 | 284 | 0.000 | 0.28650 |
| Tangible perception average | -2.472 | 284 | 0.014 | -0.19608 |
| Reliability perception average | -11.807 | 282 | 0.000 | -1.19233 |
| Responsiveness perception average | -11.861 | 282 | 0.000 | -1.07814 |
| Assurance perception average | -10.877 | 284 | 0.000 | -1.07366 |
| Empathy perception average | -7.474 | 284 | 0.000 | -0.57893 |

| | | | | |
|---------------------|---------|-----|-------|----------|
| Tangibles gap | -1.250 | 284 | 0.212 | -0.13928 |
| Reliability gap | -11.283 | 284 | 0.000 | -1.41625 |
| Responsiveness gap | -11.159 | 284 | 0.000 | -1.36170 |
| Assurance gap | -10.813 | 284 | 0.000 | -1.30692 |
| Empathy gap | -8.704 | 284 | 0.000 | -0.86543 |
| Overall expectation | 4.233 | 284 | 0.000 | 0.20431 |
| Overall perception | -11.464 | 284 | 0.000 | -0.82055 |
| Overall gap | -11.687 | 284 | 0.000 | -1.02485 |

5.9 Strategies that medical insurance in Zimbabwe can employ to improve service delivery in the industry

In light of the service quality gaps identified in the Zimbabwean medical insurance sector, strategies to improve service quality in the industry can be suggested along the five service quality dimensions as follows:

5.9.1 Reliability

In order to improve service quality along the reliability dimension, the following strategies are recommended:

- Medical insurance companies should strive to provide all the medical benefits services as promised. This is supported by 30.3 per cent and 28.2 per cent of the participants who disagreed and strongly disagreed respectively that medical insurance companies were fulfilling this reliability dimension (Figure 5.14). This is also supported by the results on the general questions (section D), where a greater percentage of the respondents (19.9 per cent strongly disagreed and 27.6 per cent disagreed) were negative that medical insurance services allow customers to obtain healthcare when needed.
- Medical insurance companies need to provide services at the promised time as indicated by the 25.4 per cent and 30.6 per cent of the participants who were negative that this was being fulfilled by medical insurance companies (Figure 5.14).
- Medical insurance employees need to be dependable in handling customers' service problems. This was indicated by the few respondents (6 per cent strongly agreed and 28.5 agreed) who were positive that employees of medical insurance companies meet this requirement.
- Medical insurance companies need to provide services right the first time. Few respondents (4.9 strongly agreed and 27.8 agreed) were positive that this was done satisfactorily by medical insurance companies (Figure 5.14).

- Medical insurance companies need to maintain error free records. Few respondents (4.2 strongly agreed and 20.8 agreed) indicated that this was being effected by their medical insurance companies (Figure 5.14).

5.9.2 Responsiveness

Along the responsiveness dimension, the following strategies are recommended:

- Employees in medical insurance companies should keep customers informed about when services will be performed. This is supported by the negative mean gap scores (Table 5.3) and by the greater percentage of the respondents (25.4 per cent strongly disagreed and 28.8 per cent disagreed) who were negative that this was being done by their medical insurance companies (Figure 5.15).
- Medical insurance companies need to provide prompt services to their customers. This is supported by 34.2 percent and 24.3 per cent of the respondents who strongly disagreed and disagreed respectively that this was being effected by their medical insurance companies.
- Medical insurance employees need to show willingness in assisting customers.
- Medical insurance customers should always be ready to respond to customers' requests.

5.9.3 Assurance

In order to improve service quality along the assurance dimension, the following strategies are recommended:

- Medical insurance companies need to train their employees to instil confidence in customers.
- Medical insurance companies need to train their employees to make customers feel safe in their transactions.
- Medical insurance companies should train employees to be consistently courteous.
- Medical insurance companies should train employees to be knowledgeable in answering customers' questions.

5.9.4 Empathy

On the empathy dimension, the following strategies are recommended:

- Medical insurance employees need to improve on giving customers individual attention.
- Medical insurance employees need to deal with customers in a caring manner.
- Medical insurance employees should be trained to have customers' best interest at heart.
- Medical insurance employees should be trained to understand customers' needs.
- Medical insurance companies should improve at providing convenient business hours.

5.9.5 Tangibles

In order to enhance tangibles, the following strategies are suggested:

- Medical insurance companies should have modern equipment.
- Medical insurance companies should have visually appealing facilities.
- Materials associated with the service of medical insurance companies, like posters, brochures, and websites should be visually appealing.

Furthermore, from the data collected in Section D of the questionnaire on general questions about medical insurance companies in Zimbabwe (Figure 5.18), the following strategies can also be suggested:

- Medical insurance companies in Zimbabwe should effectively use technology to build strong and lasting relations with customers. Very few respondents (5.2 per cent strongly agreed and 22.4 per cent agreed) were positive that their medical insurance companies were effecting this.
- Medical insurance companies in Zimbabwe need to have customised service packages, which enable them to build long-term relationships with customers. Few respondents were positive that this was being effected by their companies (only 10.8 per cent strongly agreed and 25.2 per cent agreed).
- Medical insurance companies need to have proactive and not reactive customer service and retention programmes, probably through closing the service quality gaps identified as evidenced by 6.7 per cent and 21.5 per cent who strongly agreed and agreed respectively to the existence of such measures in their companies.

Employees in medical insurance companies need to be empowered to serve customers better, as shown by only 4.5 per cent and 31.8 percent of the respondents who strongly agreed and agreed respectively that this was observable in their companies.

5.10 Inferential statistics

This section presents results on the hypotheses proposed in Chapters 1 and 4. In order to do this further analysis, all the mean scores for each of the statements for each of the dimensions were added to get the overall scores. The final scores were then tested for normality, and as these were not normally distributed (significance level less than 0.05, Table 5.4), non-parametric tests, namely the Kruskal–Wallis and Mann–Whitney tests, were used for further analysis.

Table 5.6: Normality test output

| Tests of normality | | | | | | |
|--------------------|---------------------------------|-----|-------|--------------|-----|-------|
| | Kolmogorov–Smirnov ^a | | | Shapiro–Wilk | | |
| | Statistic | df | Sig. | Statistic | df | Sig. |
| Tangibility gap | 0.252 | 286 | 0.000 | 0.882 | 286 | 0.000 |
| Reliability gap | 0.095 | 286 | 0.000 | 0.963 | 286 | 0.000 |
| Responsiveness gap | 0.109 | 286 | 0.000 | 0.958 | 286 | 0.000 |
| Assurance gap | 0.145 | 286 | 0.000 | 0.956 | 286 | 0.000 |
| Empathy gap | 0.116 | 286 | 0.000 | 0.971 | 286 | 0.000 |
| Overall gap | 0.104 | 286 | 0.000 | 0.963 | 286 | 0.000 |

a. Lilliefors significance correction (see Author, date)

A) Hypotheses on customer perceptions

5.10.1 Hypothesis 1.1: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers in different age groups.

The Kruskal–Wallis test was used to test the above hypothesis. The ranks table and the test statistics table below (Tables 5.7 and 5.8) show the results of the tests. Table 5.4: Ranks table for customers’ perceptions by age group

Table 5.7: Ranks table for customer perceptions by age

| Ranks | | | |
|--------------------------------|------------------|-----|-----------|
| | Age group | N | Mean rank |
| Tangible perception average | 20 years or less | 2 | 175.25 |
| | 21–30 years | 49 | 143.68 |
| | 31–40 years | 109 | 145.47 |
| | 41–50 years | 92 | 141.61 |
| | >50 years | 34 | 140.16 |
| | Total | 286 | |
| Reliability perception average | 20 years or less | 2 | 171.00 |
| | 21–30 years | 48 | 141.73 |
| | 31–40 years | 109 | 155.15 |
| | 41–50 years | 91 | 135.02 |
| | >50 years | 34 | 121.40 |
| | | | |

| | | | |
|-----------------------------------|------------------|-----|--------|
| | Total | 284 | |
| Responsiveness perception average | 20 years or less | 2 | 134.50 |
| | 21–30 years | 48 | 153.85 |
| | 31–40 years | 109 | 154.48 |
| | 41–50 years | 91 | 131.85 |
| | >50 years | 34 | 117.04 |
| | Total | 284 | |
| Assurance perception average | 20 years or less | 2 | 154.75 |
| | 21–30 years | 49 | 162.54 |
| | 31–40 years | 109 | 153.50 |
| | 41–50 years | 92 | 134.33 |
| | >50 years | 34 | 108.16 |
| | Total | 286 | |
| Empathy perception average | 20 years or less | 2 | 204.00 |
| | 21–30 years | 49 | 155.21 |
| | 31–40 years | 109 | 147.93 |
| | 41–50 years | 92 | 135.93 |
| | >50 years | 34 | 129.35 |
| | Total | 286 | |

Table 5.5: Test statistics table for no differences in customer perceptions by age groups

| Test statistics ^{a,b} | | | | | |
|---------------------------------|-----------------------------|--------------------------------|-----------------------------------|------------------------------|----------------------------|
| | Tangible perception average | Reliability perception average | Responsiveness perception average | Assurance perception average | Empathy perception average |
| Chi-square | .467 | 5.869 | 8.103 | 11.735 | 4.171 |
| df | 4 | 4 | 4 | 4 | 4 |
| Asymp. sig. | .977 | .209 | .088 | .019 | .383 |
| a. Kruskal–Wallis test | | | | | |
| b. Grouping variable: age group | | | | | |

The findings show no statistically notable differences in medical insurance customers' perceptions between the different age groups in the sample on tangibles, reliability, responsiveness, and empathy dimensions ($p > 0.05$).

However, some statistical noteworthy differences were found in customers' perceptions of the assurance variable between the different age groups in the sample ($p < 0.05$). The ranks table above

(Table 5.7) illustrates that on the assurance dimension the 21–30 years age group had the highest mean rank of 162.54, showing strongest perceptions on assurance. From these results it can be concluded that, even though all age groups in the sample regarded their medical insurance companies as showing only slight assurance (mean = 3.0545: Table 5.2), strongest positive perceptions were recorded in age group 21–30 years, followed by the age group of 20 years and below (Table 5.7). These age groups may possibly perceive their companies as showing assurance because they have few medical problems and use their insurances less frequently than other age groups.

5.10.2 Hypothesis 1.2: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers.

To test this hypothesis, the Mann–Whitney test was used. The ranks table and the test statistics table below (Tables 5.9 and 5.10) show the results for these tests.

Table 5.6: Ranks table for customer perceptions by gender

| Ranks | | | | |
|-----------------------------------|--------|-----|-----------|--------------|
| | Gender | N | Mean rank | Sum of ranks |
| Tangible perception average | Female | 145 | 141.86 | 20569.50 |
| | Male | 136 | 140.08 | 19051.50 |
| | Total | 281 | | |
| Reliability perception average | Female | 143 | 141.51 | 20235.50 |
| | Male | 136 | 138.42 | 18824.50 |
| | Total | 279 | | |
| Responsiveness perception average | Female | 143 | 141.04 | 20169.00 |
| | Male | 136 | 138.90 | 18891.00 |
| | Total | 279 | | |
| Assurance perception average | Female | 145 | 145.01 | 21027.00 |
| | Male | 136 | 136.72 | 18594.00 |
| | Total | 281 | | |
| Empathy perception average | Female | 145 | 140.62 | 20390.50 |
| | Male | 136 | 141.40 | 19230.50 |
| | Total | 281 | | |

Table 5.7: Test statistics for no differences in perceptions by gender

| Test statistics ^a | | | | | |
|------------------------------|-----------------------------|--------------------------------|-----------------------------------|------------------------------|----------------------------|
| | Tangible perception average | Reliability perception average | Responsiveness perception average | Assurance perception average | Empathy perception average |
| Mann–Whitney U | 9735.500 | 9508.500 | 9575.000 | 9278.000 | 9805.500 |
| Wilcoxon W | 19051.500 | 18824.500 | 18891.000 | 18594.000 | 20390.500 |
| Z | -0.184 | -0.321 | -0.222 | -0.861 | -0.080 |
| Asymp. sig. (2-tailed) | 0.854 | 0.748 | 0.824 | 0.389 | 0.936 |
| a. Grouping variable: gender | | | | | |

As shown in Table 5.10 above, the findings show no statistically notable differences in medical insurance customers' perceptions of the tangibles, reliability, responsiveness, assurance and empathy dimensions between female and male participants ($p>0.05$).

5.10.3 Hypothesis 1.3: There are no statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy.

The Kruskal–Wallis test was conducted to test the above hypothesis and the ranks table and the test statistics table below (Tables 5.11 and 5.12) show the results of these tests.

Table 5.8: Ranks table for customer perceptions by sector of the economy employed in

| Ranks | | | |
|-----------------------------------|--------------------------------------|-----|-----------|
| | WHICH_SECTOR_OF_THE_ECONOMY_EMPLOYED | N | Mean rank |
| Tangible perception average | Private sector | 78 | 163.29 |
| | Public sector | 122 | 135.26 |
| | State-owned enterprise | 82 | 130.05 |
| | Total | 282 | |
| Reliability perception average | Private sector | 77 | 175.88 |
| | Public sector | 122 | 116.06 |
| | State-owned enterprise | 81 | 143.68 |
| | Total | 280 | |
| Responsiveness perception average | Private sector | 77 | 179.03 |
| | Public sector | 122 | 115.92 |
| | State-owned enterprise | 81 | 140.90 |
| | Total | 280 | |
| Assurance perception average | Private sector | 78 | 182.01 |

| | | | |
|----------------------------|------------------------|-----|--------|
| | Public sector | 122 | 118.67 |
| | State-owned enterprise | 82 | 136.93 |
| | Total | 282 | |
| Empathy perception average | Private sector | 78 | 164.28 |
| | Public sector | 122 | 123.82 |
| | State-owned enterprise | 82 | 146.14 |
| | Total | 282 | |

Table 5.9: Test statistics for no differences in customers’ perceptions by sector of the economy employed in

| Test statistics ^{a,b} | | | | | |
|--|-----------------------------|--------------------------------|-----------------------------------|------------------------------|----------------------------|
| | Tangible perception average | Reliability perception average | Responsiveness perception average | Assurance perception average | Empathy perception average |
| Chi-square | 8.028 | 26.115 | 28.848 | 29.462 | 12.201 |
| df | 2 | 2 | 2 | 2 | 2 |
| Asymp. sig. | .018 | .000 | .000 | .000 | .002 |
| a. Kruskal–Wallis test | | | | | |
| b. Grouping variable: WHICH_SECTOR_OF_THE_ECONOMY_ARE YOU EMPLOYED IN? | | | | | |

Some statistically noteworthy differences were found in the customers’ perceptions of all the service quality dimensions between members employed in the different sectors of the economy ($p < 0.05$). The ranks table above (Table 5.11) shows that in all the dimensions very strong perceptions were obtained from members employed in the private sector (shown by higher mean ranks), followed by those employed in state-owned enterprises, and lastly by members employed in the public sector. The exception was only in the tangible dimension, where members of the public sector’s perceptions were stronger than those employed in state-owned enterprises.

Medical insurance customers employed in the private sector possibly have strong perceptions about the services offered by their companies because service delivery by these companies could be much better than services offered to members employed in the public sector who subscribe to a government-owned medical insurance company (section 2.9). On tangibles, members employed in the public sector could have better perceptions about the physical facilities of their company due to the efforts by the government-owned institution to improve its facilities to attract membership (section 2.9.1) from people employed in different sectors of the economy.

5.10.4 Hypothesis 1.4: There are no statistically significant differences in the perceptions of medical insurance service quality along all the dimensions amongst customers with different periods of membership with their medical insurance companies.

The Kruskal–Wallis test was used to test this hypothesis and the ranks table and the test statistics table below (Tables 5.13 and 5.14) show the results for these tests.

Table 5.13: Ranks table for customer perceptions by period of membership with the medical insurance company

| Ranks | | | |
|-----------------------------------|---|-----|-----------|
| | PERIOD_OF_MEMBERSHIP_OF _THE_MED_INS_COMPANY | N | Mean rank |
| Tangible perception average | 0–1 year | 28 | 137.25 |
| | 2–3 years | 51 | 136.23 |
| | 4–5 years | 43 | 148.06 |
| | >5 years | 164 | 145.63 |
| | Total | 286 | |
| Reliability perception average | 0–1 year | 28 | 174.02 |
| | 2–3 years | 51 | 191.82 |
| | 4–5 years | 43 | 144.41 |
| | >5 years | 162 | 121.02 |
| | Total | 284 | |
| Responsiveness perception average | 0–1 year | 28 | 175.41 |
| | 2–3 years | 51 | 193.56 |
| | 4–5 years | 43 | 155.69 |
| | >5 years | 162 | 117.24 |
| | Total | 284 | |
| Assurance perception average | 0–1 year | 28 | 183.73 |
| | 2–3 years | 51 | 182.76 |
| | 4–5 years | 43 | 153.06 |
| | >5 years | 164 | 121.91 |
| | Total | 286 | |
| Empathy perception average | 0–1 year | 28 | 176.04 |
| | 2–3 years | 51 | 173.51 |
| | 4–5 years | 43 | 160.00 |
| | >5 years | 164 | 124.29 |
| | Total | 286 | |

Table 5.14: Test statistics for no differences in perceptions by period of membership

| Test statistics ^{a,b} | | | | | |
|---|-----------------------------|--------------------------------|-----------------------------------|------------------------------|----------------------------|
| | Tangible perception average | Reliability perception average | Responsiveness perception average | Assurance perception average | Empathy perception average |
| Chi-square | .807 | 33.847 | 40.889 | 30.309 | 21.816 |
| df | 3 | 3 | 3 | 3 | 3 |
| Asymp. sig. | .848 | .000 | .000 | .000 | .000 |
| a. Kruskal–Wallis test | | | | | |
| b. Grouping variable: PERIOD_OF_MEMBERSHIP_OF_THE_MED_INS_COMPANY | | | | | |

The results show no statistically notable differences in the perceptions of medical insurance customers of the tangibles dimension between members who have different membership periods with their medical insurance companies ($p > 0.05$).

However, some statistically noteworthy differences were found in the customers' perceptions of the reliability dimension between members who have different membership periods with their medical insurance companies ($p < 0.05$). Although all members on average perceive medical insurance companies to be less reliable (mean = 2.6514: Table 5.2), members with a period of membership of 2–3 years have strongest perceptions (mean rank = 191.82), followed by those with 0–1 years (Table 5.13). These respondents possibly perceive medical insurance companies to be somewhat reliable due to their few experiences or encounters with medical insurances (denoted by their few years of membership), which gave them better impressions on the reliability of these companies. Weakest perceptions are recorded in those with >5 years of membership (mean rank = 121.02: Table 5.13), and these respondents could possibly perceive medical insurance companies to be less reliable due to their long-time experiences with these companies.

Some statistically notable differences were also found in the customers' perceptions of the responsiveness dimension between members who have different membership periods with their medical insurance companies ($p < 0.05$). Although on average medical insurance members did not perceive their companies to be responsive (mean = 2.8444: Table 5.2), members with 2–3 years of membership had strongest perceptions (mean rank = 193.56), followed by those with 0–1 year of membership (Table 5.13). The little experience of these members with their medical insurance companies could possibly make them view their companies as being better in the responsive dimension. However, members with >5 years period of membership had weakest perception (mean rank = 117.24: Table 5.13), probably emanating from their long experience with their companies.

Furthermore, some statistically noteworthy differences were found in the customers' perceptions of the assurance dimension between members who have different membership periods with their medical

insurance companies ($p < 0.05$). Although on average medical insurance customers perceived their companies as slightly showing assurance (mean = 3.0545: Table 5.2), strongest perceptions were recorded in members with 0–1 year of membership (mean rank = 183.73), followed by those with 2–3 years of membership (Table 5.13). These customers could possibly have better perceptions about the assurance given by their companies due to their slight experience with medical insurance companies.

Some statistically notable differences were also found in the customers’ perceptions of the empathy dimension between members who have different membership periods with their medical insurance companies ($p < 0.05$). Although on average medical insurance customers perceived medical insurance companies as showing empathy (mean = 3.2916: Table 5.2), strongest positive perceptions were recorded in members with 0–1 year of membership (mean rank = 176.04), followed by those with 2–3 years of membership. This could also be possibly due to their slight experiences with their medical insurance companies, which impressed them with their empathetic behaviour.

5.10.5 Hypothesis 1.5: There are no statistically significant differences in the perceptions of medical insurance service quality between customers who either have or have not switched between medical insurance companies.

The Mann–Whitney test was used to test this hypothesis. The ranks table and the test statistics table below (Tables 5.15 and 5.16) show the results of the tests.

Table 5.105: Ranks table for customers’ perceptions by whether members have either switched between medical insurance companies or not

| Ranks | | | | |
|-----------------------------------|---|-----|-----------|--------------|
| | HAVE_YOU_EVER_SWITCHED_BETWEEN_MED_INS_COMPANIES? | N | Mean rank | Sum of ranks |
| Tangible perception average | No | 168 | 143.33 | 24079.50 |
| | Yes | 118 | 143.74 | 16961.50 |
| | Total | 286 | | |
| Reliability perception average | No | 167 | 126.04 | 21049.50 |
| | Yes | 117 | 165.99 | 19420.50 |
| | Total | 284 | | |
| Responsiveness perception average | No | 167 | 127.70 | 21326.50 |
| | Yes | 117 | 163.62 | 19143.50 |
| | Total | 284 | | |
| Assurance perception average | No | 168 | 134.51 | 22597.50 |
| | Yes | 118 | 156.30 | 18443.50 |
| | Total | 286 | | |

| | | | | |
|----------------------------|-------|-----|--------|----------|
| Empathy perception average | No | 168 | 136.75 | 22973.50 |
| | Yes | 118 | 153.11 | 18067.50 |
| | Total | 286 | | |

Table 5.16: Test statistics for no differences in customers’ perceptions between those who have or have not switched between medical insurance companies

| Test statistics ^a | | | | | |
|---|-----------------------------|--------------------------------|-----------------------------------|------------------------------|----------------------------|
| | Tangible perception average | Reliability perception average | Responsiveness perception average | Assurance perception average | Empathy perception average |
| Mann–Whitney U | 9883.500 | 7021.500 | 7298.500 | 8401.500 | 8777.500 |
| Wilcoxon W | 24079.500 | 21049.500 | 21326.500 | 22597.500 | 22973.500 |
| Z | -.042 | -4.047 | -3.638 | -2.210 | -1.655 |
| Asymp. sig. (2-tailed) | 0.967 | 0.000 | 0.000 | 0.027 | 0.098 |
| a. Grouping variable: HAVE_YOU_EVER_SWITCHED_BETWEEN_MED_INS_COMPANIES? | | | | | |

The results show no statistically noteworthy differences in the perceptions of medical insurance customers of the tangibles and empathy dimensions between members who had either switched between medical insurance companies or not ($p>0.05$).

However, some statistically noteworthy differences were found in the customers’ perceptions of the reliability, responsiveness, and assurance dimensions between customers who had switched between medical insurance companies and those who had not switched ($p<0.05$). In all these dimensions, strongest negative perceptions are recorded in members who have switched between medical insurance companies as shown by higher mean ranks (Table 5.15). These customers possibly perceive their new medical insurance companies as offering better services in those service quality dimensions since their main reason for switching was poor service delivery (Figure 5.7).

B) Hypotheses on customer expectations

5.10.6 Hypothesis 2.1: There are no statically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups.

To test the above hypothesis, the Kruskal–Wallis test was used. The ranks table and the test statistics tables below (Table 5.17 and 5.18) show the results for these tests.

Table 5.117: Ranks table for customer expectations by age

| Ranks | | | |
|------------------------------------|------------------|-----|-----------|
| | Age group | N | Mean rank |
| Tangible expectation average | 20 years or less | 2 | 79.25 |
| | 21–30 years | 49 | 137.01 |
| | 31–40 years | 109 | 145.53 |
| | 41–50 years | 92 | 145.29 |
| | >50 years | 34 | 145.28 |
| | Total | 286 | |
| Reliability expectation average | 20 years or less | 2 | 151.00 |
| | 21–30 years | 49 | 126.20 |
| | 31–40 years | 109 | 134.89 |
| | 41–50 years | 92 | 155.66 |
| | >50 years | 34 | 162.68 |
| | Total | 286 | |
| Responsiveness expectation average | 20 years or less | 2 | 126.50 |
| | 21–30 years | 49 | 123.32 |
| | 31–40 years | 109 | 138.76 |
| | 41–50 years | 92 | 150.03 |
| | >50 years | 34 | 171.12 |
| | Total | 286 | |
| Assurance expectation average | 20 years or less | 2 | 148.25 |
| | 21–30 years | 49 | 116.50 |
| | 31–40 years | 109 | 137.90 |
| | 41–50 years | 92 | 154.77 |
| | >50 years | 34 | 169.60 |
| | Total | 286 | |
| Empathy expectation average | 20 years or less | 2 | 211.50 |
| | 21–30 years | 49 | 121.46 |
| | 31–40 years | 109 | 135.94 |
| | 41–50 years | 92 | 156.68 |
| | >50 years | 34 | 159.84 |
| | Total | 286 | |

Table 5.18: Test statistics table for no differences in customers’ expectations by age group

| Test statistics ^{a,b} | | | | | |
|---------------------------------|------------------------------|---------------------------------|------------------------------------|-------------------------------|-----------------------------|
| | Tangible expectation average | Reliability expectation average | Responsiveness expectation average | Assurance expectation average | Empathy expectation average |
| Chi-square | 1.734 | 8.374 | 9.949 | 12.809 | 11.028 |
| df | 4 | 4 | 4 | 4 | 4 |
| Asymp. sig. | .785 | .079 | .041 | .012 | .026 |
| a. Kruskal–Wallis test | | | | | |
| b. Grouping variable: age group | | | | | |

The findings show no statistically significant differences in medical insurance customers’ expectations between the different age groups in the sample on tangibles and reliability ($p>0.05$).

However, there were statistically noteworthy differences in the medical insurance customers’ expectations of the responsiveness, assurance, and empathy dimensions between participants in different age groups in the sample. On the responsiveness and assurance dimensions, although all age groups expect their companies to offer more of these in their service delivery (Table 5.2), strongest expectations were recorded from the >50 years age group. This is shown by the highest mean ranks of 171.12 and 169.60 for responsiveness and assurance respectively (Table 5.17). The reason could possibly be that this age group is aging (many suffering from chronic diseases) and they frequently use or require medical insurance services and thus their expectations tend to increase.

Although all age groups expect their medical insurance companies to show more empathy, very strong expectations were obtained on the empathy dimension from the <20years age group as shown by the highest mean rank of 211.50 (Table 5.17). This may possibly be because this age group is still growing and they need more affection, and therefore they demand more of this service quality dimension. Furthermore, this group comprises the young and educated members who have been enlightened about customer rights and customer care, and therefore they tend to have high expectations about the empathy dimension.

5.10.7 Hypothesis 2.2: There are no statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers.

To test this hypothesis, the Mann–Whitney test was used. The ranks table and the test statistics table below (Tables 5.19 and 5.20) show the results of these tests.

Table 5.19: Ranks table for customer expectations by gender

| Ranks | | | | |
|------------------------------------|--------|-----|-----------|--------------|
| | Gender | N | Mean rank | Sum of ranks |
| Tangible expectation average | Female | 145 | 132.72 | 19244.50 |
| | Male | 136 | 149.83 | 20376.50 |
| | Total | 281 | | |
| Reliability expectation average | Female | 145 | 137.00 | 19865.50 |
| | Male | 136 | 145.26 | 19755.50 |
| | Total | 281 | | |
| Responsiveness expectation average | Female | 145 | 134.37 | 19484.00 |
| | Male | 136 | 148.07 | 20137.00 |
| | Total | 281 | | |
| Assurance expectation average | Female | 145 | 135.83 | 19696.00 |
| | Male | 136 | 146.51 | 19925.00 |
| | Total | 281 | | |
| Empathy expectation average | Female | 145 | 138.09 | 20023.00 |
| | Male | 136 | 144.10 | 19598.00 |
| | Total | 281 | | |

Table 5.20: Test statistics table for no differences in customer expectations by gender

| Test statistics ^a | | | | | |
|------------------------------|------------------------------|---------------------------------|------------------------------------|-------------------------------|-----------------------------|
| | Tangible expectation average | Reliability expectation average | Responsiveness expectation average | Assurance expectation average | Empathy expectation average |
| Mann–Whitney U | 8659.500 | 9280.500 | 8899.000 | 9111.000 | 9438.000 |
| Wilcoxon W | 19244.500 | 19865.500 | 19484.000 | 19696.000 | 20023.000 |
| Z | -1.816 | -.920 | -1.602 | -1.196 | -.671 |
| Asymp. sig. (2-tailed) | 0.069 | 0.357 | 0.109 | 0.232 | 0.502 |

a. Grouping variable: gender

The results showed no statistically noteworthy differences in the medical insurance customers' expectations of the tangibles, reliability, responsiveness, assurance and empathy dimensions between female and male participants in the sample ($p>0.05$), as shown in Table 5.20 above.

5.10.8 Hypothesis 2.3: There are no statistically significant differences in the customer expectations of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy.

To perform this test, the Kruskal–Wallis test was used. The ranks table and the test statistics table (Tables 5.21 and 5.22) below show the results of the tests.

Table 5.121: Ranks table for customer expectations by sector of the economy in which they are employed

| Ranks | | | |
|------------------------------------|--|-----|-----------|
| | WHICH_SECTOR_OF_THE_ECONOMY_ARE YOU EMPLOYED IN? | N | Mean rank |
| Tangible expectation average | Private sector | 78 | 144.51 |
| | Public sector | 122 | 139.99 |
| | State-owned enterprise | 82 | 140.88 |
| | Total | 282 | |
| Reliability expectation average | Private sector | 78 | 120.80 |
| | Public sector | 122 | 155.32 |
| | State-owned enterprise | 82 | 140.62 |
| | Total | 282 | |
| Responsiveness expectation average | Private sector | 78 | 125.24 |
| | Public sector | 122 | 152.56 |
| | State-owned enterprise | 82 | 140.51 |
| | Total | 282 | |
| Assurance expectation average | Private sector | 78 | 121.78 |
| | Public sector | 122 | 156.07 |
| | State-owned enterprise | 82 | 138.58 |
| | Total | 282 | |
| Empathy expectation average | Private sector | 78 | 113.29 |
| | Public sector | 122 | 159.91 |
| | State-owned enterprise | 82 | 140.95 |
| | Total | 282 | |

Table 5.132: Test statistics table for no differences in customer expectations by sector of the economy in which they are employed

| Test statistics ^{a,b} | | | | | |
|---|------------------------------|---------------------------------|------------------------------------|-------------------------------|-----------------------------|
| | Tangible expectation average | Reliability expectation average | Responsiveness expectation average | Assurance expectation average | Empathy expectation average |
| Chi-square | .163 | 10.029 | 6.876 | 10.106 | 18.236 |
| df | 2 | 2 | 2 | 2 | 2 |
| Asymp. sig. | .922 | .007 | .032 | .006 | .000 |
| a. Kruskal–Wallis test | | | | | |
| b. Grouping variable: IN WHICH_SECTOR_OF_THE_ECONOMY_ARE THEY EMPLOYED? | | | | | |

The findings revealed no statistically noteworthy differences in the medical insurance customers' expectations of the tangibles dimension between participants in the sample who are employed in different sectors of the economy ($p > 0.05$).

However, the study revealed statistically noteworthy differences in the medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions between participants in the sample who are employed in different sectors of the economy ($p < 0.05$). Although all medical insurance customers employed in different sectors of the economy have high expectations of the above service quality dimensions (Table 5.2), strongest expectations were recorded in customers employed in the public sector, followed by those employed in state-owned enterprises, as shown by the high mean ranks recorded (Table 5.21). This could possibly be because participants employed in these sectors earn very modest salaries and they therefore feel their subscriptions are very high compared to the poor salaries they earn from the government. They therefore expect more value for the hard-earned money they pay as coverage against the risk of impoverishment through ill health.

5.10.9 Hypothesis 2.4: There are no statistically significant differences in medical insurance customers' expectations of service quality along all the dimensions amongst customers with different periods of membership with the medical insurance company.

The Kruskal–Wallis test was used to perform the above test. The mean ranks table and the Kruskal–Wallis output table (Tables 5.23 and 5.24) below show the results of these tests.

Table 5.23: Mean ranks table for customer expectations by period of membership with the medical insurance company

| Ranks | | | |
|------------------------------------|--|-----|-----------|
| | PERIOD_OF_MEMBERSHIP_TO F_THE_MED_INS_COMPANY | N | Mean rank |
| Tangible expectation average | 0–1 year | 28 | 132.39 |
| | 2–3 years | 51 | 165.53 |
| | 4–5 years | 43 | 149.00 |
| | >5 years | 164 | 137.10 |
| | Total | 286 | |
| Reliability expectation average | 0–1 year | 28 | 121.91 |
| | 2–3 years | 51 | 125.17 |
| | 4–5 years | 43 | 123.70 |
| | >5 years | 164 | 158.08 |
| | Total | 286 | |
| Responsiveness expectation average | 0–1 year | 28 | 127.57 |
| | 2–3 years | 51 | 123.07 |
| | 4–5 years | 43 | 135.77 |
| | >5 years | 164 | 154.60 |
| | Total | 286 | |
| Assurance expectation average | 0–1 year | 28 | 123.57 |
| | 2–3 years | 51 | 119.92 |
| | 4–5 years | 43 | 133.44 |
| | >5 years | 164 | 156.87 |
| | Total | 286 | |
| Empathy expectation average | 0–1 year | 28 | 112.02 |
| | 2–3 years | 51 | 120.51 |
| | 4–5 years | 43 | 139.23 |
| | >5 years | 164 | 157.14 |
| | Total | 286 | |

Table 5.24: Test statistics table for no differences in customer expectations by period of membership with the medical insurance company

| Test statistics ^{a,b} | | | | | |
|---|------------------------------|---------------------------------|------------------------------------|-------------------------------|-----------------------------|
| | Tangible expectation average | Reliability expectation average | Responsiveness expectation average | Assurance expectation average | Empathy expectation average |
| Chi-square | 5.621 | 14.014 | 9.635 | 12.656 | 14.745 |
| df | 3 | 3 | 3 | 3 | 3 |
| Asymp. sig. | 0.132 | 0.003 | 0.022 | 0.005 | 0.002 |
| a. Kruskal–Wallis test | | | | | |
| b. Grouping variable: PERIOD_OF_MEMBERSHIP_OF_THE_MED_INS_COMPANY | | | | | |

The study revealed no statistically notable differences in the medical insurance customers’ expectations of the tangibles dimension between participants in the sample who have different periods of membership with their medical insurance companies ($p>0.05$).

However, statistically notable differences were found in the medical insurance customers’ expectations of the reliability, responsiveness, assurance, and empathy dimensions between participants in the sample who have different periods of membership with their medical insurance companies ($p<0.05$). Although all medical insurance customers with different periods of membership with their medical insurance companies have high expectations of the above service quality dimensions (Table 5.2), strongest expectations were obtained from customers in the >5 years group. This is shown by high mean ranks recorded in this group (Table 5.23) and could possibly be because medical insurance customers in this group are long-time members of these companies and their past experiences and accumulated knowledge about medical insurance services have raised their expectations. Another possibility could be that they feel they are important stakeholders who have been loyal to the medical insurance company for a long time and therefore need to be rewarded for their loyalty through excellent services. This therefore tends to increase their expectations about service delivery in these dimensions.

5.10.10 Hypothesis 2.5: There are no statistically significant differences in the expectations of medical service quality along all the dimensions between customers who have either or not switched between medical insurance companies.

To perform this test, the Mann–Whitney test was used. The mean ranks table and the test statistics table (Tables 5.25 and 5.26) below show the results of these tests.

Table 5.25 Mean ranks table for customer expectations by whether customers have either switched between medical insurance companies or not

| Ranks | | | | |
|------------------------------------|---|-----|-----------|--------------|
| | HAVE_YOU_EVER_SWITCHED_BETWEEN_MED_INS_COMPANIES? | N | Mean rank | Sum of ranks |
| Tangible expectation average | No | 168 | 141.33 | 23744.00 |
| | Yes | 118 | 146.58 | 17297.00 |
| | Total | 286 | | |
| Reliability expectation average | No | 168 | 149.24 | 25071.50 |
| | Yes | 118 | 135.33 | 15969.50 |
| | Total | 286 | | |
| Responsiveness expectation average | No | 168 | 147.94 | 24854.00 |
| | Yes | 118 | 137.18 | 16187.00 |
| | Total | 286 | | |
| Assurance expectation average | No | 168 | 145.11 | 24379.00 |
| | Yes | 118 | 141.20 | 16662.00 |
| | Total | 286 | | |
| Empathy expectation average | No | 168 | 150.45 | 25275.50 |
| | Yes | 118 | 133.61 | 15765.50 |
| | Total | 286 | | |

Table 5.26: Test statistics for no differences in customer expectations by whether customer have either switched between medical insurance companies or not

| Test statistics ^a | | | | | |
|------------------------------|------------------------------|---------------------------------|------------------------------------|-------------------------------|-----------------------------|
| | Tangible expectation average | Reliability expectation average | Responsiveness expectation average | Assurance expectation average | Empathy expectation average |
| Mann–Whitney U | 9548.000 | 8948.500 | 9166.000 | 9641.000 | 8744.500 |
| Wilcoxon W | 23744.000 | 15969.500 | 16187.000 | 16662.000 | 15765.500 |
| Z | -.545 | -1.514 | -1.230 | -.428 | -1.836 |
| Asymp. sig. (2-tailed) | 0.586 | 0.130 | 0.219 | 0.669 | 0.066 |

a. Grouping variable: HAVE_YOU_EVER_SWITCHED_BETWEEN_MED_INS_COMPANIES?

The study revealed no statistically noteworthy differences in the medical insurance customers' expectations of all the service quality dimensions between participants in the sample who have either switched between medical insurance companies or not ($p>0.05$).

C) Hypotheses on gap scores

5.10.11 Hypothesis 3.1: There are no statistically significant differences in service quality gaps experienced by medical insurance customers in different age groups.

To ascertain if the mean gap scores for all the service quality variables were the same between different age groups, a Kruskal–Wallis test was conducted and Table 5.27 below shows the results.

Table 5.27: Ranks and test statistics table for no differences in service quality gaps in customers of different age groups

| Ranks | | | | | | |
|--------------------|------------------|-----|-----------|------------|----|---------|
| | Age group | N | Mean rank | Chi-square | df | p-value |
| Tangibles gap | 20 years or less | 2 | 198.00 | 1.198 | 4 | 0.878 |
| | 21–30 years | 49 | 141.51 | | | |
| | 31–40 years | 109 | 144.29 | | | |
| | 41–50 years | 92 | 141.24 | | | |
| | >50 years | 34 | 146.72 | | | |
| Reliability gap | 20 years or less | 2 | 161.25 | 8.661 | 4 | 0.07 |
| | 21–30 years | 49 | 145.40 | | | |
| | 31–40 years | 109 | 159.11 | | | |
| | 41–50 years | 92 | 132.89 | | | |
| | >50 years | 34 | 118.40 | | | |
| Responsiveness gap | 20 years or less | 2 | 142.00 | 10.019 | 4 | 0.04 |
| | 21–30 years | 49 | 157.50 | | | |
| | 31–40 years | 109 | 155.45 | | | |
| | 41–50 years | 92 | 133.63 | | | |
| | >50 years | 34 | 111.79 | | | |
| Assurance gap | 20 years or less | 2 | 149.00 | 14.508 | 4 | 0.006 |
| | 21–30 years | 49 | 167.82 | | | |
| | 31–40 years | 109 | 153.30 | | | |
| | 41–50 years | 92 | 132.79 | | | |
| | >50 years | 34 | 105.69 | | | |
| Empathy gap | 20 years or less | 2 | 165.00 | 7.122 | 4 | 0.13 |
| | 21–30 years | 49 | 164.35 | | | |
| | 31–40 years | 109 | 148.83 | | | |
| | 41–50 years | 92 | 132.66 | | | |
| | >50 years | 34 | 124.46 | | | |
| Overall gap | 20 years or less | 2 | 171.00 | 9.644 | 4 | 0.047 |

| | | | | | | |
|--|-------------|-----|--------|--|--|--|
| | 21–30 years | 49 | 158.55 | | | |
| | 31–40 years | 109 | 154.17 | | | |
| | 41–50 years | 92 | 133.54 | | | |
| | >50 years | 34 | 112.91 | | | |

The results show statistically notable differences in the responsiveness and assurance gap scores between customers of different age groups ($p < 0.05$), as shown in Table 5.27 above. Thus, the hypothesis will be accepted.

Customers in the 21–30 years age group had the highest gap scores, as shown by the high mean ranks of 157.50 and 167.82 for responsiveness and assurance respectively (Table 5.27). This shows that medical insurance customers in this age group are more dissatisfied with the responsiveness and assurance service quality dimensions than customers in other age groups.

However, the study did not find any notable differences in gap scores for tangibles, reliability, and empathy between customers in different age groups at the 95% level ($p > 0.05$).

5.10.12 Hypothesis 3.2: There are no statistically significant differences in service quality gaps experienced between male and female medical insurance customers.

To determine if the mean gap score for all the dimensions were similar between male and female, a Mann–Whitney test was conducted and the results are shown in Table 5.28 below.

Table 5.28: Test statistics for no differences in gap scores in customers by gender

| Test statistics ^a | | | | | | |
|------------------------------|---------------|-----------------|--------------------|---------------|-------------|-------------|
| | Tangibles gap | Reliability gap | Responsiveness gap | Assurance gap | Empathy gap | Overall gap |
| Mann–Whitney U | 9040.000 | 9777.000 | 9562.000 | 9027.000 | 9698.000 | 9362.500 |
| Wilcoxon W | 18356.000 | 19093.000 | 18878.000 | 18343.000 | 19014.000 | 18678.500 |
| Z | -1.306 | -.122 | -.438 | -1.227 | -.239 | -.731 |
| Asymp. sig. (2-tailed) | 0.192 | 0.903 | 0.661 | 0.220 | 0.811 | 0.465 |
| a. Grouping variable: gender | | | | | | |

The findings show no statistically notable differences in the gap scores between male and female medical insurance customers for all the dimensions at the 95% level ($p > 0.05$), as shown in Table 5.28 above. Thus, the hypothesis is rejected.

5.10.13 Hypothesis 3.3: There are no statistically significant differences in service quality gaps experienced by medical insurance customers employed in different sectors of the economy.

The Kruskal–Wallis test was used to test the above hypothesis and the results are shown in Table 5.29 and Table 5.30 below.

Table 5.29: Test statistics for no differences in service quality gaps in customers with regard to different sectors of the economy they are employed in

| Test statistics ^{a,b} | | | | | | |
|---|---------|--------|--------|--------|--------|------------|
| | tanggap | relgap | resgap | assgap | empgap | overallgap |
| Chi-square | 2.587 | 26.503 | 28.236 | 32.357 | 26.202 | 34.495 |
| df | 2 | 2 | 2 | 2 | 2 | 2 |
| Asymp. sig. | .274 | .000 | .000 | .000 | .000 | .000 |
| a. Kruskal–Wallis test | | | | | | |
| b. Grouping variable: SECTOR OF THE ECONOMY | | | | | | |

The results show some statistically noteworthy differences in the reliability, responsiveness, assurance, and empathy gap scores between medical insurance customers employed in the different sectors of the economy ($p < 0.05$). Thus, the hypothesis will be accepted. However, no statistically notable differences in gap scores for the tangibles dimension between customers employed in different sectors of the economy were found.

In all the four dimensions highlighted above, gap scores for medical insurance customers employed in the public sector were the highest, as shown by high mean ranks in Table 5.30 below. This indicates that medical insurance customers employed in the public sector are experiencing higher levels of dissatisfaction, as shown by the higher gap scores. This is shown by Table 5.30 below.

Table 5.140: Mean rank of all the dimensions with regard to different sectors of economy

| Ranks | | | |
|--------------------|------------------------|-----|-----------|
| | SECTOR OF THE ECONOMY | N | Mean rank |
| Tangibility gap | Private sector | 78 | 136.44 |
| | Public sector | 122 | 153.17 |
| | State-owned enterprise | 82 | 137.93 |
| Reliability gap | Private sector | 78 | 117.77 |
| | Public sector | 122 | 178.58 |
| | State-owned enterprise | 82 | 141.54 |
| Responsiveness gap | Private sector | 78 | 118.20 |

| | | | |
|---------------|------------------------|-----|--------|
| | Public sector | 122 | 180.79 |
| | State-owned enterprise | 82 | 138.79 |
| Assurance gap | Private sector | 78 | 117.43 |
| | Public sector | 122 | 184.09 |
| | State-owned enterprise | 82 | 136.79 |
| Empathy gap | Private sector | 78 | 117.07 |
| | Public sector | 122 | 177.32 |
| | State-owned enterprise | 82 | 143.77 |
| Overall gap | Private sector | 78 | 115.69 |
| | Public sector | 122 | 184.97 |
| | State-owned enterprise | 82 | 138.54 |

5.10.14 Hypothesis 3.4: There are no statistically significant differences in service quality gaps experienced by medical insurance customers with different periods of membership with the medical insurance companies.

A Kruskal–Wallis test was used to test this hypothesis and the results obtained are shown in Table 5.31 and Table 5.32 below.

Table 5.31: Test statistics for no differences in service quality gaps in customers with regard to periods of membership

| Test statistics ^{a,b} | | | | | | |
|---|-----------------|-----------------|--------------------|---------------|-------------|-------------|
| | Tangibility gap | Reliability gap | Responsiveness gap | Assurance gap | Empathy gap | Overall gap |
| Chi-square | 8.891 | 36.818 | 45.283 | 32.121 | 27.340 | 33.057 |
| df | 3 | 3 | 3 | 3 | 3 | 3 |
| Asymp. sig. | .031 | .000 | .000 | .000 | .000 | .000 |
| a. Kruskal-Wallis test | | | | | | |
| b. Grouping variable: PERIOD_OF_MEMBERSHIP_TO_THE_MED_INS_COMPANY | | | | | | |

The results show statistically notable differences in gap scores between customers with different periods of membership for all the dimensions ($p < 0.05$). The hypothesis was therefore accepted.

Customers with more than 5 years of membership had the highest gap scores for tangibility (shown by highest mean ranks in Table 5.32), indicating that these customers had higher expectations for their companies to improve the service-scape. The reliability and responsiveness gap scores for customers with 2–3 years of membership were the highest, showing higher expectations for the improvement of reliability and responsiveness by customers within this period of membership with their companies. The

assurance and empathy gap scores for customers with less than 1 year of membership were the highest, also showing higher levels of dissatisfaction with empathy and assurance dimensions by customers with less than 1 year of membership in their companies. This is shown by the mean rank figures in Table 5.32 below.

Table 5.32: Ranks table for gap scores of all the dimensions with regard to period of membership

| Ranks | | | |
|--------------------|----------------------|-----|-----------|
| | Period of membership | N | Mean rank |
| Tangibility gap | 0–1 year | 28 | 145.21 |
| | 2–3 years | 51 | 114.71 |
| | 4–5 years | 43 | 150.12 |
| | >5 years | 164 | 150.43 |
| | Total | 286 | |
| Reliability gap | 0–1 year | 28 | 177.09 |
| | 2–3 years | 51 | 192.47 |
| | 4–5 years | 43 | 154.16 |
| | >5 years | 164 | 119.74 |
| | Total | 286 | |
| Responsiveness gap | 0–1 year | 28 | 176.96 |
| | 2–3 years | 51 | 197.28 |
| | 4–5 years | 43 | 160.20 |
| | >5 years | 164 | 116.68 |
| | Total | 286 | |
| Assurance gap | 0–1 year | 28 | 185.55 |
| | 2–3 years | 51 | 184.19 |
| | 4–5 years | 43 | 152.58 |
| | >5 years | 164 | 121.29 |
| | Total | 286 | |
| Empathy gap | 0–1 year | 28 | 185.55 |
| | 2–3 years | 51 | 177.68 |
| | 4–5 years | 43 | 155.05 |
| | >5 years | 164 | 122.66 |
| | Total | 286 | |
| Overall gap | 0–1 year | 28 | 181.82 |
| | 2–3 years | 51 | 185.50 |
| | 4–5 years | 43 | 156.79 |
| | >5 years | 164 | 120.41 |

| | | | |
|--|-------|-----|--|
| | Total | 286 | |
|--|-------|-----|--|

5.10.15 Hypothesis 3.5: There are no statistically significant differences in service quality gaps experienced by medical insurance customers who have either switched or not switched between medical insurance companies.

The above hypothesis was tested using the Mann–Whitney test and the results obtained are shown in Table 5.33 and Table 5.34 below.

Table 5.33: Test statistics table for no differences in service quality gaps in customers who have either or not switched between medical insurance companies

| Test statistics ^a | | | | | | |
|---|-----------------|-----------------|--------------------|---------------|-------------|-------------|
| | Tangibility gap | Reliability gap | Responsiveness gap | Assurance gap | Empathy gap | Overall gap |
| Mann–Whitney U | 9775.500 | 7284.000 | 7424.000 | 8448.000 | 8445.000 | 7853.000 |
| Wilcoxon W | 16796.500 | 21480.000 | 21620.000 | 22644.000 | 22641.000 | 22049.000 |
| Z | -.214 | -3.820 | -3.619 | -2.132 | -2.136 | -2.990 |
| Asymp. sig. (2-tailed) | 0.830 | 0.000 | 0.000 | 0.033 | 0.033 | 0.003 |
| a. Grouping variable: HAVE_YOU_EVER_SWITCHED_BETWEEN_MED_INS_COMPANIES? | | | | | | |

The findings show statistically noteworthy differences in the gap scores between customers who have switched between medical insurance companies for all the dimensions ($p < 0.05$), except for the tangibility dimension, as shown in Table 5.33 above. Therefore, the hypothesis is accepted.

In all the four dimensions, customers who indicated to have switched between medical insurance companies had the highest gap scores, shown by high mean ranks in Table 5.34 below. This shows that customers who once switched between medical insurance companies had higher expectations for their companies to be more reliable, responsive, empathetic, and to show more assurance.

Table 5.34: Ranks table for service quality gaps with regard to whether or not customers switched between companies

| Ranks | | | | |
|--------------------|--|-----|-----------|--------------|
| | EVER_SWITCHED_BETWEEN_MED_INS_COMPANIES? | N | Mean rank | Sum of ranks |
| Tangibility gap | No | 168 | 144.31 | 24244.50 |
| | Yes | 118 | 142.34 | 16796.50 |
| | Total | 286 | | |
| Reliability gap | No | 168 | 127.86 | 21480.00 |
| | Yes | 118 | 165.77 | 19561.00 |
| | Total | 286 | | |
| Responsiveness gap | No | 168 | 128.69 | 21620.00 |
| | Yes | 118 | 164.58 | 19421.00 |
| | Total | 286 | | |
| Assurance gap | No | 168 | 134.79 | 22644.00 |
| | Yes | 118 | 155.91 | 18397.00 |
| | Total | 286 | | |
| Empathy gap | No | 168 | 134.77 | 22641.00 |
| | Yes | 118 | 155.93 | 18400.00 |
| | Total | 286 | | |
| Overall gap | No | 168 | 131.24 | 22049.00 |
| | Yes | 118 | 160.95 | 18992.00 |
| | Total | 286 | | |

5.10.16 Hypothesis 4.1: There are no statistically significant differences in customer perceptions of service quality between government-owned and privately owned medical insurance companies.

As explained in section 5.8, the study also sought to test the above hypothesis. The Mann–Whitney U test was used to test the hypothesis and the results are shown in Tables 5.35 and 5.36 below. It was found that government-owned medical insurance companies had lower mean rank value for all the constructs, as shown in Table 5.36 below.

Table 5.35: Ranks table comparing customer perceptions of service quality between government-owned and privately owned medical insurance companies

| Ranks | | | | |
|-----------------------------------|-------------------|-----|-----------|--------------|
| | Form of ownership | N | Mean rank | Sum of ranks |
| Tangible perception average | Private | 142 | 157.65 | 22387.00 |
| | Government | 144 | 129.54 | 18654.00 |
| Reliability perception average | Private | 141 | 190.43 | 26851.00 |
| | Government | 143 | 95.24 | 13619.00 |
| Responsiveness perception average | Private | 141 | 190.72 | 26891.00 |
| | Government | 143 | 94.96 | 13579.00 |
| Assurance perception average | Private | 142 | 187.17 | 26578.00 |
| | Government | 144 | 100.44 | 14463.00 |
| Empathy perception average | Private | 142 | 179.25 | 25454.00 |
| | Government | 144 | 108.24 | 15587.00 |
| Overall perception | Private | 142 | 191.60 | 27206.50 |
| | Government | 144 | 96.07 | 13834.50 |

Table 5.36: Mann–Whitney U test output for equality of means of customer perceptions between government-owned and privately owned medical insurance companies

| | Mann–Whitney U | Z | p-value |
|---|----------------|--------|---------|
| Tangible perception average | 8214,000 | -2.897 | 0.004 |
| Reliability perception average | 3323,000 | -9.799 | 0.000 |
| Responsiveness perception average | 3283,000 | -9.854 | 0.000 |
| Assurance perception average | 4023,000 | -8.933 | 0.000 |
| Empathy perception average | 5147,000 | -7.294 | 0.000 |
| Overall perception | 3394,500 | -9.766 | 0.000 |
| a. Grouping variable: form of ownership | | | |

The results show that government-owned medical insurance companies had significantly lower mean rank scores for tangible perceptions, reliability perceptions, responsiveness perceptions, assurance perceptions, and empathy perceptions ($p < 0.05$), as shown in Table 5.35 and Table 5.36. It can thus be concluded that customers in the government-owned institution perceived service quality as lower than those in privately owned institutions.

5.10.17 Hypothesis 4.2: There are no statistically significant differences in customer expectations of service quality between government-owned and privately owned medical insurance companies.

In order to test the above hypothesis, the Mann–Whitney U test was used, and the results are shown in Tables 5.37 and 5.38 below. It was found that public institutions had the higher mean rank value for reliability expectation, responsiveness expectation, assurance expectation, and empathy expectation, as shown in Table 5.37.

Table 5.37: Ranks table comparing customer expectations of service quality between government-owned and privately owned medical insurance companies

| Ranks | | | | |
|------------------------------------|-------------------|-----|-----------|--------------|
| | Form of ownership | N | Mean rank | Sum of ranks |
| Tangible expectation average | Private | 142 | 148.62 | 21104.00 |
| | Government | 144 | 138.45 | 19937.00 |
| Reliability expectation average | Private | 142 | 115.77 | 16439.50 |
| | Government | 144 | 170.84 | 24601.50 |
| Responsiveness expectation average | Private | 142 | 120.68 | 17136.00 |
| | Government | 144 | 166.01 | 23905.00 |
| Assurance expectation average | Private | 142 | 118.51 | 16829.00 |
| | Government | 144 | 168.14 | 24212.00 |
| Empathy expectation average | Private | 142 | 116.64 | 16563.50 |
| | Government | 144 | 169.98 | 24477.50 |
| Overall expectation | Private | 142 | 119.90 | 17026.50 |
| | Government | 144 | 166.77 | 24014.50 |

Table 5.38: Mann–Whitney U test output for equality of means of customer perceptions between government-owned and privately owned medical insurance companies

| | Mann–Whitney U | Z | p-value |
|---|----------------|--------|---------|
| Tangible expectation average | 9497,000 | -1,071 | 0.284 |
| Reliability expectation average | 6286,500 | -6,091 | 0.000 |
| Responsiveness expectation average | 6983,000 | -5,259 | 0,000 |
| Assurance expectation average | 6676,000 | -5,519 | 0,000 |
| Empathy expectation average | 6410,500 | -5,905 | 0,000 |
| Overall expectation | 6873,500 | -4,819 | 0,000 |
| a. Grouping variable: form of ownership | | | |

Results found that public institutions significantly had higher mean rank scores for reliability expectation, responsiveness expectation, assurance expectation, and empathy expectation average ($p < 0.05$), as shown in Table 5.38 above. This indicates that customers of government-owned medical insurance companies expect their insurer to be more reliable, responsive, to offer more assurance, and to be empathetic.

5.10.18 Hypothesis 4.3: There are no statistically significant gaps in service quality experienced by customers in government-owned and privately owned medical insurance companies.

The Mann–Whitney U test was used to test this hypothesis and the results are shown in Tables 5.39 and 5.40 below.

Table 5.39: Ranks table comparing gap scores between government-owned and privately owned medical insurance companies

| Ranks | | | | |
|--------------------|-------------------|-----|-----------|--------------|
| | Form of ownership | N | Mean rank | Sum of ranks |
| Tangibles gap | Private | 142 | 138.56 | 19675.50 |
| | Government | 144 | 148.37 | 21365.50 |
| Reliability gap | Private | 142 | 96.37 | 13685.00 |
| | Government | 144 | 189.97 | 27356.00 |
| Responsiveness gap | Private | 142 | 98.12 | 13933.50 |
| | Government | 144 | 188.25 | 27107.50 |
| Assurance gap | Private | 142 | 101.34 | 14390.00 |
| | Government | 144 | 185.08 | 26651.00 |
| Empathy gap | Private | 142 | 105.74 | 15015.50 |
| | Government | 144 | 180.73 | 26025.50 |
| Overall gap | Private | 142 | 97.05 | 13781.00 |
| | Government | 144 | 189.31 | 27260.00 |

Table 5.40: Mann–Whitney U test output for equality of means of gap scores between government-owned and privately owned medical insurance companies

| | Mann–Whitney U | Z | p-value |
|---|----------------|--------|---------|
| Tangibles gap | 9235.500 | -1.527 | 0.127 |
| Reliability gap | 3245.000 | -9.989 | 0.000 |
| Responsiveness gap | 3493.500 | -9.639 | 0.000 |
| Assurance gap | 3950.000 | -8.998 | 0.000 |
| Empathy gap | 4575.500 | -8.099 | 0.000 |
| Overall gap | 3341.000 | -9.843 | 0.000 |
| a. Grouping variable: form of ownership | | | |

It was also found that the government-owned institution had significantly higher mean rank gaps for reliability gap, responsiveness gap, assurance gap, empathy gap, overall perception, and overall gap ($p < 0.05$). This shows that there are higher levels of customer dissatisfaction with service quality in government-owned than in privately owned medical insurance companies.

The results of the hypotheses tested suggest that medical insurance companies come up with different medical insurance plans that suit the different expectations of clients in different categories. This is supported by customers in different age groups who had significant differences in expectations with regard to responsiveness, assurance, and empathy (Table 5.20). Furthermore, medical insurance companies can come up with different plans that suit members employed in the different sectors of the economy, as these groups also had different expectations with regard to reliability, responsiveness, assurance, and empathy (Table 5.24). Moreover, since members with different periods of membership with the medical insurance companies had different expectations with regard to reliability, responsiveness, assurance, and empathy (Table 5.26), medical insurance companies can consider coming up with plans that give different benefits according to membership period.

As the study also showed lower perceptions and higher service quality gaps in the government-owned medical insurance company, this institution should make more effort to improve their service quality. The government is the largest employer and offers medical insurance services to a large number of citizens, and failure to improve service quality can cause members to opt out of medical insurance, thereby negatively affecting the sustainability of the sector and the health sector in general.

5.11 Correlation among the service quality dimensions

The Spearman's rho correlation test was conducted to find significant relationships between the dimensions. Results showed that the gap scores were significantly positively correlated with each other ($p < 0.05$) (Table 5.39). As shown in the table, the tangibles gap and the reliability gap were positively related ($r = 0.278$, $p < 0.05$). This shows that if the gap score for tangibles increased, the gap score for reliability would also increase. The reliability gap score and the responsiveness gap score were also

very strongly positively correlated ($r = 0.806, p < 0.05$). This indicates that if the gap score increased for reliability, then the gap score for responsiveness would also increase. Moreover, the responsiveness gap and the assurance gap were strongly positively correlated ($r = 0.791, p < 0.05$). Thus, if the responsiveness gap increased, the assurance gap would also increase. Furthermore, the assurance gap and the empathy gap were strongly positively correlated ($r = 0.785, p < 0.05$), which implies that if the assurance gap increased, the empathy gap would also increase. This applies to all the correlations shown in Table 5.39 below.

Table 5.15: Spearman's rho correlation output

| Correlations | | | | | | | | |
|----------------|--------------------|-------------------------|---------|--------|--------|--------|--------|------------|
| | | | tanggap | relgap | resgap | assgap | empgap | overallgap |
| Spearman's rho | Tangibles gap | Correlation coefficient | 1.000 | .278** | .182** | .259** | .259** | .424** |
| | | Sig. (2-tailed) | . | .000 | .002 | .000 | .000 | .000 |
| | Reliability gap | Correlation coefficient | .278** | 1.000 | .806** | .756** | .664** | .889** |
| | | Sig. (2-tailed) | .000 | . | .000 | .000 | .000 | .000 |
| | Responsiveness gap | Correlation coefficient | .182** | .806** | 1.000 | .791** | .711** | .889** |
| | | Sig. (2-tailed) | .002 | .000 | . | .000 | .000 | .000 |
| | Assurance gap | Correlation coefficient | .259** | .756** | .791** | 1.000 | .785** | .907** |
| | | Sig. (2-tailed) | .000 | .000 | .000 | . | .000 | .000 |
| | Empathy gap | Correlation coefficient | .259** | .664** | .711** | .785** | 1.000 | .846** |
| | | Sig. (2-tailed) | .000 | .000 | .000 | .000 | . | .000 |
| | Overall gap | Correlation coefficient | .424** | .889** | .889** | .907** | .846** | 1.000 |
| | | Sig. (2-tailed) | .000 | .000 | .000 | .000 | .000 | . |

** . Correlation is significant at the 0.01 level (2-tailed).

5.2 Conclusion

This chapter provided the presentation and analytical interpretation of the data obtained from the survey. The data was analysed using descriptive and inferential statistics to provide answers to the research questions and hypotheses. The results indicated that medical insurance customers were dissatisfied with the service offerings of medical insurance companies. The next chapter is centred on the discussion of the results obtained from the data analysis.

CHAPTER SIX

DISCUSSION OF RESULTS

6.1 Introduction

This chapter gives a statistical interpretation of the results obtained in Chapter 5. These results are discussed in line with the literature provided in the previous chapters and in the context of the hypotheses postulated in Chapters 1 and 4. The chapter will start by discussing the results around the demographic data.

6.2 Demographic data

This section will discuss results obtained around the demographic aspects of the study. Demographic variables have been regarded as critical determinants of consumer behaviour (Kwok *et al.*, 2016) and a variety of demographic variables like age, gender, and income have been used to segment markets (Omar *et al.*, 2016; Devi Juwaheer, 2011). In earlier studies conducted on service quality, demographic variables were found to have a significant effect on clients' perceptions of service quality. For instance, in a study by Boonen *et al.* (2015:339–353), switching propensities of customers in the Dutch health insurance market were found to be dependent on the age, health, and education levels of customers. Furthermore, in a study conducted in Ghana, subscription to medical insurance companies was largely determined by gender (Amo-Adjei *et al.*, 2016:311). Social theory has also proven that men are more risk taking than women and have a higher propensity to change service providers when their satisfaction levels change (Omar *et al.*, 2016).

The present study sought to understand customer perceptions and expectations of service quality in the medical insurance sector. A thorough understanding of service quality in the sector required further investigation of the extent to which customer perceptions and expectations varied with different age groups, gender, and different sectors of the economy where customers were employed, among others. This knowledge can assist in designing health insurance plans suitable for different customers' needs and enhance the sustainability of the sector. This section will therefore discuss the patterns found in analysing data obtained around the age groups of the participants, their gender, medical insurance subscribed to, and their employment by economic sector, among others.

6.2.1 Age groups of participants

The results indicated that about 70 per cent of the participants were between the ages 31 years and 50 years (Figure 5.1), which shows that a greater percentage of medical insurance customers are in the productive age group of the dwindling formal employment sector in Zimbabwe. This concurs with views of Musungwini (2012) who advocates that the survival of the medical insurance industry in Zimbabwe mainly hinges on the formal employment sector, which caters for only 7 per cent of the

population. As highlighted before, this sector is continuously shrinking due to the poor macro-economic conditions prevailing in the country, which is further stiffening competition in the sector (section 1.2). Thus, efforts to improve service delivery along the service quality dimensions must be more centred on meeting the health care needs of this age group to enhance customer satisfaction and sustainability in the industry.

6.2.2 Gender of participants

The results also indicated that there were more female (52 per cent) than male (48 per cent) participants (Figure 5.2), although the difference was not significant. Similar results were found in a study by Kwok *et al.* (2016) where females constituted 56.8 per cent of the respondents. In the present study, gender was found to have a strong moderating effect on service quality and customer satisfaction. Since the study was conducted at the medical institutions where members were seeking health care, the results further indicate that female members tend to seek more medical attention than their male counterparts. Therefore, the determination of health risks and design of health insurance plans by medical insurance companies should be more centred on the health care needs of females to promote profitability and sustainability of their companies.

6.2.3 Medical insurance subscribed to and employment by economic sector

Of the five medical insurance companies investigated, the government-owned PSMAS commanded the largest number (50 per cent) of participants, followed by CIMAS (23.4 per cent) (Figure 5.3). This is because PSMAS and CIMAS dominated the industry until 1990 when the industry was deregulated as a result of the adoption of ESAP (section 2.1). Research shows that previously government-owned institutions tend to command larger percentages of market share in the markets they choose to serve. A similar situation was encountered in India where the government deregulated the general insurance industry and allowed more private players to enter the industry. However, just like PSMAS, Life Insurance Corporation of India (LIC) is still recognised as the leading and oldest public sector company in the insurance sector (Madan, 2012) and has managed to maintain a bigger market share (though declining) due to the reliability of its services when compared to those offered by the private players (Madan, 2012).

The public sector also commanded a large percentage (43 per cent) of participants (Figure 5.4) in the present study. Although membership of medical insurance companies in Zimbabwe is voluntary (Munyuki & Jasi, 2009; Shamu *et al.*, 2010), the systems or conditions of membership seem to compel members of the public sector to subscribe to PSMAS. The government is the largest employer in the country, which might be the reason why a larger proportion of the respondents (43 per cent) were employed in the public sector (Figure 5.4). Furthermore, since medical insurance in Zimbabwe is offered through employers, the choice for health insurers among employees tend to be limited within the range of insurers negotiated with their employers. This is supported by Austin and Hungerford

(2010) who argue that in health insurances offered through employers, consumer choices are limited, and a person's job limits his or her health insurance choices. Thus, although the industry experienced some deregulation which allowed more players to enter the industry (section 2.1), PSMAS seems to enjoy a monopoly of membership among most public sector employees due to a limited choice of health insurers offered to government employees.

6.2.4 Period of membership with medical insurance companies and switching between medical insurance companies

More than half of the participants (57 per cent) have been members of their medical insurance companies for more than five years (Figure 5.5). Furthermore, about 41 per cent of the participants indicated that they had switched between medical insurance companies, whilst 59 per cent had never switched (Figure 5.6). The main reason for switching (as cited by 64 per cent of the participants) was poor service delivery, followed by change of job (35 per cent) (Figure 5.7). Longer periods of membership to medical insurance companies can be explained by the limited choices available to employees due to the limited numbers of health insurers negotiated with their employers, as explained above. The substantial percentage of participants who switched between health insurers (41 per cent) and their main reason for switching confirm findings from recent studies which have shown that clients' contentment with the service of their existing insurer is a significant factor in determining whether or not to stay insured with that insurer (Reitsma-Van Rooijen *et al.*, 2011:30; Wendel *et al.*, 2011:311). Furthermore, in a study by Bhat and Jain (2007), customer satisfaction was found to be a significant factor in the renewal and long-term continuity of the medical insurance member in the pool. In support of the above, Madan (2012) highlights that today customers have become more delicate and discriminatory, and that service quality and customer satisfaction have become significant elements of contemporary marketing theory and practice in the service sector. He therefore recommends that insurance companies use service quality as a strategic tool to gain competitive advantage over competitors.

6.3 Research objectives

This section will discuss how the research objectives set in Chapter 1 were met. As mentioned earlier, the findings around the objectives will be discussed in the context of the literature reviewed in the study in order to find the areas of convergence and divergence from previous studies. This would be necessary for filling research gaps.

6.3.1 Research objective 1

The first objective of the study was to ascertain medical insurance customers' perceptions of service quality with respect to reliability, tangibility, responsiveness, empathy and assurance. In order to find

answers to this objective, responses to 22 questions on medical insurance clients' perceptions of the service quality dimensions in Section C of the questionnaire were analysed.

6.3.1.1 Customer perceptions of the tangibles

Tangibles have been defined as the physical representations or images of the service that are used by customers as the basis for assessing quality (Zeithaml *et al.*, 2009). Elements considered here include layout of the “physical facilities, personnel, communication material, and other physical features used to provide the service in the service facility” (Barber & Scarcelli, 2010). From the results obtained on the tangibles dimension, more participants agreed or strongly agreed to all the statements, which showed that medical insurance customers had high perceptions of the tangibles dimension (Figure 5.8). Using the mean scores, highest perceptions were also recorded in the tangibles dimension ($m = 3.5192$: Table 5.2). This shows that medical insurance customers perceived their companies as offering pleasant and excellent facilities. Mixed results have been obtained from previous studies investigating the significance of the tangible dimension in the perceptions of clients. For instance, results obtained in a study by Prentice (2013) indicated that certain groups of customers had positive perceptions of tangibles, while other groups in the study had very low perceptions of the tangible elements. Yet, the results obtained in the present study concur with the results obtained by Gopalkrishna *et al.* (2008:49–61) which indicated that insurance providers give more importance to the ‘tangibles of service’ whilst giving less importance to ‘core service’. Furthermore, the findings support the view that poor knowledge of service quality in organisations cause managers to focus too much on things of less importance to the customer (Candido & Morris, 2000:466; Storey & Larbig, 2017). Due to the limited research in this area, medical insurance companies in Zimbabwe could have adopted Zeithaml's (1981:187) view that customers' perceptions of quality were “often based on tangible evidence rather than on the core service”. According to Zeithaml *et al.* (2009:115), tangible evidence is commonly utilised by service firms to boost their image and to ensure business sustainability.

Literature has shown that the service-scape has greater significance for customers who spend a longer time in the facility as opposed to services that entail quick transactions (Baloglu, Mao & Busser, 2010; Bitner, 1992; Chowdhary & Prakash, 2007; Reimer & Kuen, 2005). Studies have also shown that in equipment- or facility-based sectors, tangibility appears to be of great significance when compared with the people-based service industries (Lee *et al.*, 2000; Lee, Lee & Dewald, 2016). Since medical insurance customers do not spend a long time in the facilities of health insurance companies, and since the service can be classified as more people-based, tangibility can be classified as a less important factor in health insurance. This could have caused customer perceptions of the tangibles dimension to be positive in the present empirical study.

6.3.1.2 Customer perceptions of reliability

The average mean score for reliability was $m = 2.6514$ (table 5.2), showing that medical insurance customers did not perceive their companies as having reliability. As shown in Figure 5.14, more than half of the participants reported that their medical insurance company neither provide all the medical benefits services as promised, nor do they provide services at the promised time. When the average mean scores of the service quality dimensions were ranked, reliability had the least mean score when compared to the other dimensions. These results differ from those obtained in a study by Asghari and Babu (2017:145), where the highest mean score for customer perceptions were recorded in the reliability dimension ($m=3.06$), though the value was regarded as low.

Reliability has been considered a significant antecedent of perceptions of service quality among US customers (Gunawadane, 2011:1005; Parasuraman *et al.*, 1988:31; Zeithaml *et al.*, 2009:113). Reliability entails the company delivering on its promises. The term can also be used interchangeably with trust, which is defined by Wendel *et al.* (2011:312) as clients' assurance in a trade partner's reliability and integrity to deliver on its promises. Eisingerich and Bell (2008:256–268) have found that the trust customers have in the health-care insurer is a critical component and contributes to maintaining sustainable relationships and profitability of a company. According to Jain *et al.* (2014), insurance is a business of settling claims and the claimant waits patiently for the moment of the fulfilment of the promise to pay the sum assured by the insurer. Jain *et al.* (2014) also believe that an insurer's ability to fulfil promise builds confidence in the policy holder and is a great motivator for keeping the contract alive, whereas the rejection of a medical claim disheartens the claimant, causing regret at being associated with the insurance company. Although reliability has been considered seriously among the Dutch health insurers (Boonen & Schut, 2011:226), the results obtained in the present study indicate the opposite.

6.3.1.3 Customer perceptions of responsiveness

Responsiveness assesses a firm's willingness and ability to offer timely service when clients have problems or questions (Zeithaml *et al.*, 2002:364). Lee *et al.* (2000:222) point out that responsiveness is the service quality dimension that is closely associated with people. Since health insurance is people based, responsiveness was expected to be a significant factor that determines perception of service quality.

The present study found that most participants had negative perceptions regarding responsiveness. More than half of the participants reported that their medical insurance company does not have employees who constantly inform them about when the services will be provided and that their medical insurance company does not provide prompt service to customers (section 5.5.3).

Yet, Joseph *et al.* (2003:89) reiterate that in the insurance industry it is imperative to develop a personal relationship with the customer and that customers' claims should be handled as quickly as possible. The

results of the present study also conflict with those obtained by Atinga (2011:144–161) who examined the perceptions of premium holders of the National Health Insurance Scheme in Ghana on health-care quality. In that study the insured considered their dealings with the service provider and their opinions of health-care providers to be good and the human dimensions of service quality constituted a significant determinant of positively perceived service quality.

The results of the present study substantiate the views of Lee *et al.* (2000:222) who argue that, although the human component is significant in various services sectors, the influence of people or personnel on service quality on the whole varies across service industries.

6.3.1.4 Customer perceptions of assurance

As shown in Figure 5.16, about half of the participants responded either positively or negatively to all the statements about assurance. It was thus concluded that the participants' perceptions towards assurance were not very good. Assurance had a mean score of $m = 3.0545$ (Table 5.2), which also showed that medical insurance customers perceived their companies as offering assurance only to a slight extent. Assurance, or trust, is considered to exist “when one party has confidence in a partner’s reliability and integrity” (Kassim & Abdullah, 2010:356). The results of the present study conform to this view, since the empirical results have also shown customers as having low-rated perceptions of the reliability dimension.

Literature has shown that in a managed competition system, assurance could be attained through allowing health insurers to contract some providers selectively (Hall *et al.*, 2002:197–206). This was likely to intensify competitive pressures among care providers and consequently improve the quality of care, thereby containing healthcare overheads in the process. Research has also confirmed “that trust in the health insurer is an important prerequisite for enrolees’ acceptance of selective contracting” (Bes *et al.*, 2013:375).

As indicated in Chapter 2, many medical insurance companies in Zimbabwe adopted the managed care system in the 2000s in reaction to the unfavourable economic situation experienced in the country. The empirical results of the present study on the assurance perception are contrary to the views of Hall *et al.* (2002:197–206) in which a managed competition system is believed to build more assurance through allowing health insurers to contract some providers selectively. Rather, the results of the present study conform to the findings of Shamu *et al.* (2010:13) that, despite the acquisitions of health-related businesses by medical insurance companies in Zimbabwe to reduce overcharging, co-payments and ultimately service delivery, medical insurance patients were still making huge payments to healthcare providers for amounts not covered by their medical schemes. In their survey it was also testified that very few medical insurance policies provided adequate financial cover for services offered by other companies. In a study by Kitapci *et al.* (2014:161–169), assurance and empathy were found to be

important antecedents of satisfaction in public healthcare. Yet, it does not seem as though most medical insurance companies in Zimbabwe have embraced this notion.

6.3.1.5 Customer perceptions of empathy

The study found that more participants responded positively to all the statements regarding perceptions related to empathy. For example, 68 per cent of the participants agreed or strongly agreed that their medical insurance company provides convenient business hours, and 58 per cent responded positively that their medical insurance company has employees who give customers individual attention (section 5.5.5). When the perception dimensions were ranked, the empathy dimension ($m=3.2479$) was ranked second, showing that customers perceived medical insurance companies as showing empathy (Table 5.2).

Although the participants of this study had positive perceptions about the empathy dimension, the results do not conform to those from many studies conducted in which empathy has been found to result in increased total service quality perceptions and the organisation's competitiveness (Costa *et al.*, 2004:334). This is because of the negative perceptions still reported in reliability and responsiveness in the present study, despite positive perceptions on empathy.

6.3.2 Research objective 2

This objective was to establish medical insurance customers' expectations of service quality provided by medical insurers with respect to tangibles, reliability, responsiveness, assurance, and empathy. Knowing what customers expect is considered an essential process in the delivery of service quality at any level of an operation (Ramseook-Munhurrun *et al.*, 2010). This study therefore sought to determine the service quality expectations of medical insurance customers along the five dimensions to establish the basis for improving service quality in the industry.

Results obtained indicated that customers' expectations were high in all the dimensions, with the highest mean scores being recorded in the reliability dimension, followed by responsiveness, assurance, empathy and, lastly, tangibles. The results of this study are similar to those obtained in several studies where customer expectations were very high to the extent of exceeding customer perceptions (Asghari & Babu, 2017; Roohi, Asayesh, Abdollahi & Abbasi, 2011; Yousapronpaiboon, 2014).

Highest expectations recorded in the reliability dimension are in sync with the views of Eisingerich and Bell (2008) who found customers' confidence in the health insurer a significant variable in promoting profitability and sustainability of the company. Contrary to the findings of the present study, this has been seriously considered among health insurers in the Netherlands (Boonen & Schut, 2011). The results of the present study conform to the findings of Pashaie *et al.* (2013:172) in which reliability was found to be critical in determining service quality among insurers. The results also confirm findings from earlier studies on service quality which regard reliability as the most important dimension, and

tangibility regarded as the least important service quality dimension (Parasuraman *et al.*, 1985). The results of this study are also supported by earlier studies which found that customers tend to have high expectations in critical variables like reliability and are thus less tolerant to unreliable services (Zeithaml *et al.*, 2009). In the same vein, customers are also believed to have lower expectations in less important dimensions like empathy and tangibles, thus becoming more tolerant to poor service quality in these variables (Berry *et al.*, 1993:98; Parasuraman *et al.*, 1991:447; Zeithaml *et al.*, 2009). Furthermore, the results from the present study confirm the views of Zeithaml *et al.* (2009:113) that clients desire to deal with business organisations “that keep their promises about service outcomes and core service attributes”. Moreover, the results of this study also conform to those of several studies that have shown reliability as “the most important determinant of perceptions of service quality among customers” (Gunawardnane 2011:1004; Zeithaml *et al.*, 2009:113).

On responsiveness, the empirical results show that medical insurance customers expect an ideal medical insurance company to keep clients updated about when services will be provided and to offer timely services. These results concur with the views of Joseph *et al.* (2003:89) who emphasise that in the insurance industry, it is firstly imperative to build personal relationships with clients, and secondly to handle customers’ claims as quickly as possible. It has also been noted that in health insurance, the shorter the delay in settling the claims, the better it is for both the beneficiary and the health service provider (Nsiah-Boateng *et al.*, 2016). This is because prompt settlement of health insurance claims has been found to greatly assist health insurance providers in managing their finances and thus enabling them in the provision of adequate and continuous services to the insured (Nsiah-Boateng *et al.*, 2016). Thus, to meet customer needs according to the expectations of the responsiveness dimension, medical insurance companies are compelled to be highly responsive in offering financial protection to the sick when the need arises.

Higher expectations in the assurance and empathy dimensions concur with earlier findings where assurance and empathy were confirmed as critical determinants of satisfaction in public health care (Ramanujam, 2011). Customers had high expectations of the assurance dimension. This implies that customers expect an ideal medical insurance company to have workers who instil in their clients not only confidence, but also a sense of security in their dealings with them. In other words, customers expect an ideal medical insurance company to inculcate confidence and trust in clients. These results confirm the views of Zeithaml *et al.* (2009:114) that assurance tends to be of great importance for services that are perceived to be of high risk or for services of which customers are unable to evaluate the outcomes with certainty, like insurance. Thus, the high expectations in assurance confirm the importance of assurance in health insurance.

Although customers’ expectations of tangibles were high, they ranked lowest in this study. The empirical results therefore confirmed the findings of Chowdhary and Prakash (2007:73–78), in which tangibility was found to be a more significant element in cinema halls and universities than in

accounting firms and insurance companies. These findings were also in line with those from previous studies where the service-scape was found to have greater significance for customers who spend a large amount of time on the business premises (e.g. restaurants, theatres, and sporting facilities), as opposed to services associated with quick transactions, like banks. Medical insurance companies also fall into this second category (Baloglu *et al.*, 2010; Bitner, 1992; Chowdary & Prakash, 2007; Reimer & Kuen, 2005). The results of the present study also conform to those in the study by Lee *et al.* (2000:217–231) where it was concluded that tangibles would be a key determinant in equipment- or facility-based industries, as compared to people-based service sectors like health insurance.

Overall, on the expectation dimensions, the empirical results of this study confirmed that the earlier views of regarding reliability as a critical dimension of service quality were accurate, whilst tangibility was correctly taken as the least important dimension (Parasuraman *et al.*, 1988:31).

6.3.3 Research objective 3

This objective was to measure the service quality gaps experienced by medical insurance clients in Zimbabwe. In order to calculate the gap scores experienced by medical insurance clients in Zimbabwe, the differences between customer expectations and perceptions of service were calculated along the five service quality dimensions, namely tangibility, reliability, responsiveness, assurance, and empathy (Parasuraman, *et al.*, 1988:12–40). The gap scores help to identify the services firms' areas of strengths and weaknesses, which can be utilised by managers to diagnose areas where improvements should be directed (Ladhari, 2008:80). If expectations exceed performance, then quality perceived is unsatisfactory, leading to customer discontentment (Büyüközkan *et al.*, 2011:9408).

The empirical results of this study show that all the gap scores for medical insurance customers are negative. This indicates that the medical insurance customers' expectations exceeded their perceptions; thus, the medical insurance customers were dissatisfied with the service offerings of medical insurance companies. The highest gap score was recorded in the reliability dimension (-2.0434), followed by responsiveness (-1.8434), assurance (-1.6017), empathy (-1.3245), and tangibles (-1.0420). Similar results were obtained in several previous studies where all scores for perceptions were lower than expectations (Asghari & Babu, 2017; Ramseook-Munhurrun *et al.*, 2010; Roohi *et al.*, 2011; Yousapronpaboon, 2014). However, contrary to the results of the present study, in a study by Yiusapronpaboon (2014), highest service quality gaps were recorded in tangibles, whilst lowest service quality gaps were recorded in reliability.

Overall, the empirical results of this study confirm earlier views regarding reliability as the key dimension of service quality, whilst tangibility was taken as the least important dimension (Parasuraman *et al.*, 1988:31). The findings of the present study also support the findings of research conducted by Pashaie *et al.* (2013:172) to investigate clients' "general expectation and perception of insurers in terms of services" delivered "at the insurance service counter". The study found reliability as the most critical

determinant of service quality among insurers. Lien and Kao (2008:522–526) support this view and advise managers to invest more in enhancing core benefits when rivals are providing comparable choices of services. The findings of this study are also confirmed by Zeithaml *et al.* (2009:113) who argue that clients want to deal with business organisations that are faithful to their promises, in particular their promises about core service attributes and service outcome.

To understand why medical insurance companies are performing poorly in this area, it is necessary to identify what the reliability dimension entails. Reliability is defined as consistency in the service delivery (Gunawardane, 2011:1004). With this variable, services should be performed with dependability and as promised (Parasuraman *et al.*, 1985:47). From the present study, it seems that medical insurance companies are not providing all the medical benefits as promised in their plans, resulting in clients paying huge shortfalls. Insurers could also be failing to settle medical claims in time, while late settlement of payments may cause customers to be faced with demands for cash upfront for medical services received, causing great dissatisfaction in them. This notion is supported by Nsiah-Boateng (2016) who argue that the failure of medical insurance companies to promptly settle medical claims results in health service providers not being unable to provide adequate and continuous services to the insured, causing the unreliability of health insurance services. In addition, a study by Dalinjong and Laar (2012:1) found failure to provide medical cover to the insured as promised was attributed to increased utilisation of health care services by insurance beneficiaries, which resulted in larger workloads for the health insurers and delayed disbursement of funds.

6.3.4 Research objective 4

This objective was to compare service quality gaps between customers in government-owned and privately owned medical insurance companies. The results of the study indicated that customers of the government-owned medical insurance company experienced higher service quality gaps in all the dimensions than customers in privately owned institutions (Table 5.4). This shows higher levels of customer dissatisfaction in government-owned than privately owned medical insurance companies. These results differ from those obtained by Bhardwaj and Chawla (2013), which indicated that public hospitals were found to provide better service in terms of reliability, prompt security, and accuracy when compared to private hospitals. In a study by Goutam (2011), customers also perceived public sector insurance companies as offering better service quality than private insurance companies. However, similar to the present study, results obtained in studies by Banerjee and Sah (2012) and Selvakumar (2016) showed that public sector banks were found to have higher service quality gaps than private sector banks. Moreover, a study by Rao (2012) found that quality of health care was poor and weak in the public sector, which resulted in the growth of the private sector health care.

Hence, with the growth of competition in the Zimbabwean medical insurance sector, which can prompt health insurers to offer best deals to employers, the government-owned institution is urged to take more

measures to close service quality gaps experienced by customers. This will assist in building competitive advantage that will enhance its sustainability in the sector.

6.3.5 Research objective 5

This objective was to find strategies medical insurance companies can employ to improve service delivery in the industry. The negative service quality gap scores recorded in all the service quality dimensions indicate a lot of service improvements that need to be made in order to enhance service quality in the medical insurance sector in Zimbabwe. Higher service quality gaps experienced by customers in the government-owned institution indicate that even more effort is required to improve service quality in this sector. Strategies that companies in the medical insurance sector can use to enhance service quality can be derived from the results on service quality gaps obtained from the study.

Knowledge about service quality gaps in the Zimbabwean medical insurance industry forms the basis for setting clear standards that enhance service delivery in the industry (Chikwendu *et al.*, 2012; Naidoo & Mtinta, 2014). A good service quality strategy has been found very useful in enabling organisations to chart their competitive scope through proper selection and positioning themselves along the fundamental service quality dimensions that are likely to give them some competitive advantage (Candido & Morris, 2000:466; Storey & Larbig, 2017). Such a strategy enables an organisation to come up with specifications of quality dimensions to compete with. This view is supported by Dabholkar (2015) who asserts that with intense competition and hostility of the external business domain, service quality has greatly contributed to the companies' strategies to survive and grow. This is because service quality has been found to be directly linked to sales, image, and profitability.

From the results obtained from objectives 1 to 3 and from the hypotheses tested, the following strategies for enhancing service delivery can be formulated:

6.3.5.1 Channelling resources to improve the delivery of core services (especially providing financial coverage to the sick)

Highest negative gap scores recorded in reliability imply that strategies to improve service delivery in the medical insurance sector in Zimbabwe should focus on delivering their services as promised. This is because the reliability gap implies that medical insurance companies are failing to provide the promised services accurately and dependably. According to Zeithaml *et al.* (2009:113), "customers want to do business with companies that keep their promises, particularly their promises about the service outcomes and core service attributes".

Weber (2013) also asserts that keeping promises is essential in building customer relationships. In medical insurance, keeping promises involves providing medical benefits as promised in the medical insurance plans. Customers judge the reliability of a medical insurance service by the ability of the company to provide financial coverage when a member falls sick. This implies that when medical

insurance customers fall sick, health insurers should take every opportunity to build trust in customers through meeting their medical costs so as to build positive customer relationships.

Gronroos (2009), in his discussion of some related marketing activities, classifies the reliability dimension under enabling promises and keeping promises, or interactive marketing. He highlights that under enabling promises it is imperative for service employees and systems to deliver on promises initially made to customers. This therefore requires organisations to have ample resources and skilled employees who are motivated to deliver on those promises (Weber, 2013). Thus, if medical insurance companies make promises to their members through improved external marketing, but their systems do not allow them to deliver on those promises, it will be impossible to keep promises made to customers. These views are substantiated by Nsiah-Boateng *et al.* (2016) who found systems (in the form of excessive required documentation and government involvement in the distribution of medical insurance funds) as a major cause of significant delays in settling medical claims for the insured in Ghana. Such delays had the likely effect of forcing health service providers to take actions that defeat the purpose of providing financial coverage to the sick (Nsiah-Boateng, 2016). Ultimately, this has a negative effect on the ability of health insurers to keep their promises. Thus, without proper systems and ample organisational resources, including willing and motivated employees, promises are difficult to fulfil (Weber, 2013). This perspective is supported by Hoffman and Bateson (2016) who argue that the ability to perform services in a reliable manner heavily relies on the extent to which different aspects on a service system function together. Such elements include the personnel who perform various services and the equipment and systems that support these performances. Hence, medical insurance companies are encouraged to invest in resources, systems, and activities that keep employees motivated and willing to fulfil promises made to customers. This also entails that medical insurance companies should work on their capabilities to retain, attract, and employ high quality employees who will enable them to cope with dynamic business conditions (Gatoto *et al.*, 2015:84). This view is underscored by Dhar (2015) who found a strong relationship between employee training and the service quality offered by hotel employees. Thus, medical insurance companies are encouraged to invest in employee training earmarked at enhancing the reliability of their services.

Focusing resources on delivering reliable services in the medical insurance industry is critical, since reliability is considered as a very important service quality dimension that determines the perceptions of service quality among customers (Gunawadane 2011:1004; Parasuraman *et al.*, 1988:31; Zeithaml *et al.*, 2009:113). Eisingerich and Bell (2008:256) confirm that customers' trust in the healthcare insurer is a critical component and contributes significantly towards building sustainable dealings and profitability of a company. Regarding strategies earmarked for improving reliability, the following should be considered:

- Health insurance companies should put in place systems that enable them to provide all medical benefits as promised in their plans.
- Health insurance employees should be trained to perform services timeously.
- Health insurance employees should be dependable in solving customers' queries. This can be achieved through training in various areas.
- Health insurance companies should make practical and truthful promises that correctly represent the service actually delivered.
- Health insurance companies should shun being involved in price or advertising wars with rivals which may cause them to promise more than they can provide.
- Health insurance companies must make sure that tangible elements of service truthfully reflect the level of service provided, since expectations are also caused by implicit service promises.

Since negative gap scores were obtained in all service quality dimensions, the following strategies are also recommended in the following service quality dimensions:

i) Responsiveness

The results obtained on the responsiveness gap scores do not portray Zimbabwean health insurance companies in a positive light. These results are not in line with those obtained by Handrinou, Folinas & Rotsios (2015), where customers' perceptions exceeded expectations and thus showed satisfaction with the company's responsiveness offerings. However, results similar to those of the present study were obtained in a study by Debabish and Dey (2015), where customers' perceptions of the responsiveness elements were lower than expectations. In medical insurance, responsiveness is mainly judged by the ability of medical insurance companies to promptly settle medical claims. This also undoubtedly determines the reliability of the services, as highlighted by Nsiah-Boateng *et al.* (2016) who argue that prompt settlement of claims assists health insurance providers to properly administer their funds and to be able to offer continuous and adequate services to the insured. Thus, substantial delays in settling claims are likely to compel medical service providers to take actions that defeat the purpose of providing financial coverage to the sick. Medical insurance companies should acknowledge the fact that failure to be responsive defeats the whole essence of providing financial protection to the sick and may cause customers to lose confidence in the whole system. This was confirmed in a study by Amo-Adjei *et al.* (2016), where poor perceptions of service quality offered by the National Health Insurance Scheme (NHIS) resulted in a larger percentage of the respondents not owning health insurance policies. Thus, in order to improve on responsiveness, the following should be considered:

- Health insurance companies should settle customers' medical claims promptly.

- Health insurance companies should keep customers informed about when payments for their medical claims will be made.
- Employees of health insurance companies should always be willing to help customers on queries pertaining the settlement of their medical claims.

ii) Assurance

Negative gap scores in assurance also show that medical insurance customers are dissatisfied with the assurance elements offered by their companies. Customers' dissatisfaction with the assurance dimension in Zimbabwean health insurers where managed health care systems are in operation (section 2.10) nullifies the previously claimed assumption that in such systems, assurance is likely to be attained through allowing health insurers to selectively contract some providers (Hall *et al.*, 2002). Similar negative gap scores in assurance have also been found in a study by Ramseook-Munhurrun *et al.* (2010), where all provider gaps were found to be negative. Yousapronpaiboon (2014) defines assurance as the ability of employees and the firm at large to inspire confidence and trust in customers and the personnel's knowledge of courtesy. Trust can exist at either organisational or individual level and it is considered to exist when one party is confident in another partner's integrity and reliability (Kassim & Abdullah, 2010). Since trust is positively correlated to corporate image and customer loyalty (Hussain *et al.*, 2014), medical insurance companies in Zimbabwe are urged to improve their service offerings along this dimension in their efforts to enhance quality and sustainability of the industry. This is because assurance has been confirmed as a significant determinant of satisfaction in healthcare (Kitapci *et al.*, 2014). Zeithaml *et al.* (2009) also argue that assurance tends to be of great significance in services that are considered as risky, or those services that are difficult to evaluate with certainty, like insurance. Moreover, research has confirmed that confidence in the health insurance provider is a significant determinant for beneficiaries' consent to selective contracting in managed care systems (Bes *et al.*, 2013). It is therefore imperative that medical insurance companies make a serious effort to improve on those elements that ensure assurance. To attain assurance, the following is recommended for employees of medical insurance companies:

- Employees should be trained to inspire trust in clients that their medical claims will be settled without fail.
- Employees should be trained to make customers feel safe in their transactions with medical insurance companies.
- Employees should be trained to be constantly polite and have the expertise to respond to clients' questions.

iii) Empathy

Although customers' perceptions of the empathy dimension were positive ($m=3.2479$: Table 5.2), the negative service quality gap scores in empathy (-1.3248 ; Table 5.3) indicate that customers are dissatisfied with the empathetic aspects in the services offered by their medical insurance companies. In the marketing literature, empathy is regarded as a significant variable in understanding business relationships that result in customer loyalty, since it deals with the individualised attention that organisations give its clients (Zeithaml, 2009). This view is supported by Aggarwal *et al.* (2005) who argue that empathy results in enhanced business relationships through its significant role of building positive attitudes in customers towards sales people. In a study by Zhang *et al.* (2013), empathy was found as the most important aspect that influenced service quality. It was also found to have great effect on customer satisfaction and loyalty. In addition, Itani and Inyang (2015) argue that sales people who demonstrate empathy through taking the perspective of their customers can better understand customers' needs, since they are able to see things from the customers' point of view. Correspondingly, empathy is a vital trait required by medical insurance employees, since it helps them to comprehend and satisfy their customers' needs better. In a study by Costa *et al.* (2004) it was recommended that organisations should teach employees empathy, along with other service quality characteristics. Therefore, in order to improve on the empathetic elements, the following is recommended to medical insurance companies:

- employees should be trained to give customers individual attention; and
- employees should be trained to be compassionate to clients and be able to appreciate the explicit desires of their clients.

According to Ofori-Okyere and Aboagye (2015:20), the above can be achieved through training employees in the necessary technical, knowledge, and interactive skills, where interactive skills help personnel to provide caring, courteous, responsive, and empathetic service. High performing companies invest heavily in training, ensuring that the training aligns well with their business strategies and goals strategies (Gatoto *et al.*, 2015:84).

iv) Tangibles

Although customers' perceptions about medical insurance tangible dimensions were positive ($m = 3.5192$: Table 5.2), some negative service quality gap scores were recorded in this dimension. This shows that customers were not fully contented with the physical aspects of the medical insurance companies' service environment, like layout, brochures, and equipment, and thus their expectations exceeded their perceptions. These results were at variance with those of Handrinós *et al.* (2015), where all customers' perceptions on the tangible elements exceeded expectations. However, results relatively similar to those from the present study were obtained from a study by Asogwa, Asadu, Ezema and Ugwuanyi (2014), where tangibles were ranked least. With increased competition being experienced in

the industry (section 1.2), such results are feared to put companies who are failing to update their physical environment at risk. This is because the creation of a good corporate image through tangibles has been found to be an indispensable tool for strengthening market position and enhancing competitiveness in the market. Since tangibles are used by customers to judge service quality (Santos, 2002), the current physical environment of medical insurance companies can have negative effects on customer perceptions towards medical insurance service quality and can thus discourage their subscription to these companies. In support of this, Mack (2017) argues that poor service-scape causes customers to look down upon the services offered by a company. Thus, medical insurance companies should seriously consider their tangibles, as it assists in building customers' confidence in their service and ensure the sustainability of the industry. To improve the tangibility dimension in health insurance companies, the following measures should be taken:

- Health insurance companies should invest in modern equipment, especially in their managed-care systems.
- Health insurance companies should upgrade their physical facilities, like buildings, to continue being physically attractive.
- Health insurance personnel should dress neatly and have a professional outlook.
- Health insurance companies should continue to improve the materials associated with services, like websites, brochures, and posters.

6.3.5.2 Coming up with different medical insurance plans that suit the different expectations of clients in different categories

Health insurance companies are urged to incorporate the following in their strategies:

- Different medical insurance plans must be designed which suit customers in different age groups, since they have different service quality expectations. The results of this research showed some statistically notable differences in the medical insurance customers' expectations of the responsiveness, assurance, and empathy dimensions between participants in different age groups (Table 5.20). Hence, service delivery should be designed to cater for the particular needs of clients in different age groups. For instance, customers in the age group of 50 and above had strongest expectations in the responsiveness and assurance dimensions, whereas customers in the age group of <20years had strongest expectations of the empathy dimension (Table 5.19). Thus, medical insurance employees should show more responsiveness and assurance when dealing with the age group of 50 and above so that they remain loyal to the company. Likewise, employees should show more empathy when dealing with customers in the <20 years age group. This is in line with the views of many writers who argue that age is among the demographic variables used to segment consumer markets and is also useful in

determining markets likely to achieve greater market penetration (Devi Juwaheer, 2011; Kwok *et al.*, 2016).

- Health insurance plans should be designed to suit the particular desires of clients economically engaged in different parts of the economy. This is supported by the findings of the present study which revealed some statistically noteworthy differences in the customers' expectations of the service quality dimensions between participants in the sample who were employed in different sectors of the economy (Table 5.24). This is also in support of the view of Selvakumar (2015) that customers' expectations and perceptions of service quality tend to vary across different service sectors.
- Customers who have many years of membership with a company should be given some incentives or extra services as reward for loyalty to the company. The statistically significant differences found in the medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions between participants in the sample who had different periods of membership support this. In all the above dimensions, strongest expectations were recorded in customers who had more than 5 years of membership (Table 5.25 and Table 5.26). These findings support the views of various scholars that past experiences of customers contribute to shaping their desires and expectations (William *et al.*, 2016; Urban, 2010; Zeithaml *et al.*, 2009). According to Hess, Ganesan and Klein (2007), past experiences include earlier experiences with the current service provider, as well as experiences with comparable service offerings. In a study by Urban (2010), reliability, assurance, and responsiveness were found to be affected by customer experiences, whereas tangibles and empathy were found to be independent of customer experiences. Similar views were found in a study by Yamaguchi, Akiyoshi, Yamaguchi and Nogawa (2015), where past experiences were found to have a positive effect on behavioural intentions and destination image. This, therefore, compels medical insurance companies in Zimbabwe to seriously consider membership period in designing their medical insurance packages for different members.

6.3.5.3 Building strong customer relationships

Medical insurance companies are also urged to build strong relationships with customers. This will help them to understand customer expectations better and to reduce the service quality gaps. The results of this study revealed that medical insurance companies in Zimbabwe are not building strong customer relationships (Figure 5.17), which might explain their failure to understand customer expectations accurately, ultimately leading to higher service quality gaps. This proposed strategy is in line with the views of Joseph *et al.* (2003:89) who emphasise the importance of building a personal relationship with customers in the insurance industry. These authors also believe that customers' claims should be

handled as quickly as possible. Personal relationships with customers can be built through customer relationship management (CRM) strategies, which have been found to allow customers to do business easily and allow businesses to deliver personalised services (Kotler & Keller, 2012; Nikolova, 2005). The importance of delivering and measuring service quality from a relationship based and culturally sensitive approach was also brought up by Sigala (2008). In the same vein, a study by Valmohammadi and Beladpas (2014) found communication with customers essential in building and sustaining a service quality base, and managers were encouraged to come up with strategies that improve communication with customers and acquire information about customer needs.

Using information technologies

The use of information technologies is another proactive strategic tool that can be used by medical insurance companies to understand customer expectations and to provide better service in the industry. This is supported by Zeithaml *et al.* (2009:96) who argue that building customer relationships using information technologies helps to provide highly personalised services which delight customers and surpass their expectations. A study by Itumalla (2012) also found that information technology can be a significant factor for providing better service quality in a healthcare setting. It was therefore recommended that overburdened manual processes should be relieved by employing technology.

6.4 Discussion around the general questions

Ten general questions were asked in Section D of the questionnaire to establish customers' general overview of service delivery in the medical insurance industry and to determine how service quality can be improved. Results from the general questions confirm that service quality in Zimbabwean medical insurance companies is unsatisfactory, as shown by 95 per cent of the respondents indicating the need to improve service delivery in most medical insurance companies (Figure 5.18). Furthermore, only 38.1 per cent agreed that medical insurance services in Zimbabwe enable patients to obtain health care when needed (Figure 5.18). These results concur with those obtained on the service quality gaps where negative gap scores were obtained, showing that medical insurance clients were discontented with the service offerings of medical insurance companies (Table 5.3). These results therefore validated the concerns to improve quality, costs, and access to health care in the sector, raised at the stakeholders' consultation meeting of 2014 (Sanyanga, 2014).

Although the results of the study point to poor service quality in the industry in general, it should be highlighted that some medical insurance companies have better service offerings than others. This is supported by 73.4 per cent of the respondents who reported that quality standards are not uniform in all medical insurance companies in Zimbabwe. Although it was indicated that there are quality standards that all companies adhere to, only 16.1 per cent of the respondents responded positively to this statement, while 10.5 per cent were neutral (Figure 5.18). Different quality standards are also indicated by the significant differences obtained in the service quality gaps experienced between government-

owned and privately owned medical insurance companies and lower perceptions found in the government-owned institution (Table 5.36). Thus, a conclusion can be reached that service quality is better in privately owned medical insurance companies than in government-owned companies. The results of this study are similar to those obtained in a study by Rao (2012), where it was found that quality of health care was poor and weak in the public sector, which led to the growth of the private sector health care. Thus, the managers of the government-owned institution are encouraged to put measures in place to close service quality gaps so as to become more competitive.

Furthermore, despite the poor service delivery in the industry, customers still regard medical insurance services as quite beneficial, as indicated by 57.7 per cent of the respondents who were positive to this view (Figure 5.18). This shows that medical insurance services in Zimbabwe are quite important to members and despite poor service delivery, customers have no option but to continue to subscribe to the medical insurance companies. The results also suggest that members are quite aware of the catastrophic effects of sickness and that they highly regard medical insurance as a means of distributing the financial burden of health care among many people (Austin & Hungerford, 2010).

From the results of the study it is also evident that a larger proportion of the respondents (59 per cent) have never switched medical insurance companies, despite poor service delivery (Figure 5.6), and that more than half of the respondents (57.3 per cent) have been members of their medical insurance companies for more than 5 years. Thus, although service quality expectations are not being met, customers have no choice but to continue to subscribe to these companies. Furthermore, despite the lower perceptions recorded in the government-owned institution (Table 5.4), PSMAS (which is government-owned) still has the larger percentage of the respondents (50.3 per cent), who are also employed by the government. These employees seem to have limited choices of medical insurance companies they can subscribe to, as compared to their counterparts employed in the private sector. This is supported by literature which has shown that under health insurances offered through employers, interlinkages between insurers and employers limit consumer choices and a person's job limits his or her health insurance choices (Austin & Hungerford, 2010; Buchmueller & Monheit, 2009). The issue of limited choices also explains the loyalty of customers highlighted above, as employees in the public sector are not free to opt for other medical insurance companies.

Further research should determine the reasons for unsatisfactory service quality in medical insurance companies in Zimbabwe. It is imperative that service quality gaps are addressed, since poor service quality may cause customers to fail to perceive the benefits of medical insurance and opt out of such services. This may cause further impoverishment of the nation due to the consequences of ill health (Kasule, 2012; Preker *et al.*, 2007).

Measures should also be taken to provide employees in the public sector with equal opportunities to choose medical insurance companies they want to subscribe to. This is likely to increase competition in the sector and improve service quality.

Another reason for concern is the study results that suggest that medical insurance companies in Zimbabwe are not building strong customer relationships. This may be the reason for their failure to understand customer expectations accurately and to narrow the service quality gaps. Only 28.2 per cent of the respondents indicated that medical insurance companies have proactive and not reactive customer service and retention programmes. Furthermore, a smaller percentage of the respondents (36 per cent) were positive that their medical insurance companies have customised service packages which would enable them to develop lasting relationships with clients. Building strong customer relationships through CRM strategies has been highly regarded for bringing several benefits to organisations in the form of customer loyalty, reduced marketing costs, and increased profitability (De Meyer & Mostert, 2011; Kotler & Keller, 2012). Zimbabwean medical insurance companies are encouraged to seriously consider this in their efforts to improve service quality in the sector.

Furthermore, a smaller percentage of the respondents (27.6 per cent) were positive that medical insurance companies use technology effectively to build strong and lasting relations with customers. A larger percentage of the respondents (47.6 per cent) were negative to this statement, while 24.8 per cent were neutral. These results show that the usage of information technologies by medical insurance companies in Zimbabwe is still very low. Using information technology is a proactive strategic move that can be used by medical insurance companies to understand customer expectations and to provide better service in the industry (Zeithaml *et al.*, 2009:96). In a study by Rasheed and Latif (2011), a strong and positive correlation was found between organisational performance and technology enabled service quality. This therefore calls for medical insurance companies in Zimbabwe to improve their usage of information technology in their effort to improve service quality.

Only 36.9 per cent of the respondents felt that quality will be compromised if medical insurance companies built alliances with service providers, while 42.4 per cent of the respondents disagreed with this statement. To confirm this point, a further related question was asked in which a greater percentage of the respondents (56.1 per cent) were positive that alliances between medical insurance companies and service providers will help to improve quality. These views conform to the views of Hall *et al.* (2002:197–206) in which a managed competition system is believed to intensify rivalry between health care providers and in turn improve the quality of care. This is also believed to contain health care costs in the process.

The above views are, however, contrary to the Zimbabwean situation where poor service quality is experienced in managed health care systems, as witnessed by the results of this study. For instance, as noted in Chapter 2 (section 2.9.1), PSMAS, through its investment arm PSMI (Public Service Medical

Investments), owns several health care clinics, dental surgeries, and hospitals, among others. PSMI was formed as “PSMAS’s blue ocean strategy to forward integrate medical insurance into medical services provision” (PSMI: Our History, n.d.). Although PSMAS sought to provide its clients with greater access to quality health care services and value for money, the results of this study demonstrate that service quality is still poor. The poor service quality revealed in the present study substantiates the views of Chidza (2016) who claims that rapid expansions of PSMI is resulting in operational and service inefficiencies. He therefore asserts that there is urgent need to restructure the organisation.

In light of the above, medical insurance companies in Zimbabwe are urged to contract reputable service providers (not themselves) to enhance the quality of service in the industry. It is evident that their integrated systems do not promote competition and have failed to improve service quality. They should therefore concentrate on providing health insurance services and subcontract to health care providers who will compete to provide better health care services. Focusing more on their core business will enable insurers to improve on the reliability of their service. Thus, there is need for further inquiry into the implementation of the managed care systems offered by Zimbabwean medical insurance companies in order to improve on their operation.

6.5 Discussion around the hypotheses

This section will discuss the results obtained around the hypotheses tested in the study. About eighteen hypotheses were postulated and the findings obtained will be discussed in line with the literature reviewed in the previous chapters.

6.5.1 Perceptions of service quality dimensions by the age groups of the respondents

Some statistically noteworthy differences were found in the customers’ perceptions of the assurance dimension between participants in the different age groups in the sample ($p < 0.05$). Very strong perceptions were recorded in the participants in the age group of 21–30 years, followed by those in the age group of <20 years.

These age groups appear to have strong perceptions about the ability of the employees in their companies to generate trust and faith through their knowledge, skill, and competence (Bhattacharjee, 2010:67). Respondents in these age groups have few medical problems which require them to use their medical insurances infrequently. Their few service encounters with their medical insurance companies could be the reason why they are more impressed by the knowledge, courteousness, and the confidence of their insurers’ employees. The results of the present study correspond with the views of Padma *et al.* (2009:171) that in the healthcare sector, the desires of patients fluctuate with gender, age, and other demographic variables.

6.5.2 Perceptions of service quality dimensions by gender

The results obtained in this study did not show any statistically noteworthy differences in the perceptions of medical insurance customers between female and male participants along all the service quality variables. These results did not confirm the results obtained in earlier studies where gender was found to affect service quality perceptions and the significance attached to the various dimensions of service quality (Devi Juwaheer, 2011; Mokhlis, 2012). Yet, in a study by Kwok *et al.* (2016), gender was also found to play a moderating role between customer satisfaction and service quality. The results of this present study suggests that in the medical insurance sector, gender is not very important in designing health insurance plans.

6.5.3 Perceptions of service quality by employment in economic sector

Some statistically noteworthy differences were observed in the perceptions of all the service quality dimensions between members employed in the different sectors of the economy ($p < 0.05$). In all the dimensions, strongest perceptions were recorded in members employed in the private sector, followed by members employed in state-owned enterprises, as shown by higher mean rank scores (Table 5.11). Members employed in the private sector mostly subscribe to privately owned medical insurance companies where service quality is likely to be slightly better than the service quality of companies owned by the government (Gopalkrishna, 2008:51). This is in line with the views of Selvakumar (2015) that customer perceptions and expectations tend to vary across different service sectors. This therefore calls for medical insurance companies to develop medical insurance plans which suit the different needs of customers economically engaged in different segments of the economy.

6.5.4 Perceptions of service quality by period of membership to the medical insurance company

While some statistically notable differences were noted in the customers' perceptions of the reliability, responsiveness, assurance, and empathy dimensions between customers with different periods of membership with their medical insurance companies, there were no notable differences with regard to the tangibles perceptions of customers (Table 5.14). The results of this study confirm Urban's (2010), findings that relationships with service providers and frequency of use of service have an influence on some dimensions of service quality. In relation to the reliability and responsiveness dimensions, strongest perceptions were recorded in customers with 2–3 years of membership, followed by customers with 0–1 year of membership, as shown by higher mean rank scores (Table 5.13). These results support Urban's (2010) findings that perceptions with regard to reliability and responsiveness were influenced by the longitudinal experiences of customers, and tangibles were found to be completely independent from customers' experiences. With regard to assurance and empathy, strongest perceptions were recorded in customers with 0–1 year of membership, followed by customers with 2–3 years of membership (Table 5.13). Members being impressed by their new experiences in the few years they

have been with their medical insurance companies could be the reason for strongest perception of assurance and empathy. Furthermore, membership of only a few years might be explained by switches made between medical insurance companies due to poor service delivery in former companies, or changes in job (section 5.3.7). Therefore, these customers could have little knowledge about their new medical insurance companies, which gives them a good impression of these companies. This is confirmed by Urban (2010) who contends that customers always need new impressions. In addition, Mohammed *et al.* (2011:1) found that enrolees' contentment with health insurance services was influenced by various factors, including insufficient or lack of knowledge about health insurance. Research has therefore shown that it is imperative for companies to continuously assess customer perceptions of their services and to implement suitable corrective actions for retaining existing customers and attracting new customers (Kushwah & Bhargav, 2014).

6.5.5 Perceptions of health insurance by whether customers have switched between medical insurance companies or not

Customers' perceptions of the reliability, responsiveness, and assurance dimensions revealed some statistically noteworthy differences between customers who have switched between medical insurance companies and those who have not (Table 5.16). In all these dimensions, strongest perceptions were recorded in members who have switched between medical insurance companies, as shown by higher mean ranks (Table 5.15). As illustrated in Figure 5.7, most of these customers switched due to poor service delivery (64 per cent) or change of jobs (35 per cent). The strong perceptions of these customers could possibly be because they perceive their new medical insurance companies as offering better services, since poor service delivery was their main reason for switching.

The above conforms to the findings of Boonen *et al.* (2015:339–353). In a study on the Dutch health insurance market, they found that switching tendencies depend not only on the price of the health insurance plan, but also on service quality. The empirical results of the present study further confirm the findings of recent studies which have found that clients' contentment with the service of their existing insurer is a significant determinant of being loyal to that insurance provider (Reitsma-Van Rooijen *et al.*, 2011:30; Wendel *et al.*, 2011:311). Amo-Adjei *et al.* (2016:317) also concluded that investing in quality service to subscribers had the potential of offering "important gains to sustaining the scheme as well as offering affordable health services". Therefore, medical insurance companies in Zimbabwe are encouraged to make serious efforts to improve service quality so as to reduce the switching tendencies of members.

6.5.6 Expectations of service quality by age groups of respondents

Some statistically notable differences were found in medical insurance customers' expectations of the responsiveness, assurance, and empathy dimensions between participants in different age groups in the sample. On the responsiveness and assurance dimensions, strongest perceptions were recorded in the

>50years age group. The reason could be that this group is aging and becoming less patient. Moreover, they are likely to use medical insurance services more frequently than respondents from other age groups, due to chronic diseases associated with aging.

Zeithaml *et al.* (2009:82) mention two major factors that determine desired service, namely personal needs of customers and lasting service intensifiers. They define personal needs as the physical, psychological, social, and functional factors that are pivotal and essential to the psychological and physical well-being of a customer that shape what customers desire in a service. Lasting service intensifiers are factors that increase the customer's sensitivity to service and are further classified as personal service philosophy and derived service expectations. Derived service expectations exist when a client's expectations are determined by a certain group of people or another person. Thus, the high propensity of the aging population to seek medical services can be classified under personal needs of customers and derived service expectations. Personal service philosophy refers to the underlying knowledge, beliefs, and attitudes that a customer has about the service and appropriate behaviour of service providers. Therefore, many years of service encounters of the aging population with their medical insurance companies can be taken to justify the increased acquired knowledge, beliefs, and attitudes which could have resulted in high expectations among customers in this age group.

On the empathy dimension, however, strongest expectations were recorded in the <20 years age group. This may possibly be because, as pointed out earlier, this age group is still growing and needs more affection and therefore demands more of this service quality dimension. Furthermore, this group comprises the young and educated members who have been recently enlightened about customer rights and customer care, which may increase expectations about the empathy dimension. These views are supported by Zeithaml *et al.* (2009:82) who claim that the personal needs of a customer shape what the customer desires in a service.

6.5.7 Expectations by employment in economic sector

Medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions revealed some statistically noteworthy differences between participants in the sample employed in different sectors of the economy ($p < 0.05$). In all these dimensions, strongest expectations were recorded in customers employed in the public sector, followed by those employed in government-owned enterprises, as shown by higher mean scores (Table 5.21). Participants employed in these sectors are restricted to subscribe to the government-owned institution (PSMAS) where poorer service quality is experienced, as shown by higher service quality gaps (Table 5.4). Consumer choices are limited in health insurances offered through employers and a person's job limits his or her health insurance choices (Austin & Hungerford, 2010; Buchmueller & Monheit, 2009). Thus, the poor service quality experienced by customers in the government-owned institution causes their expectations to be high.

This is supported by the results shown in Table 5.4, where customer expectations of service quality were also higher in government-owned than in privately owned medical insurance companies.

Higher expectations experienced could be connected with the government-owned medical insurance company over-promising its services in its efforts to attract membership from the private sector as a result of the deregulation of the industry (section 2.1). This notion is affirmed by Zeithaml *et al.* (2009:88–90) who argue that at times the nature of services (for instance heterogeneity), together with the activities of the companies, cause them to over-promise customers about their service delivery, thereby raising the levels of desired service and predicted service expectations in customers which may be difficult to fulfil.

Moreover, in trying to attract membership from the private sector, PSMAS could have improved its physical facilities, which would explain high perceptions of the tangibles dimension (Table 5.4). These improvements could have raised expectations through implicit service promises, defined by Zeithaml *et al.* (2009:89) as quality cues like price and tangibles connected with the service that lead to assumptions about what the service should be like. According to Zeithaml *et al.* (2009:89), higher prices and more exciting tangibles generally cause customers to expect more from the service. It is thus common for a customer shopping for insurance to think that the company which charges higher prices provides better service quality and coverage.

Increasing competitive conditions in the medical insurance industry can be another reason for high customer expectations in the above variables. This is supported by Zeithaml *et al.* (2009:96) who argue that in a turbulent environment characterised by rapidly changing and highly competitive industry conditions, adequate service expectations are expected to rise quickly.

6.5.8 Expectations by customer's period of membership to the medical insurance company

Some statistically significant differences were found in the medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions between participants in the sample who have different periods of membership with their medical insurance companies ($p < 0.05$), as shown in Table 5.24. These results partly confirm results obtained by Vadyba (2010) which revealed customers' expectations of assurance to be affected by lengths of relationships with a service company and frequency of use of service. In the present study, strongest expectations were recorded in customers in the >5years age group, as shown by higher mean ranks (Table 5.23). This age group are long-time members of these companies and have many past experiences, which tend to increase their expectations about service delivery in these dimensions. This is supported by Banerjee and Sah (2012) who argue that previous experiences are among the uncontrollable factors that influence customer expectations. According to Zeithaml *et al.* (2009:88–90), past experience refers to the previous exposure of the customer to service that is relevant to the particular current service. Hess *et al.* (2007:129) are of the

view that past experiences also “include previous experience with the focal service provider, typical performance of similar service offerings and experience with the last service purchased”. These past experiences help to shape desires and predictions to a great extent, and medical insurance should therefore take note of these in designing medical insurance plans for their customers.

6.5.9 Service quality gaps experienced by medical insurance customers in different age groups

As shown in Table 5.27, there were statistically notable differences in mean gap scores between respondents in the different age groups for the responsiveness and assurance dimensions ($p < 0.05$). In both dimensions, highest gaps were recorded in the 21–30 years age group, as shown by the higher mean rank scores (Table 5.27). This could be due to the fact that this age group falls in the reproductive age group who have many health care needs and demand more health insurance services. Besides being reproductive, with children to take care of, their schedules tend to be busy due to work-related and domestic demands. Hence, their expectations of responsiveness tend to be higher than in other age groups. This view is supported by Zeithaml *et al.* (2009:82) who classify these as personal needs of customers and lasting service intensifiers. Thus, in the present study, increased demand for health care needs in the 21–30 years age group can be classified under personal needs of customers and should be seriously considered by medical insurance companies in designing medical insurance plans for customers.

6.5.10 Service quality gaps for medical insurance customers employed in the three different sectors of the economy

Some noteworthy statistical differences were found in mean gap scores between customers in the sample employed in the different sectors of the economy for the reliability, responsiveness, assurance, and empathy dimensions ($p < 0.05$), as shown in Table 5.29. In all these dimensions, highest gaps were recorded from customers employed in the public sector, followed by those employed in state-owned enterprises, as shown by the higher mean rank scores (table 5.30). These results show that customers employed in the public sector are experiencing more service quality deficiencies, followed by those employed in state-owned enterprises. This could be because these customers subscribe to the government-owned medical insurance institution where service quality is lower, as demonstrated by the lower customer perceptions and higher service quality gap scores (section 5.8). This is because medical insurance in Zimbabwe is ‘employer driven’ (Shamu *et al.*, 2010:8), and members’ choices for health insurers tend to be limited within the range of health insurers selected by their employers (Austin & Hungerford, 2010; Buchmueller & Monheit, 2009).

6.5.11 Service quality gaps for medical insurance customers with different periods of membership with the medical insurance companies

For the reliability, responsiveness, assurance, and empathy dimensions, some statistically significant differences were found in the mean gap scores between customers in the sample with different periods of membership with their insurers (Table 5.31). For the reliability and responsiveness gaps, highest gaps were recorded in customers with 2–3 years of membership with the medical insurance companies, as shown by the higher mean rank scores (Table 5.32). However, for the assurance and empathy gaps, highest gaps were recorded in customers in the 0–1 year membership group.

These results show that customers with 2–3 years of membership have higher expectations of the reliability and responsiveness dimensions. These higher expectations could be due to some past experiences of customers in their medical insurance companies. This view is supported by earlier researchers who argue that the previous exposure of the customer to service that is relevant to the current service is an important factor that shapes desires and predictions (Berry, 2000:130; Zeithaml *et al.*, 2009:90). Researchers further argue that customers tend to compare their experiences with those of other service providers offering similar services. According to Berry (2000:130), past experiences may include past experience with the current service provider, typical performance of similar service offerings, and experience with the last purchased service. It can therefore be argued that some past experiences of medical insurance customers with 2–3 years of membership could be the reason for high expectations and higher service quality gaps in this age group.

Highest service quality gaps in assurance and empathy dimensions recorded in the 0–1 year age group could be due to the fact that these customers are still new in their medical insurance companies. They therefore tend to have high desires for trust and confidence to be instilled in them by medical insurance companies, which tend to raise their expectations and gaps in the assurance dimension. They also tend to have high needs for individualised attention and caring, given to them as new members of the medical insurance companies. These high expectations and gaps could be the result of predicted service which is defined as the level of service that customers hope to get. According to Zeithaml *et al.* (2009:88–90), this is usually a result of explicit service promises, implicit service promises, word-of-mouth communication, and past experiences. It can therefore be argued that high service quality gaps in the assurance and empathy dimensions could result from the fact that the choice of these customers to join their new medical insurance companies was influenced by the above factors, which raised their expectations and ultimately led to the service quality gaps.

6.5.12 Service quality gaps for medical insurance customers who have either switched or not switched between medical insurance companies

Some noteworthy statistical differences were found in the mean gap scores between customers in the sample who either switched or did not switch between medical insurance companies for the reliability,

responsiveness, assurance, and empathy gaps. In all these dimensions, highest gaps were recorded in customers who switched between medical insurance companies. Since most of these customers (64 per cent) had switched between medical insurance companies due to poor service delivery (Figure 5.7), this could have raised their expectations in all service quality dimensions, leading to high service quality gaps. These high expectations can also be attributed to past experiences, implicit and explicit service promises and word of mouth communications (Zeithaml *et al.*, 2009:88–90).

Under the Gaps Model, the above gaps can be classified under the communication gap (Gap 4) and the performance gap (Gap 3). The communication gap shows the discrepancy between the actual service delivered and the external communications made by the service provider. This gap is usually caused by over-promising (in advertising, personal selling, and through tangibles), inappropriate pricing which raises customer expectations, ineffective management of customer expectations and lack of integrated marketing communications (Zeithaml *et al.*, 2009:42–43).

The performance gap is the difference between customer-driven standards of service and the actual service performed by employees. Such a discrepancy can be caused by failure to match demand and supply, deficiencies in human resources policies, and some problems encountered with service intermediaries (Zeithaml *et al.*, 2009:38–39).

6.5.13 Comparison of customer perceptions of service quality between government-owned and privately owned medical insurance companies

The results of the study show that members of the government-owned medical insurance institution have lower perceptions of service quality than members of privately owned medical insurance companies. This is shown by significantly lower perceptions along all the five service quality variables ($p < 0.05$), as shown in Table 5.35 and Table 5.36. These results confirm the views of Gopalkrishna *et al.* (2008:51) that service quality of private insurance providers slightly surpasses that of the public sector. Similar results were obtained in a study by Banerjee and Sah (2012), where service quality in private sector banks was found to be far ahead of public sector banks. Public sector banks were therefore urged to improve their service in terms of tangibility, reliability, responsiveness, and empathy. Selvakumar (2015) also found that private banks were offering superior service to the customers in all areas when compared to public banks. Basing on the results of the present study, government-owned medical insurance companies need to put measures in place to improve service quality. The reasons behind poor service quality in government-owned institutions should also be investigated.

6.5.14 Comparison of customer expectations of service quality between government-owned and privately owned medical insurance companies

The results show that customers of government-owned medical insurance companies expect their health insurer to be more reliable, responsive, to offer more assurance, and to be more empathetic. This is

shown by significant higher mean rank expectation scores recorded in customers of government-owned medical insurance companies (Table 5.37 and Table 5.38). The results of this study are in conflict with those obtained by Banerjee and Sah (2012), which indicated that customer expectations of private banks were higher than that of public banks, while their levels of satisfaction were also high when dealing with private banks. Higher expectations could be a result of poor service quality and the government-owned medical insurance company's efforts to open up membership to employees also employed in the private sector after the deregulation of the industry in the '90s (section 2.1). In this process it could have over-promised its services to customers, thereby raising expectations in these customers. This notion is confirmed by Zeithaml *et al.* (2009:88–90) who argue that, at times, the nature of services (for instance heterogeneity), together with the activities of the companies, causes companies to over-promise customers about their service delivery, thereby raising the levels of desired service and predicted service expectations in customers, which may be difficult to fulfil. According to Zeithaml *et al.* (2009:88–90), organisations need to make accurate promises to ensure that what they promise matches with what they deliver. This will help them to manage customer expectations.

6.5.15 Comparison of service quality gaps experienced between government-owned and privately owned medical insurance companies

The results show that there were significant service quality gaps experienced by customers in government-owned and privately owned medical insurance companies. In all the dimensions, significantly higher service quality gaps were experienced in customers of government-owned medical insurance companies, as indicated by higher mean gap scores (0.05) (Table 5.39 and Table 5.40).

Higher service quality gaps in reliability may be due to the failure of the company to address the expectations of the customers (customer gap). As suggested by Zeithaml *et al.* (2009:38–39), this could also be due to the fact that the promises made by the company through its sales force, media advertising, and other communications raised customer expectations. Zeithaml *et al.* (2009:42) assert that broken promises can be a result of many things, which include over-promises “in advertising or personal selling, inadequate coordination between operations and marketing and differences in policies and procedures across service outlets”.

Higher service quality gaps in responsiveness indicate that there is a wide gap in the attentiveness and promptness of employees in attending customer requests, questions, complaints, and problems (Zeithaml *et al.*, 2009). In medical insurance, responsiveness is mainly assessed by the ability of medical insurance companies to promptly settle medical claims and failure to do this is likely to compel health insurance providers to take actions that defeat the purpose of providing financial coverage to the sick (Nsiah-Boateng, 2016). According to Weber (2013), responsiveness gaps in medical insurance can be caused by too much documentation required and government involvement in the disbursement of health insurance funds. Thus, medical insurance companies are urged to come up with systems that do not

delay the prompt settlements of customers' medical insurance claims, since failure to do so cause customers to lose confidence in the whole medical system. This may cause potential members not to own medical insurance policies, as observed by Amo-Adjei *et al.* (2016).

On the assurance gap, the results indicate that government-owned medical insurance companies are failing to instil confidence and trust in customers. A strong empathy gap also indicates that customers feel the company is failing to provide caring and individual attention as per their expectations. Since the dimensions involved here are people-based, these gaps can be classified under the service performance gap (Gap 3) (Zeithaml *et al.*, 2009:38). This gap arises when the actual performance of service by company employees fails to match the customer-driven service designs and standards. This could be attributed to human resources factors, which include the failure of employees to understand their roles in the company, conflicts that employees experience between company management and customers, poor remuneration, inadequate technology, poor employee selection, and lack of teamwork and empowerment (Zeithaml *et al.*, 2009:38–39).

In light of the above findings, government-owned medical insurance companies are encouraged to come up with systems that enable them to provide promised medical benefits promptly. They are also encouraged to train employees and motivate them to deliver services of exceptional quality. This will help them to build some competitive advantage that will ensure their sustainability in this volatile sector.

6.5 Summary

This chapter discussed the data from the survey of medical insurance customers from the five medical insurance companies in Zimbabwe. The key research questions were answered using both descriptive and inferential statistics. The results obtained from the studies, which are in line with the research objectives and hypotheses, indicated that medical insurance customers are dissatisfied with the service offerings of medical insurance companies. In light of these findings, some strategies to improve service delivery in medical insurance companies in Zimbabwe were suggested.

CHAPTER SEVEN

CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

The study aimed to make an empirical assessment of the perceptions and expectations of Zimbabwean medical insurance customers regarding the five service quality variables, namely tangibles, reliability, responsiveness, assurance, and empathy. This study will help to identify individual and overall service quality gaps that exist as well as levels of customer satisfaction and dissatisfaction experienced in the medical insurance industry. This, in turn, will allow the formulation of strategies to enhance service quality and promote sustainability in the industry. This chapter will indicate whether answers to the research questions and hypotheses have been obtained. Thus, conclusions and recommendations based on the empirical study will be summarised. The chapter will also discuss the contributions that the study makes to the body of knowledge as well as make suggestions for future research.

7.2 Conclusions

Conclusions will be discussed on the basis of the literature review and the results of the empirical study.

7.2.1 Literature review-based conclusions

The definitions from the literature reviewed show that services have some unique characteristics that “make service quality an abstract construct that is difficult to define and measure” (Zeithaml *et al.*, 2009:20). Yet, service quality has been “defined as the difference between customer expectations of service and perceived service, and if expectations are greater than performance perceived, quality is less than satisfactory and there is dissatisfaction” (Büyüközkan *et al.*, 2011:9408).

Although extensive studies exist on service quality in many services sectors, very little research has been undertaken on service quality in the area of private health insurance. This view is supported by Sekhri and Savedoff (2005:127) who contend that very little has been documented through research and in policymaking issues on private health insurance. Literature has also revealed that health insurance schemes in less-developed countries are still in their implementation stages. Furthermore, there is insufficient literature that deals with client satisfaction under a health insurance scheme setting in developing countries (Mohammed *et al.*, 2011:20).

Moreover, scant research has been undertaken into service quality in the health insurance sector. The nearest related studies were in the health care sector where consensus has not been reached on the service quality dimensions most significant in determining service quality. This has been attributed to different circumstances prevailing in the environments studied (Purcarea *et al.*, 2013:583). Other

related studies were on the National Health Insurance Scheme (NHIS); however, these did not dwell much on service quality dimensions.

Literature has also shown that various models have been proposed to understand and measure service quality. The present study adopted the SERVQUAL and Gaps models in an effort to understand service quality in the medical insurance sector in Zimbabwe. The SERVQUAL model was used because it has been tested and tried in various service sectors, such as banking, education, healthcare, and insurance, among others. Furthermore, despite the criticism that has been levelled against the SERVQUAL tool, it continues to be very useful in service quality studies and is most preferred because it is easy to apply and flexible (Asubonteng *et al.*, 1996:80).

The Gaps model was adopted for its usefulness in identifying areas of weakness and strength in a firm's services and the areas where improvements should be targeted (Ladhari, 2008:75). Literature has shown that in different studies conducted on service quality, various service quality variables have proved to be more significant than others in influencing service quality, depending on the circumstances existing in the situation studied (Purcarea *et al.*, 2013:583). The fact that the applicability of the SERVQUAL model has never been tested empirically in the private health insurance sector in general, let alone in the Zimbabwean context in particular, was a strong justification for conducting this study. The results of the empirical study would enable the crafting of strategies suitable for the industry, which would promote the viability and sustainability of the industry.

From the theoretical side, this research has contributed significantly towards filling the knowledge gap in the area of service quality in medical insurance in Zimbabwe, since insufficient studies exist on service quality within the medical insurance industry. The research was significant in that the service quality of medical insurance companies, as experienced by medical insurance customers, was unclear. It was also not clear whether medical insurance companies were focusing on the things that are important to customers. The results of this empirical study have managed to clear up the uncertainty and have helped to provide information on the subject under investigation. Earlier efforts to improve quality in the industry were centred on managing costs and some regulatory reforms of which the results had not been empirically evaluated, benchmarking against systems employed in developed countries like America (Doherty, 2015; Sanyanga, 2014). This study, therefore, brought a new dimension of improving quality in the industry through the formulation of some service quality strategies. The information obtained from this study would enable organisations in the medical insurance industry to chart their competitive scope through proper selection and positioning themselves along the fundamental service quality dimensions that are likely to give them some competitive advantage (Storey & Larbig, 2017).

7.2.2 Conclusions based on empirical results

This section contains conclusions based on the empirical findings.

7.2.2.1 Medical insurance customers' perceptions of service quality variables, namely tangibles, reliability, responsiveness, assurance, and empathy

Highest positive perceptions were recorded in the tangible dimension ($m=3.5192$), showing that medical insurance customers perceived their companies as offering pleasant and excellent facilities. This was followed by the empathy dimension ($m=3.2479$), indicating that customers also perceived medical insurance companies as showing empathy. The assurance dimension ($m=3.0545$) followed, the scores of which demonstrated that medical insurance customers perceived their companies as offering assurance only to a slight extent. This was followed by the responsiveness dimension ($m=2.8444$), revealing that medical insurance customers did not perceive their companies as being responsive. Lastly, lowest positive perceptions were recorded in the reliability dimension ($m=2.6514$), showing that medical insurance customers also did not perceive their companies as being reliable. These results are shown in Table 5.2.

7.2.2.2 Medical insurance customers' expectations of service quality variables, namely tangibles, reliability, responsiveness, assurance, and empathy

In terms of expectations, highest mean scores were recorded in the reliability dimension ($m=4.6762$), indicating that reliability is what medical insurance customers expected most of their insurance companies. This was followed by the responsiveness dimension ($m=4.6678$), demonstrating that customers also expected their companies to show more responsiveness. They further expected their companies to give more assurance ($m=4.6562$) and empathy ($m=4.6161$) and to provide more appealing facilities (tangibles) ($m=4.4554$). These results are shown in Table 5.2.

7.2.2.3 Service quality gaps experienced by medical insurance clients in Zimbabwe

The results show that all the gap scores for medical insurance customers are negative. This indicates that medical insurance customers' expectations exceeded their perceptions; thus, medical insurance customers were dissatisfied with the service offerings of medical insurance companies. The highest gap score was recorded in the reliability dimension (-2.0434), followed by responsiveness (-1.8434), assurance (-1.6017), empathy (-1.3245), and tangibles (-1.0420), as shown in Table 5.3.

7.2.2.4 Comparison of service quality experienced by customers in government-owned and privately owned medical insurance companies

The study revealed that customer perceptions of service quality were significantly lower in the government-owned institutions (Table 5.35 and Table 5.36) and customer expectations were higher in

government-owned than in privately owned institutions (Table 5.37 and Table 5.38). Overall, service quality gaps were higher in government-owned than privately owned medical insurance companies (Table 5.39 and Table 5.40). This shows that poorer service quality was experienced in government-owned than privately owned medical insurance companies. Therefore, the government-owned medical insurance companies should put more measures in place to improve service quality to ensure their sustainability.

7.2.2.5 Strategies on how companies in the medical insurance industry can improve service quality

Clients prefer to deal with businesses that are loyal to their promises, specifically their promises about core service attributes and service outcomes (Zeithaml *et al.*, 2009:113). Strategies to enhance service quality in the industry should therefore focus on closing all the service quality gaps identified in the study, channelling more resources towards closing the reliability gap, which had the highest gap score, followed by responsiveness, assurance, empathy and, lastly, tangibles. Thus, more resources should be channelled towards improving the delivery of core services (providing financial coverage to the sick). Furthermore, health insurance companies should focus on delivering their services as promised.

Moreover, medical insurance companies should settle customers' medical claims promptly and train their employees to be courteous at all times and to be able to instil confidence in customers. Employees should also be trained to give customers individual attention and to have customers' best interest at heart.

In addition, medical insurance companies should aim at building strong customer relationships, which will help them to understand customer expectations better and to reduce the service quality gaps. In this process, they should make use of information technologies.

The results from the hypotheses tested further suggest that health care insurance strategies should include different medical insurance plans that suit the different expectations of different customers in different categories.

The sections that follow will reflect on the results from the hypotheses tested.

7.2.2.6 No statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions among customers in different age groups

The results show that there is no statistically noteworthy difference in the medical insurance customers' perceptions between the different age groups in the sample on tangibles, reliability, responsiveness, and empathy dimensions ($p > 0.05$).

However, a noteworthy statistical difference was found in the customers' perceptions of the assurance dimension between the different age groups in the sample ($p < 0.05$). Although all age groups in the sample perceived their medical insurance companies as showing assurance to a slight extent, the strongest positive perceptions were recorded in age group 21–30 years, followed by the age group 20 years and below. These age groups may possibly perceive their companies as showing assurance because they have fewer medical problems and use their insurances less frequently than other age groups.

7.2.2.7 No statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions between male and female customers

The results indicate that there is no statistically noteworthy difference in the medical insurance customers' perceptions of the tangibles, reliability, responsiveness, assurance, and empathy dimensions amongst female and male participants ($p > 0.05$).

7.2.2.8 No statistically significant differences in the customer perceptions of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy

A notable statistical difference was found in the perceptions of all the service quality dimensions between members economically engaged in different sectors of the economy ($p < 0.05$). In all the dimensions, strongest perceptions were recorded in members employed in the private sector, followed by those employed in state-owned enterprises and, lastly, by members employed in the public sector, who recorded weak perceptions. The exception was only in the tangible dimension, where perceptions of members in the public sector were stronger than those employed in the state-owned enterprises.

Medical insurance customers employed in the private sector possibly have strong positive perceptions about the services offered by their companies because service delivery by these companies is much better than services offered to members employed in the public sector, who subscribe to a government-owned medical insurance company. On tangibles, members employed in the public sector could have better perceptions about the physical facilities of their company due to the efforts by the government-owned institution to improve its facilities to attract membership from people employed in different sectors of the economy.

7.2.2.9 No statistically significant differences in the perceptions of medical insurance service quality along all the dimensions among customers with different periods of membership with their medical insurance companies

There were no statistically noteworthy differences in the perceptions of medical insurance customers of the tangibles dimension between members who have different membership periods of subscription

to their medical insurance companies ($p>0.05$). However, statistically noteworthy differences were noted in the customers' perceptions of the reliability, responsiveness, assurance, and empathy dimensions between members in the sample who had different membership periods to their medical insurance companies ($p<0.05$).

In the reliability and responsiveness dimensions, strongest positive perceptions were recorded in members with 2–3 years of membership, followed by those with 0–1 years. These groups possibly perceive medical insurance companies to be somewhat reliable and responsive due to their few experiences or encounters with medical insurances (denoted by their few years of membership), which gave them better impressions of the reliability and responsiveness of their services. Weakest perceptions were recorded in those with >5 years period of membership. This group could possibly perceive medical insurance companies to be less reliable due to their long-time experiences with these companies.

In the assurance and empathy dimensions, strongest positive perceptions were recorded in members with 0–1 year of membership, followed by those with 2–3 years of membership. These customers could also possibly have better perceptions about the assurance given by their companies due to their short-time experiences with medical insurance companies, which gave them a good impression about their assurance and empathetic behaviour.

7.2.2.10 No statistically significant differences in the perceptions of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies

There were no notable statistical differences in the perceptions of medical insurance customers of the tangibles and empathy dimensions between members who have either switched between medical insurance companies or not ($p>0.05$). However, some noteworthy statistical differences were found in customers' perceptions of the reliability, responsiveness, and assurance dimensions between customers who have switched between medical insurance companies and those who have not switched ($p<0.05$). In all these dimensions, strongest positive perceptions were recorded in members who have switched between medical insurance companies. These customers possibly perceive their new medical insurance companies as offering better services in those service quality dimensions since their main reason for switching was poor service delivery.

7.2.2.11 No statistically significant differences in the expectations of medical insurance service quality along all the dimensions amongst customers with different age groups

The results indicate that there were no notable statistical differences in medical insurance customers' expectations between the different age groups in the sample on the tangibles and reliability dimensions ($p>0.05$). However, there were statistically significant differences in the medical insurance customers'

expectations of the responsiveness, assurance, and empathy dimensions between participants in different age groups in the sample ($p < 0.05$).

On the responsiveness and assurance dimensions, the strongest expectations were recorded in the >50 years age group. This could be possibly due to the fact that participants in this age group are aging (many suffering from chronic diseases) and use or require medical insurance services more frequently. Thus, their expectations tend to increase.

On the empathy dimension, strongest expectations were recorded from the <20 years age group. This may possibly be because respondents in this age group are still growing and need more affection. They therefore demand more of this service quality dimension. Furthermore, this group comprises the young and educated members who have been enlightened about customer rights and customer care and therefore tend to have high expectations of the empathy dimension.

7.2.2.12 No statistically significant differences in the expectations of medical insurance service quality along all the dimensions between male and female customers

The results indicate that there were no notable statistical differences in the medical insurance customers' expectations of the tangibles, reliability, responsiveness, assurance, and empathy dimensions among female and male participants in the sample ($p > 0.05$).

7.2.2.13 No statistically significant differences in the customer expectations of medical insurance service quality along all the dimensions amongst customers employed in different sectors of the economy

The results indicate that there were no notable statistical differences in medical insurance customers' expectations of the tangibles dimension between participants in the sample who are employed in different sectors of the economy ($p > 0.05$). However, there were notable statistical differences in the medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions between participants in the sample who are employed in different sectors of the economy ($p < 0.05$).

In all of the above four service quality dimensions, strongest expectations were recorded in customers employed in the public sector, followed by those employed in state-owned enterprises. This could possibly be because participants employed in these sectors subscribe to the government-owned medical institution where service quality is very poor, resulting in their high expectations.

7.2.2.14 No statistically significant differences in medical insurance customers' expectations of the service quality along all the dimensions amongst customers with different periods of membership

The results show that there were no statistical notable differences in the medical insurance customers' expectations of the tangibles dimension amongst participants in the sample who have different periods of membership with their medical insurance companies ($p>0.05$). Yet, some noteworthy statistical differences were found in medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions amongst participants in the sample who have different periods of membership with their medical insurance companies ($p<0.05$).

In all the service quality dimensions, strongest positive expectations were recorded in customers in the >5years age group. Participants in this age group are long-time members of these companies and their past experiences and accumulated knowledge about medical insurance services could have raised their expectations. Moreover, high expectations could have resulted from their belief that they are important stakeholders who have been loyal to the medical insurance company for a long time and therefore need to be rewarded for their loyalty through excellent services.

7.2.2.15 No statistically significant differences in the expectations of medical insurance service quality along all the dimensions between customers who have either or not switched between medical insurance companies

The results indicate that there were no statistical noteworthy differences in the medical insurance customers' expectations of all the service quality dimensions between participants in the sample who have either switched between medical insurance companies or not ($p>0.05$).

7.2.2.16 No statistically significant differences in service quality gaps experienced by medical insurance customers in different age groups

The study did not find any notable statistical differences in gap scores for tangibles ($p=0.878$), reliability ($p = 0.07$), and empathy ($p = 0.13$) between customers in the sample in different age groups. However, significant differences of mean gap scores were found between customers in the sample with different age groups for responsiveness and assurance dimensions ($p<0.05$).

7.2.2.17 No statistically significant differences in service quality gaps experienced between male and female medical insurance customers

The study did not find any statistical noteworthy differences in gap scores for male and female medical insurance customers in the sample for all the dimensions ($p> 0.05$).

7.2.2.18 No statistically significant differences in service quality gaps experienced by medical insurance customers employed in different sectors of the economy

The study found some statistical noteworthy differences in gap scores for customers in the sample who were economically engaged in the three different sectors of the economy for all the dimensions ($p < 0.05$), except for the tangibility dimension ($p > 0.05$).

7.2.2.19 No statistically significant differences in service quality gaps experienced by medical insurance customers with different periods of membership to the medical insurance companies

The results show some statistical notable differences in gap scores between participants in the sample with different periods of memberships ($p < 0.05$) (Table 5.40).

7.2.2.20 No statistically significant differences in service quality gaps experienced by medical insurance customers who have either switched or not switched between medical insurance companies

The results obtained show some statistical noteworthy differences in gap scores between customers in the sample who have either switched or not switched between medical insurance companies for all the dimensions ($p < 0.05$), except for the tangibility dimension ($p > 0.05$) (Table 5.43).

7.2.2.21 No statistically significant differences in customers' perceptions of service quality between government-owned and privately owned medical insurance companies

The results show that there were notable statistical differences in customers' perceptions of service quality between government-owned and privately owned medical insurance companies for all the service quality variables ($p < 0.05$). Lower perceptions were recorded for customers in government-owned health insurance companies.

7.2.2.22 No statistically significant differences in customers' expectations of service quality between government-owned and privately owned medical insurance companies

The results show statistically noteworthy differences in customer expectations of service quality in all the dimensions between government-owned and privately owned medical insurance companies ($p < 0.05$). Higher expectations were found in customers of government-owned medical insurance companies.

7.2.2.23 No statistically significant differences in service quality gaps experienced by customers in government-owned and privately owned medical insurance companies

The results show statistically significant service quality gaps in all the dimensions experienced by customers in government-owned and privately owned medical insurance companies ($p < 0.05$). Higher service quality gaps were recorded in customers of government-owned medical insurances, indicating poor service quality offered by these companies.

7.3 Recommendations

In light of the above conclusions, some recommendations will be made, firstly on what companies in the medical insurance industry can do to close the gaps along the service quality variables in general, and secondly on the measures that can be taken by managers to enhance service quality in their respective companies.

7.3.1 General recommendations to close service quality gaps

The following recommendations are suggested to close the gaps along the service quality dimensions:

Reliability

In order to close service quality gaps related to reliability, the following recommendations are suggested:

- Health insurance companies should provide all medical benefits as promised in their medical insurance plans.
- Health insurance companies should settle medical claims at the time they promise to do so.
- Health insurance companies should be dependable in solving customers' queries.
- Health insurance companies should make practical and truthful promises that correctly represent the service actually delivered.
- Health insurance companies should not engage in advertising and price wars with rivals, which cause them to promise customers more than what they can provide.
- Health insurance companies must ensure that tangible elements of service truly reflect the provided levels of service.

Responsiveness

On responsiveness, the following aspects are recommended:

- Health insurance companies should keep customers informed about when payments for their medical claims will be made.
- Health insurance companies should settle customers' medical claims promptly.

- Employees of health insurance companies should always be eager to assist clients.
- Employees of health insurance companies should be trained to respond to customers' requests promptly.

Assurance

In relation to the assurance dimension, employees of health insurance companies should be trained to obtain the following skills:

- Employees must be capable of instilling confidence in clients.
- Employees must be able to make clients feel secure in their dealings with them.
- Employees must be courteous at all times and have the competence to answer questions from clients.

Medical insurance companies should also concentrate on their core business of providing financial cover to the sick. In this process, they should sub-contract to reputable service providers in their managed care systems and should avoid performing the services themselves, as this has failed to improve service delivery in the industry.

Empathy

In order to close service quality gaps related to empathy, it is recommended that:

- Employees should be trained to offer clients personal attention.
- Employees should also be trained to have clients' best interest at heart.
- Employees should also be trained to understand the specific needs of their clients.

Tangibles

On tangibles, the following recommendations are suggested:

- Health insurance companies should invest in modern equipment, especially in their managed care systems.
- Health insurance companies should upgrade their physical facilities, like buildings, so that they can continue to be visually appealing; however, these facilities should accurately reflect the quality of the services they offer.
- Health insurance employees should dress neatly and have a professional appearance.
- Health insurance companies should continue to improve the materials associated with service, like websites, brochures, and posters.

7.3.2 Recommendations to managers of medical insurance companies

This section puts forward some recommendations that managers of medical insurance companies in Zimbabwe could implement in order to improve service quality in the sector.

7.3.2.1 Channelling resources towards providing reliable financial coverage to the sick

The study has managed to highlight the areas where gaps in service quality in the medical insurance industry exist and to determine how service can be improved. For instance, the study has revealed that reliability is the most critical service quality dimension, as shown by the highest customer expectations of this dimension and the highest service quality gaps recorded for this dimension. Evidently, managers should channel more resources into improving this critical service quality dimension.

7.3.2.2 Building strong customer relationships

Management is also urged to invest more resources in building strong customer relationships. This will help medical insurance companies to understand customer expectations accurately and be able to narrow the service quality gaps.

7.3.2.3 Investing in information technologies

Investment in information technologies will assist in transforming the way health insurance companies relate to their customers. This is another strategic tool they can use to understand customer expectations and to provide better service in the industry.

7.3.2.4 Coming up with different medical insurance plans which suit the different expectations of customers in different categories

Based on the results of the hypotheses tested, medical insurance companies should design their various medical insurance plans in a way that suits the expectations of clients in different categories as follows:

i) Different age groups

- Health insurance companies should develop different health insurance plans, which suit customers in different age groups. As different service quality expectations were exhibited by customers in different age groups, service delivery should also be designed to cater for the particular needs of clients in different age groups.

ii) Health insurance plans for people in different sectors of the economy

- Health insurance companies should design medical insurance plans suitable for the particular needs of clients employed in different sectors of the economy.

iii) Incentives for long-serving members

- Customers who have many years of membership with a company should be given some incentives or extra services as reward for loyalty to the company.

7.4 Contribution to the body of knowledge

Literature has shown that health insurance schemes in many less-developed countries are still in their early implementation stages. Moreover, insufficient literature exists that deals with client satisfaction under a health insurance scheme setting in developing African countries (Mohammed *et al.*, 2011:1). Therefore, this study makes a significant contribution to the knowledge body through portraying medical insurance customers' perceptions and expectations of service quality in Zimbabwe and determining the levels of customers' satisfaction or dissatisfaction.

Through the application of the SERVQUAL model to the Zimbabwean medical insurance sector, the study recorded the perceptions and expectations of customers in the sector. The study has also identified some service quality gaps in the five service quality dimensions, and recommendations were made to close these gaps. These results could be utilised by various medical insurance companies in Zimbabwe in developing service quality strategies that meet the different expectations of their customers. The results will also be useful to medical insurance companies in designing marketing strategies for their service offerings. Since previous efforts to improve quality standards in the sector have been centred on regulations and benchmarked against systems adopted in developed countries like America (section 2.10), the results obtained can also be useful to the Association of Healthcare Funders of Zimbabwe (AHFoZ) in formulating quality standards designed for improving service delivery in the Zimbabwean health insurance industry. Thus, the results of the study will contribute significantly to enhancing service delivery and ultimately profitability and sustainability of the industry.

As already mentioned, this study has been conducted on private health insurance in a developing African country, Zimbabwe, which has a unique socio-economic background and ultimately a unique medical insurance industry when compared to its European and Asian counterparts. Medical insurance members are required to pay subscriptions unlike their counterparts in developed countries and under a different National Health Insurance Scheme. Zimbabwean medical insurance customers are likely to be more critical in their service quality expectations as they require value for their money. The study has thus generated further knowledge on the nature of service quality experiences encountered in this unique setting and has brought to the fore some crucial service quality elements that will enhance the creation of viable strategies for the sustainability of the medical insurance sector in Zimbabwe.

It is therefore hoped that the results of this study will be disseminated to the various medical insurance companies in Zimbabwe to raise their awareness of the expectations and perceptions of customers in the industry. It is further hoped that these companies will utilise this knowledge in their efforts to build some competitive advantage in the industry. Information will also be disseminated to AHFoZ, which should find it useful in formulating quality standards in the industry.

7.5 Areas for further research

Based on the results of this study and how it was conducted, the following areas are recommended for further research:

- This study focused on medical insurance customers in five medical insurance companies who had visited the selected five medical institutions in Harare. This was done to capture the perceptions of medical insurance customers who had fresh encounters with their medical insurance companies. Only five medical institutions were selected due to financial constraints. A natural progression of this study would be to target all medical insurance customers, irrespective of their immediate encounters with their companies, so as to capture a more comprehensive range of perceptions from customers.
- Further research could also be conducted across customers from all 31 medical insurance companies in Zimbabwe. This will give a comprehensive analysis of how medical insurance customers view service quality in the industry.
- It is recommended that further research be undertaken to investigate the causes of poor service quality in Zimbabwean medical insurance companies.
- A further study could be undertaken in other African countries that have adopted private medical insurance to examine the nature of service quality in these countries and to show how they are similar to or different from the Zimbabwean experiences.
- Since the study relied on a literature based validation of the SERVQUAL dimensions, it is recommended that a qualitative study be conducted on the validation of the dimensions in the medical insurance sector that will result in theory building.

7.6 Conclusion

This study examined service quality in Zimbabwean medical insurance companies, focusing mainly on medical insurance customers' perceptions and expectations of service quality in the industry. The processes followed in carrying out the study are highlighted in the previous chapters. From the theoretical perspective, very few researchers have reflected on service quality in private health insurance, particularly in the Zimbabwean context. Therefore, the study helps to close a research gap regarding customers' perceptions and expectations and quality gaps in the industry. It thus helps to extend the frontiers of knowledge for academia, the business fraternity, and the society at large. The study is significant in that service quality dimensions most important in the medical insurance industry were not known. Furthermore, it was also unclear whether medical insurance customers were experiencing good service quality from medical insurance companies. This study has helped to clear up this uncertainty. Since earlier efforts to enhance quality standards in the industry were centred on

regulating the sector and benchmarked against systems employed in developed countries, this study has brought a new dimension of enhancing quality in the sector through service quality strategies.

With the limited literature available on service quality in private health insurance, an extensive literature review was carried out drawing from various fields related to the study, which included insurance, health care, national health insurance, banking, and tourism, among others. Literature was also reviewed around the various constructs of service quality.

The underlying theoretical models adopted were the Gaps and the SERVQUAL models. The SERVQUAL model enabled the evaluation of service quality in the medical insurance industry along the five service quality dimensions suggested by Parasuraman *et al.* (1988:12–40), namely tangibles, reliability, responsiveness, assurance, and empathy. Using the two models, the service quality gaps in the service offerings of medical insurance companies in Zimbabwe were identified and statistically evaluated to provide service delivery solutions to the industry.

In order to understand customer perceptions and expectations in the medical insurance industry in Zimbabwe, the objectivist stance was adopted. Thus, the positivist research philosophy was adopted in which service quality was regarded as an observable social reality that could be reduced to simple elements in the form of the five service quality dimensions highlighted above. The study was quantitative in nature and the cross-sectional survey approach was considered suitable for collecting large amounts of data from a large population in a cost effective way. Data was collected using questionnaires.

Based on the research findings, the following conclusions regarding the Zimbabwean health care insurance industry were drawn from the study:

- 1) Medical insurance customers had very low positive perceptions of service offerings by medical insurance companies, with highest perceptions recorded in the tangible dimension ($m=3.5192$) and lowest perceptions recorded in the reliability dimension ($m=2.6514$).
- 2) Medical insurance customers had very high expectations of service quality from medical insurance companies, with highest expectations recorded in the reliability dimension and lowest expectations recorded in the tangibles dimension.
- 3) Medical insurance customers are dissatisfied with service offerings from medical insurance companies as shown by negative gap scores for all service quality dimensions. Highest gap scores were recorded in the reliability dimension (-2.0434), followed by responsiveness (-1.8434), assurance (-1.6017), empathy (-1.3245), and tangibles (-1.0420).

- 4) Customers of government-owned medical insurance companies are experiencing higher levels of dissatisfaction, as shown by significantly higher service quality gaps when compared to customers of privately owned medical insurance companies.
- 5) Strategies to improve service quality in the industry should focus on closing all the service quality gaps identified in the study, channelling more resources towards closing the reliability gap which had the highest gap score, followed by responsiveness, assurance, empathy and, lastly, tangibles. Medical insurance companies should also aim at building strong customer relationship, which will help them to understand customer expectations better and reduce the service quality gaps. In this process, they should make use of information technologies. In their strategies, they should also develop different medical insurance plans that suit the different expectations of different customers in different categories, as supported by the findings of the hypotheses tested. More measures to improve service quality in the sector are expected from government-owned companies, as their customers had very low perceptions and were experiencing higher service quality gaps when compared to customers of privately owned medical insurance companies.

The noteworthy differences in the perceptions, expectations, and gap scores among customers obtained in the hypotheses tests show some variation in customers' tastes and preferences that need to be considered in service offerings made to medical insurance customers. Therefore, medical insurance companies should design different medical insurance plans, which suit the different expectations of customers in different categories. For instance, they can create different medical insurance plans, which suit customers in different age groups, since they had different service quality expectations. They can also design medical insurance plans that are suitable for the particular needs of clients employed in different sectors of the economy. Moreover, they can consider giving some incentives or extra services as reward for loyalty to long-time members, as statistically significant differences were found in the medical insurance customers' expectations of the reliability, responsiveness, assurance, and empathy dimensions between participants in the sample who had different periods of membership with the medical insurance companies.

The study contends that medical insurance companies should centre their service quality strategies on those service quality dimensions considered important by customers rather than on management assumptions of what customers expect. They should therefore channel more of their resources towards providing reliable financial coverage to the sick. In order to understand customer expectations accurately and thus reducing the service quality gaps, they should also invest more resources towards building strong customer relationships. This will enable them to satisfy customers who will as a result continue to perceive the importance of medical insurance and continue their membership with them. It will further enable them to build some competitive advantage along those dimensions considered

important by customers, thereby enhancing the sustainability of their companies in an industry threatened by increased competition and economic challenges. It is anticipated that the results of this research will also provide insights to organisations like AHFoZ that are working towards improving quality in this crucial sector.

REFERENCE LIST

- Abdelfattah, F.A., Rahman, M.S. & Osman, M. 2015. Assessing the antecedents of customer loyalty on healthcare insurance products: Service quality; perceived value embedded model. *Journal of Industrial Engineering and Management*, 8(5):1639–1660.
- Adams, J., Khan, H.T.A., Raeside, R. & White, D. 2007. *Research methods for graduate business and social science students*. New Delhi: Sage.
- AHFoZ (Association of Healthcare Funders of Zimbabwe). 2008. *BHF Conference, Funding and Providing Healthcare in Zimbabwe*. Retrieved from crm.bhfglobal.com/files/bhf/Cuthbert%20Dube.pdf [Accessed 18 December 2104].
- AHFoZ (Association of Healthcare Funders of Zimbabwe). 2014. *Healthcare puzzle: Retracing the steps and sustaining the momentum*. AHFOZ All-Stakeholders' Conference on Health, Elephant Hills Resort, Victoria Falls. Retrieved from www.ahfoz.org/ahfoz-2014-all-stakeholders-conference-on-health [Accessed 18 December 2014].
- Aldhizer, G.R. & Juras, P. 2015. Improving the effectiveness and efficiency of healthcare delivery systems. *The CPA Journal*, 85(1):66–71.
- Ali, I. & Garg, R.K. 2017. Marketing of services: Challenges and opportunities in the context of the globalisation of business. *International Journal of Engineering and Management Research*, 7(3):522–526.
- Al-Neyadi, H.S., Abdallah, S. and Malik, M. 2018. Measuring patient's satisfaction of healthcare services in the UAE hospitals using SERVQUAL. *Journal of Healthcare Management*, 11(2):96–105.
- Amo-Adjei, J., Anku, P.J., Amo, H.F. & Effa, M.O. 2016. Perception of quality of health delivery and health insurance subscription in Ghana. *BMC Health Services Research*, 16(1):317–327.
- Andronikidis, A. & Bellou, V. 2010. Verifying alternative measures of the service-quality construct: Consistencies and contradictions. *Journal of Marketing Management*, 26(5/6):570–587.
- Argarwal, P., Castleberry, S.B., Ridnar, R. & Shepherd, C.D. 2005. Salesperson empathy and listening: Impact on relationship outcomes. *Journal of Marketing Theory and Practice*, 13(3):16–31.
- Asghari, M. & Babu, S.H. 2017. Understanding of customer expectations and perceptions of Indian health insurance companies. *International Journal of Engineering Trends and Technology*, 43(3):138–146.
- Asogwa, B.E., Asadu, B.U., Ezema, J.U. & Ugwuanyi, F.C. 2014. Use of SERVQUAL in the evaluation of service quality of academic libraries in developing countries. *Library Philosophy and Practice*, 1(11):1–22.

- Asubonteng, P. McCleary, K.J. & Swan, J.E. 1996. SERVQUAL revisited: A critical review of service quality. *The Journal of Services Marketing*, 10(6):62–81.
- Atinga, R.A. 2011. Healthcare quality under the National Health Insurance Scheme in Ghana: Perspectives from premium holders. *International Journal of Quality and Reliability Management*, 29(2):144–161.
- Austin, D.A. & Hungerford, T.L. 2010. *The market structure of the health insurance industry*. Congressional Research Service. Retrieved from www.ors.govR40834 [Accessed 27 February 2018].
- Babakus, E. & Boller, G.W. 1992. An empirical assessment of the SERVQUAL scale. *Journal of Business Research*, 24(3):253–268.
- Babakus, E. & Mangold, W.G. 1992. Adapting the SERVQUAL scale to hospital services: An empirical investigation. *Health Service Research*, 26(6):767–786.
- Bailey, K.D. 1978. *Methods of social research*. New York, NY: Free Press.
- Baker, J., Parasuraman, A., Grewal, D. & Voss, D.G. 2002. The influence of multiple store environment cues on perceived merchandise value and patronage. *International Journal of Marketing*, 66(2):120–141.
- Bala, N., Sandhu, H.S. & Nagpal, N. 2011. Measuring life insurance service quality: An empirical assessment of SERVQUAL instrument. *International Business Research*, 4(4):176–190.
- Baloglu, S., Mao, Z. & Busser, J. 2010. What really brings them back? The impact of tangible quality on affect and intentions for casual dining restaurant patrons. *International Journal of Contemporary Hospitality Management*, 22(2):209–220.
- Banerjee, N. & Sah, S. 2012. A comparative study of customers' perceptions of service quality dimensions between public and private banks in India. *International Journal of Business Administration*, 3(5):33–44.
- Barber, N. & Scacelli, J.M. 2010. Enhancing assessment of tangible service quality through the creation of a cleanliness measurement scale. *Managing Service Quality: An International Journal*, 20(1):70–88.
- Barlow, J. & Maul, D. 2000. *Emotional value: Creating strong bonds with your customers*. San Francisco, CA: Berrett-Koehler.
- Bhattacharjee, A. 2012. *Social science research: Principles, methods and practices*. Textbooks Collection, book 3. Retrieved from http://scholarcommons.usf.edu/oa_textbooks/3 [Accessed 25 May 2016].
- Bhattacharjee, C. 2010. *Service marketing: Concepts, planning and implementation*. New Delhi: Excel Books.
- Berry, L.L. 2000. Cultivating service brand equity. *Journal of the Academy of Marketing Sciences*, 28(1):128–137.

- Berry, L.L., Parasuraman, A. & Zeithaml, V.A. 1993. *Ten lessons for improving service quality*. Cambridge, MA: Marketing Science Institute.
- Bes, R.E., Wendel, S., Curfs, C.E., Groenewegen, P.P. & De Jong, J.D. 2013. Acceptance of selective contracting: The role of trust in the health insurer. *BMC Health Services Research*, 13(1):375–384.
- Beuran, M., Negoï, I., Paun, S., Vartic, M., Stoica, B., Tanase, I., Negoï, R. & Hostiuç, S. 2015. Quality management in general surgery: A review of literature. *Journal of Acute Disease*, 3(4):253–257.
- Bhardwaj, S.S. & Chawla, K. 2013. Exploring competitiveness of the Indian health sector: A service quality perspective. *Journal of Health Management*, 15(4):535–547.
- Bhat, R. & Jain, N. 2007. *A study of factors affecting the renewal of health insurance policy*. Indian Institute of Management Ahmedabad. Retrieved from <https://www.researchgate.net/publication/511338> [Accessed 28 February 2018].
- Bitner, M.J. 1990. Evaluating service encounters: The effects of physical surroundings and employee responses. *Journal of Marketing*, 54(2):69–82.
- Bitner, M.J. 1992. Servicescapes: The impact of physical surroundings on customers and employees. *Journal of Marketing*, 56(2):57–71.
- Boateng-Okrah, E. & Appiah Fening, F. 2012. TQM implementation: A case of a mining company in Ghana. *Benchmarking: An International Journal*, 19(6):743–759.
- Bolton, R.N. & Drew, J.H. 1991. A multistage model of customers' assessments of service quality and value. *Journal of Consumer Research*, 17(4):375–384.
- Boonen, L.H.H.M., Laske-Aldershof, T. & Schut, F.T. 2015. Switching health insurers: The role of price, quality and consumer information search. *European Journal of Health Economics*, 17(3):339–353.
- Boonen, L.H.H.M. & Schut, F.T. 2011. Preferred providers and the credible commitment problem in health insurance: First experience with the implementation of managed competition in the Dutch health care system. *Health Economics Policy and Law*, 6(2):219–235.
- Boulding, W., Kalra, A., Staelin, R. & Zeithaml, V.A. 1993. A dynamic process model of service quality: From expectations to behavioural intentions. *Journal of Marketing Research*, 30(1):7–27.
- Boxall, P. & Purcell, J. 2011. *Strategy and human resource management*. New York, NY: Palgrave Macmillan.
- Brabers, A.E., Reitsma-Van Rooijen, M. & De Jong, J.D. 2012. The Dutch health insurance system: Mostly competition on price rather than quality of care. *Eurohealth*, 18(1):30–33.
- Brady, M.K. & Cronin, J.J. Jr. 2001. Customer orientation: Effects on customer service perceptions and outcome behaviours. *Journal of Service Research*, 3(3):241–251.

- Buchmueller, T.C. & Monheit, A.C. 2009. Employer-sponsored health insurance and the promise of health insurance reform. *INQUIRY: The Journal of Health Care Organization, Provision, and Financing*, 46(2):187–202.
- Butt, M.M. & Cyril de Run, E. 2008. Private health care quality: Applying a SERVQUAL model. *International Journal of Health Care Quality Assurance*, 23(7):658–673.
- Buttle, F. 1996. SERVQUAL: Review critique, research agenda. *European Journal of Marketing*, 30(1):8–35.
- Büyükoçkan, G., Çifçi, G. & Güteryüz, S. 2011. Strategic analysis of healthcare service quality using fuzzy AHP methodology. *Expert Systems with Applications*, 38(8):9407–9424.
- Bytheway, A. 2015. *Investing in information: The Information Management Body of Knowledge*. Retrieved from www.springer.com/gp/book/9783319119083 [Accessed 28 February 2018].
- Cadotte, E.R., Woodruff, R.B. & Jenkins, R.L. 1987. Expectations and norms in models of consumer satisfaction. *Journal of Marketing Research*, 24(3):305–314.
- Campbell, P., Quigley, K., Collins, A., Yeracaris, P. & Chaora, M. 2001. *Applying managed care concepts and tools to middle and lower income countries: The case of medical aid societies in Zimbabwe*. Retrieved from <https://www.hsph.harvard.edu/ihs/publications/pdf/No-84.PDF> [Accessed 15 January 2015].
- Candido, C.J.F. & Morris, D.S. 2000. Charting service quality gaps. *Total Quality Management*, 11(4–6):463–472.
- Carman, J. 1990. Consumer perceptions of service quality: An assessment of the SERVQUAL dimensions. *Journal of Retailing*, 66(1):33–55.
- Carrilat, F.A., Jaramillo, F. & Mulki, J.P. 2007. The validity of the SERVQUAL and SERVPREF scale. *International Journal of Service Industry Management*, 18(5):472–490.
- Chawla, S. & Singh, F. 2008. Service quality perceptions of life insurance policyholders in northern India: Pre-privatization vs. post-privatization. *The ICFAI University Journal of Marketing Management*, 7(4):24–53.
- Chidza, R. 2016. *PSMAS moves to stem bleeding*. *NewsDay*, 6 February. Retrieved from <https://www.newsday.co.zw/2016/02/psmas-moves-to-stem-bleeding/> [Accessed 15 August 2016].
- Chikwendu, D.U., Ejem, E. & Ezenwa, A. 2012. Evaluation of service quality of Nigerian Airline using Servqual model. *Journal of Hospitality Management and Tourism*, 3(6):117–126.
- Chinyadza, J. 2014. Personal interview. 11 November, Harare.
- Choudhuri, P.S. 2014. Dependency of customer satisfaction on the perceived service quality in Life Insurance Corporation of India. *Research Revolution*, 2(4):7–9.

- Chowdhary, N. 2000. Two factors theory: Quasi experiments in service quality. In Bo Edvardsson, Brown, SW, *et al.* (Eds.). *QUIS 7 – Service Quality in the New Economy: Interdisciplinary and International Dimension*. New York, NY: International Service Quality Association.
- Chowdhary, N. & Prakash, M. 2007. Prioritising service quality dimensions. *Management of Service Quality*, 17(5):493–509.
- Claxton, G., Gabel, J., DiJulio, B., Pickreign, J., Whitmore, H., Finder, B., Jacobs, P. & Hawkins, S. 2007. Health benefits in 2007: Premium increases fall to an eight-year low, while offer rates and enrolment remain stable. *Health Affairs*, 26(5):1407–1416.
- Cohen, L., Manion, L. & Morrison, K. 2007. *Research methods in education*. New York, NY: Routledge.
- Collier, D.A. 1990. Measuring and managing service quality. In *Service management effectiveness*. San Francisco, CA: Jossey-Bass, 234–265.
- Colombo, F. 2007. Lessons for developing countries from the OECD. In A.S. Preker, R.M. Scheffler & M.C. Bassett (eds.). *Private voluntary health insurance in development: Friend or foe?* Washington, DC: The World Bank, 211–240.
- Cooper, D.R. & Schindler, P.S. 2011. *Business research methods*. Third European edition. New York, NY: McGraw-Hill.
- Costa, G., Glinia, E. & Drakou, A. 2004. The role of empathy in sport tourism services. *Journal of Sport & Tourism*, 9(4):331–342.
- Craig, J.T. 2015. *Antecedents of individual innovative behavior: Examining transformational leadership, creative climate, role ambiguity, risk propensity, and psychological empowerment*. San Diego, CA: Alliant International University.
- Creswell, J.W. 2013. *Research design: Qualitative, quantitative and mixed methods approaches*. New Delhi: Sage.
- Cronin J.J. Jr & Taylor, S.A. 1992. Measuring service quality: A re-examination and extension. *Journal of Marketing*, 56(3):55–68.
- Cronin J.J. Jr & Taylor, S.A. 1994. SERVPERF versus SERVQUAL: Reconciling performance-based and perceptions-minus-expectations measurement of service quality. *The Journal of Marketing*, 58(1):125–131.
- Crosby, P.B. 1979. *Quality is free: The art of marketing quality certain*. New York, NY: New American Library.
- Crosby, P.B. & Free, Q.I. 1979. *The art of making quality certain*. New York, NY: New American Library.
- Custer, B. 2015. Improving the effectiveness and efficiency of healthcare delivery systems. *The CPA Journal*, 85(1):1.

- Cylus, J. & Papanicolas, I. 2015. An analysis of perceived access to healthcare in Europe: How universal is universal coverage? *Health Policy*, 119(9):1130–1144.
- Dabholkar, P.A. 2015. How to improve perceived service quality by increasing customer participation. In *Proceedings of the 1990 Academy of Marketing Science (AMS) annual conference*. New York: Springer, Cham: 483–487.
- Dalinjong, P.A. & Laar, A.S. 2012. The national health insurance scheme: Perceptions and experiences of health care providers and clients in two districts of Ghana. *Health Economics Review*, 2(1):13–25.
- Davidow, W.H. & Uttal, B. 1989. Services companies: Focus or falter. *Harvard Business Review*, 67(4):77–85.
- Debasish, S.S. & Dey, M.S. 2015. Customer perceptions of service quality towards luxury hotels in Odisha using Servqual Model. *International Journal of Research in Business Studies and Management*, 2(9):1–9.
- De Meyer, C.F. & Mostert, P.G. 2011. The influence of passenger satisfaction on relationship formation in the South African domestic airline industry. *South African Journal of Business Management*, 42(4):79–87.
- De Vaus, D.A. 2002. *Surveys in social research*. Fifth edition. London: Routledge.
- Devi Juwaheer, T. 2011. Gender bias in hotel guests' perceptions of service quality: An empirical investigation of hotels in Mauritius. *E-review of Tourism Research*, 9(5):164–189.
- Dhar, R.L. 2015. Service quality and the training of employees: The mediating role of organizational commitment. *Tourism Management*, 46:419–430.
- Doherty, J.E. 2015. Regulating the for-profit private health sector: Lessons from East and southern Africa. *Health Policy and Planning*, 30(1):i93–i102.
- Drollinger, T. & Comer, L.B. 2012. Salesperson's listening ability as an antecedent of relationship selling. *Journal of Business and Industrial Marketing*, 28(1):50–59.
- Dytham, C. 2011. *Choosing and using statistics: A biologist's guide*. West Sussex: Wiley.
- Einav, L. & Levin, J. 2015. Managed competition in health insurance. *Journal of the European Economic Association*, 13(6):998–1021.
- Eisingerich, A.B. & Beli, S. 2008. Perceived service quality and customer trust. *Journal of Services Research*, 208(10):256–268.
- El Saghier, N. & Nathan, D. 2013. Service quality dimensions and customers satisfaction of banks in Egypt. In *Proceedings of 20th International Business Research Conference*. Dubai: UAE, 4–5.
- First Mutual Health. N.d. *About us*. Retrieved from <https://www.fmlmedical.co.zw/about-2/> [Accessed 19 July 2016].
- Folland, S., Goodman, A.C. & Stano, M. 2013. *The economics of healthcare*. New York, NY: Pearson.

- Foster, N. 2012. *Private sector involvement in health services in East and southern Africa: Country profiles*. EQUINET discussion paper 89. Harare.
- Gatoto, F.W., Wachira, A. & Mwenda, L. 2015. Service quality strategies by private security firms in Kenya. *International Journal of Business Finance Management Research*, 3:83–89.
- Gautam, V. 2011. Investigating the moderating role of corporate image in the relationship between perceived justice and recovery satisfaction. *International Review of Management and Marketing*, 1(4):74–85.
- George, W.R. & Gibson, B.E. 1988. Blueprinting: A tool for managing quality in organisations. Paper delivered at the QUIS Symposium, University of Karlsrand, Sweden.
- Ghobadian, A., Speller, S. & Jones, M. 1994. Service quality concepts and models. *International Journal of Quality and Reliability Management*, 11(9):43–66.
- Ghotbabadi, A.R., Feiz, S. & Baharun, R. 2015. Service quality measurements: A review. *International Journal of Academic Research in Business and Social Sciences*, 5(2):267–286.
- Gilmore, A. & McMullan, R. 2009. Scales in services marketing research: A critique and way forward. *European Journal of Marketing*, 43(5/6):640–651.
- Glaitis, V.A. & Minis, I.E. 2007. Service attribute – process matrix: A tool for designing and managing services. *Journal of Systems Science and Systems Engineering*, 16(3):257–276.
- Gokilavani, R. & Durgarani, M. 2016. A study on the impact of service quality and customer satisfaction with special reference to SBI in Coimbatore District using structural equation model. *International Journal of Innovative Research and Development*, 14(4):2413–2418.
- Goldstein, S.M., Johnston, R., Duffy, J. & Rao, J. 2002. The service concept: The missing link in service design research? *Journal of Operations Management*, 20(2):121–134.
- Gopalkrishna, B., Rodrigues, L.R. & Varambally, K.V.M. 2008. Service quality in general insurance sectors: An empirical study. *Indian Journal of industrial Relations*, 44(1):49–61.
- Griffin, C.C. 1989. *Strengthening health services in developing countries through the private sector*. International Finance Corporation discussion paper no. 4. Retrieved from www.popline.org/node/379819 [Accessed 15 January 2015].
- Grönroos, C. 1982. A service quality model and its marketing implications. *European Journal of Marketing*, 18(4):36–44.
- Grönroos, C. 1984. A service quality model and its marketing implications. *European Journal of Marketing*, 18(4):36–44.
- Grönroos, C. 1988. Service quality: The six criteria of good perceived service. *Review of Business*, 9(3):10–13.
- Grönroos, C. 2004. The relationship marketing process: Communication, interaction, dialogue, value. *Journal of Business and Industrial Marketing*, 19(2):99–113.

- Gross, T. 2016. *Positively outrageous service: How to delight and astound your customers and win them for life*. New York, NY: Skyhorse.
- Gummerus, J., Liljander, V., Pura, M. & Van Riel, A. 2004. Customer loyalty to content-based web sites: The case of an online health-care service. *Journal of Services Marketing*, 18(3):175–186.
- Gunawardane, G. 2011. Reliability of the internal service encounter. *International Journal of Quality and Reliability Management*, 28(9):1003–1018.
- Hackman, M.B., Kolstad, J.T. & Kowalski, A.E. 2015. Adverse selection and an individual mandate: When theory meets practice. *American Economic Review*, 105(3):1030–1066.
- Hall, M.A., Dugan, E., Balkrishnan, R. & Bradley, D. 2002. How disclosing HMO physician incentives affects trust. *Health Affairs*, 21(2):197–206.
- Hall, M., Dugan, E., Zheng, B. & Mishra, A. 2001. Trust in physicians and medical institutions: What is it, can it be measured and does it matter? *Milbank Quarterly*, 79(4):613–639.
- Handel, B., Hendel, I. & Whinston, M.D. 2015. Equilibria in health exchanges: Adverse selection versus reclassification risk. *Econometrica*, 83(4):1261–1313.
- Handel, B.R. 2013. Adverse selection and inertia in health insurance markets: When nudging hurts. *American Economic Review*, 103(7):2634–2682.
- Handrinos, M.C., Folinas, D. & Rotsios, K. 2015. Using the SERVQUAL model to evaluate the quality of services for a farm school store. *Journal of Marketing and Consumer Behaviour in Emerging Markets*, 1(1):62–74.
- Hartline, M.D. & Ferrell, O.C. 1996. The management of customer–contact service employees: An empirical investigation. *The Journal of Marketing*, 60(4):52–70.
- Haywood-Farmer, J. 1988. A conceptual model of service quality. *International Journal of Operations and Production Management*, 8(6):19–29.
- Heskett, J.L. 1987. Lessons in the service sector. *Harvard Business Review*, 65(2):118–126.
- Hess, R.L. Jr, Ganesan, S. & Klein, N.M. 2007. Service failure and recovery: The impact of relationship factors on customer satisfaction. *Journal of the Academy of Marketing Science*, 31(2):127–145.
- Hilton, T. 2016. *Services marketing: The marketing book*. New York, NY: Routledge.
- Hoffman, K.D. & Bateson, J.E.G. 2016. *Services marketing: Concepts, strategies and cases*. Fifth edition. New York, NY: Cengage Learning.
- Hussain, R., Nasser, A.A. & Hussain, Y.K. 2015. Service quality and customer satisfaction of a UAE-based airline: An empirical investigation. *Journal of Air Transport Management*, 3:1–9.
- Ibrahim, H., Taufik, N.M., Adzmir, A.M. & Saharuddin, H. 2016. Customer satisfaction on reliability and responsiveness of self-service technology for retail banking services. *Procedia Economics and Finance*, 37:13–20.
- Iloh, G.U.P., Ofoedu, J.N., Njoku, P.U., Okafor, G.O.C., Amadi, A.N. & Godswill-Uko, E.U. 2013. Satisfaction with quality of care received by patients without national health insurance

- attending a primary care clinic in a resource-poor environment of a tertiary hospital in Eastern Nigeria in the era of scaling up of the Nigeria formal sector health insurance scheme. *Annals of Medical and Health Sciences Research*, 3(1):31–37.
- Ismail, I., Haron, H., Ibrahim, D.N. & Isa, S.M. 2006. Service quality, client satisfaction and loyalty towards audit firms. *Managerial Auditing Journal*, 21(7):738–756.
- Itani, O.S. & Inyang, A.E. 2015. The effects of empathy and listening of salespeople in relationship quality in the retail banking industry: The moderating role of felt stress. *International Journal of Bank Marketing*, 33(6):692–716.
- Itumalla, R. 2012. Information technology and service quality in health care: An empirical study on private hospitals in India. *International Journal of Innovation, Management and Technology*, 3(4):433–436.
- Jain, P. & Aggarwal, V.S. 2015. Service quality models: A review. *BVIMSR's Journal of Management Research*, 7(2):125–136.
- Jain, P., Mittal, E. & Pahuja, J. 2014. Problems faced by the health insurance policy holders of different public and private health insurance companies for settlement of their claims (case study of Punjab). *BVIMR Management Edge*, 7(1):39–52.
- Jain, S. & Jain, S.K. 2015. Does outcome quality matter? An investigation in the context of banking services in an emerging market. *Journal of Consumer Marketing*, 32(5):341–355.
- Jain, S.K. & Gupta, G. 2004. Measuring service quality: SERVQUAL vs. SERVPERF scales. *Vikalpa*, 29(2):25–38.
- Jenson, J. & Fernandez, B. 2007. *Health insurance basics: Roles for the market and government in providing, financing, and regulating private insurance coverage*. Washington, DC: Congressional Research Service.
- Johnston, R. 1995. The determinants of service quality: Satisfiers and dissatisfiers. *International Journal of Service Industry Management*, 6(5):53–71.
- Joseph, M., Stone, G. & Anderson, K. 2003. Insurance customers' assessment of service quality: A critical evaluation. *Journal of Small Business and Enterprise Development*, 10(1):81–92.
- Juran, J.M. 1992. *Juran on quality by design: The new steps for planning quality into goods and services*. New York, NY: Simon & Schuster.
- Kabir, H. & Carlsson, T. 2010. *Service quality: Expectations, perceptions and satisfaction about service quality on destination Gotland – a case study*. Visby: Gotland University.
- Kang, G.-D. & James, J. 2004. Service quality dimensions: An examination of Grönroos's service quality model. *Managing Service Quality: An International Journal*, 14(4):266–277.
- Kar, D.P. 2017. Development and implementation of an employee empowerment plan for sustainable competitive advantage. *ACADEMICIA: An International Multidisciplinary Research Journal*, 7(5):15–22.

- Karatepe, O.M. & Vatankhah, S. 2014. The effects of high-performance work practices and job embeddedness on flight attendants' performance outcomes. *Journal of Air Transport Management*, 37:27–35.
- Kasper, J.D.P., Van Helsdingen, P.J., Gabbott, M. & Fuxiang, W. 2008. *Services marketing management: A strategic perspective*. West Sussex: Wiley.
- Kassim, N. & Abdullah, N.A. 2010. The effect of perceived service quality dimensions on customer satisfaction, trust and loyalty in e-commerce settings. *Asia Pacific Journal of Marketing and Logistics*, 22(3):351–371.
- Kasule, O.H.K. 2012. Health insurance and the ethical issue of equity. *Journal of Taibah University Medical Science*, 7(2):61–68.
- Keiningham, T. & Vavra, T. 2001. *The customer delight principle: Exceeding customers' expectations for bottom line success*. New York, NY: McGraw-Hill.
- Kelly, S.W. & Hoffman, K.D. 1997. An investigation of positive affect, prosocial behaviours and service quality. *Journal of Retailing*, 73(3):407–427.
- Kincaid, C., Baloglu, S., Mao, Z. & Busser, J. 2010. What really brings them back? *International Journal of Contemporary Hospitality Management*, 22(2):209–220.
- Kinghorn, A. 1994. *The development of managed health care in South Africa: What are the implications?* Johannesburg: Centre for Applied Legal Studies, University of the Witwatersrand.
- Kitapci, O., Akdogan, C. & Dotyol, I.T. 2014. The impact of service quality dimensions on patient satisfaction, repurchase intentions and word of mouth communication in the public healthcare industry. *Procedia - Social and Behavioural Sciences*, 148:161–169.
- Knottnerus, J.A. & Ten Velden, G.H. 2007. Dutch doctors and their patients: Effects of health care reform in the Netherlands. *New England Journal of Medicine*, 357(24):2424–2426.
- Kongstvedt, P. 1997. *Essentials of managed health care*. Second edition. Gaithersburg, MA: Aspen.
- Kothari, C.R. 2004. *Research methodology: Methods and techniques*. New Delhi: New Age International.
- Kothari, C.R. 2009. *Research methodology: Methods and techniques*. Second revised edition. New Delhi: New Age International.
- Kotler, P. & Keller, K.L. 2010. *Marketing management*. New Delhi: Dorling Kindersley.
- Kotler, P. & Keller, K.L. 2012. *Marketing management*. Fourteenth edition. Boston, MA: Pearson Education.
- Koufteros, X., Vonderembse, M. & Jayaram, J. 2005. Internal and external integration for product development: The contingency effects of uncertainty, equivocality and platform strategy. *Decision Sciences*, 36(1):97–133.

- Krejcie, R.V. & Morgan, D.W. 1970. Determining sample size for research activities. *Educational and Psychological Measurement*, 30(3):607–610.
- Kushwah, S.V. & Bhargav, A. 2014. Service quality expectations and perceptions of Telecom sector in India. *International Journal of Advancements in Technology*, 5(1):1–10.
- Kwok, S.Y., Jusoh, A. & Khalifah, Z. 2016. The influence of service quality on satisfaction: Does gender really matter? *Intangible Capital*, 12(2):444–461.
- Ladhari, R. 2008. Alternative measures of service quality review. *Managing Service Quality*, 18(1):65–86.
- Ladhari, R. 2009. A review of twenty years of SERVQUAL research. *International Journal of Quality and Service Sciences*, 1(2):172–198.
- Lakshmi, S.R. & Santhi, P. 2015. Antecedents of customer perception of service quality of life insurance corporation of India. *IUP Journal of Management Research*, 14(3):70–81.
- Lassar, W.M., Manolis, C. & Winsor, R.D. 2000. Service quality perspectives and satisfaction in private banking. *Journal of Services Marketing*, 14(3):244–271.
- Lavrakas, P.J. 2008. *Encyclopedia of survey research methods*. New York, NY: Sage.
- Lee, H., Lee, Y. & Yoo, D. 2000. The determinants of perceived service quality and its relationship with satisfaction. *Journal of Services Marketing*, 14(3):217–231.
- Lee, J. 2007. SERVQUAL vs SERVPERF: Round 2 in a multicultural setting. *Journal of Academy of Business and Economics*, 7(3):77–87.
- Lee, L., Lee, M.J. & Dewald, B. 2016. Measuring the customers' perception of tangible service quality in the restaurant industry: An emphasis on the upscale dining segment. *Journal of Foodservice Business Research*, 19(1):21–38.
- Lehtinen, U. & Lehtinen, J.R. 1982. *Service quality: A study of quality dimensions*. Massachusetts, MS: Service Management Institute.
- Lehtinen, U. & Lehtinen, J.R. 1991. Two approaches to service quality dimensions. *Service Industries Journal*, 11(3):287–303.
- Leibowitz, A. 2005. Wage and benefit changes in response to rising health insurance costs. *Forum for Health Economics and Policy*, 8(3):1–23.
- Lewis, B.R. 1993. Service quality measurement. *Marketing, Intelligence & Planning*, 11(4):4–12.
- Liang, C.J., Wang, W.H. & Farquhar, J.D. 2009. The influence of customer perceptions on financial performance in financial services. *International Journal of Bank Marketing*, 27(2):129–149.
- Lien, N.H. & Kao, H.L. 2008. The effects of service quality dimensions on customer satisfaction across different services types: Alternative differentiation as a moderator. *ACR North American Advances*, 35:522–526.

- Lo, A., Wu, C. & Tsai, H. 2015. The impact of service quality on positive consumption emotions in resort and hotel spa experiences. *Journal of Hospitality Marketing & Management*, 24(2):155–179.
- Lockyer, T. 2003. Hotel cleanliness: How do guests view it? Let us get specific: A New Zealand study. *Hospitality Management*, 22(3):297–305.
- Lovelock, C. & Gummesson, E. 2004. Whither service marketing? In search of a new paradigm and fresh perspective. *Journal of Service Research*, 7(1):20–41.
- Mack, S. 2017. *How does the appearance of physical facilities affect customer service*. Chron. Retrieved from <http://smallbusiness.chron.com/appearance-physical-facilities-affect-customer-service-66223..html> [Accessed 6 February 2017].
- Madan, M. 2012. Comparison of customers' perception with regard to service quality in public and private insurance companies using SERVQUAL. *Delhi Business Review*, 13(3):55–66.
- Mamilla, R., Janardhana, G. & Anjan Babu, G. 2013. Customer satisfaction on reliability dimension of service quality in Indian higher education. *International Journal of Social, Behavioral, Educational, Economic and Management Engineering*, 7(12):3210–3215.
- Mantey, N.O. & Naidoo, V. 2016. Evaluation of passengers' perceptions on service quality in South African owned airlines. *Journal of Contemporary Management*, 13(1):330–356.
- Meesala, A. & Paul, J. 2018. Service quality, customer satisfaction and loyalty in hospitals: Thinking for the future. *Journal of Retailing and Consumer Service*, 40:261–261.
- Mei, W.O., Dean, A.M. & White, C.J. 1999. Analysing service quality in the hospitality industry. *Managing Service Quality: An International Journal*, 9(2):136–143.
- Melian-Alzola, L. & Padron-Robaina, V. 2006. Tangibility as a quality factor in electronic commerce b2c. *Managing Service Quality: An International Journal*, 16(3):320–328.
- Moeller, S. 2010. Characteristics of services: A new approach uncovers their value. *Journal of Services Marketing*, 24(5):359–368.
- Mohammed, S., Sambo, N.M. & Dong, H. 2011. Understanding client satisfaction with a health insurance scheme in Nigeria: Factors and enrollees experiences. *Health Research Policy and Systems*, 9(1):20–27.
- Mokhlis, S. 2012. The influence of service quality on satisfaction: A gender comparison. *Public Administration Research*, 1(1):103–112.
- Mufudza, T. & Naidoo, V. 2018. Customer perceptions and expectations of medical insurance service quality rendered by companies in Zimbabwe. *Journal of Contemporary Management*, 15(1):48–77.
- Mullins, J.W. & Walker, JR, O. C. 2010. *Marketing management: A strategic decision making approach*. Singapore: McGraw-Hill Irwin.

- Munyuki, E. & Jasi, S. 2009. *Capital flows in the health care sector in Zimbabwe: Trends and implications for the health system*. Equinet Discussion Paper 79.
- Musungwini, E. 2012. AHFoZ 2012: Conference summary of issues and way forward. *The Standard*, 1 October. Retrieved from <https://www.thestandard.co.zw/2012/10/01/conference-summary-of-issues-and-way-forward/> [Accessed 9 December 2014].
- Naidoo, V. & Mutinta, G. 2014. An investigation into service quality delivery at the University of KwaZulu-Natal. *Journal of Social Sciences*, 38(3):219–229.
- Nikolova, M. 2005. Customer relationship management systems. In *Proceedings of 19th International Conference SAER 2005*. Sofia: SAER Forum Group, 164–167.
- Nsiah-Boateng, E., Aikins, M., Asenso-Boadi, F. & Andoh-Adjei, F.X. 2016. Value and service quality assessment of the National Health Insurance Scheme in Ghana: Evidence from Ashiedu Keteke District. *Value in Health Regional Issues*, 10:7–13.
- Nuscheler, R. & Knaus, T. 2005. Risk selection in the German public health insurance system. *Health Economics*, 14(12):1253–1271.
- Nyandwe, J., Mapatano, M., Lussamba, P., Kandala, N.B. & Kayembe, P. 2017. Measuring patients' perception on the quality of care in the Democratic Republic of Congo using a modified, service quality scale (SERVQUAL). *Archives of Science*, 1(2):1–6.
- Oberoi, U. & Hales, C. 1990. Assessing the quality of the conference hotel service product: Towards an empirically based model. *Service Industries Journal*, 10(4):700–721.
- Ofori-Okyere, I. & Aboagye, P. 2015. An evaluation of HR strategies for delivering quality health care in the district hospitals in Ghana. *International Journal of Business and Marketing Management*, 3(1):16–30.
- Ojiako, U. 2012. Using IS/IT to enhance service delivery. *Industrial Management & Data Systems*, 112(4):584–599.
- Oliver, R. 1980. A cognitive model of the antecedents and consequences of satisfaction decisions. *Journal of Marketing Research*, 17(4):460–469.
- Oliver, R.L. 2014. *Satisfaction: A behavioral perspective on the consumer*. London: Routledge.
- Oliver, R.L. & Bearden, W.O. 1985. Disconfirmation processes and consumer evaluations in product usage. *Journal of Business Research*, 24(3):253–268.
- Olsen, L.L. & Johnson, M.D. 2003. Service equity, satisfaction and loyalty: From transaction-specific to cumulative evaluations. *Journal of Service Research*, 5(3):184–198.
- Omar, H.F.H., Saadan, K.B. & Seman, K.B. 2015. Determining the influence of the reliability of service quality on customer satisfaction: The case of Libyan e-commerce customers. *International Journal of Learning and Development*, 5(1):86–89.

- Omar, M.S., Ariffin, H.F. & Ahmad, R. 2016. Service quality, customers' satisfaction and the moderating effects of gender: A study of Arabic restaurants. *Procedia - Social and Behavioral Sciences*, 224:384–392.
- Padma, P., Rajendran, C. & Sai, P.P. 2009. A conceptual framework of service quality in healthcare: Perspectives of Indian patients and their attendants. *Benchmarking: An International Journal*, 16(2):157–191.
- Pallant, J. 2010. *SPSS survival manual: A step by step guide to data analysis using SPSS*. Maidenhead: McGraw-Hill.
- Palmer, A. 2011. *Principles of services marketing*. Maidenhead: McGraw-Hill Education.
- Parasuraman, A., Berry, L.L. & Zeithaml, V.A. 1991. Refinement and reassessment of the SERVQUAL scale. *Journal of Retailing*, 67(4):420–450.
- Parasuraman, A., Zeithaml, V.A. & Berry, L.L. 1985. A conceptual model of service quality and its implications for future research. *Journal of Marketing*, 49(4):41–50.
- Parasuraman, A., Zeithaml, V.A. & Berry, L.L. 1988. SERVQUAL: A multiple item scale for measuring customer perceptions of service quality. *Journal of Retailing*, 64(1):12–40.
- Pashaie, R., Fatemi, A. & Ahmadi, F. 2013. Evaluation of service quality in insurance industry based of customer and personnel view in Kavsar insurance institute. *Interdisciplinary Journal of Contemporary Research in Business*, 5(5):184–197.
- Pauly, M.V., Zweifel, P., Scheffler, R.M., Preker, A.S. & Bassett, M. 2006. Private health insurance in developing countries. *Health Affairs*, 25(2):369–79.
- Pizam, A. 2010. Creating memorable experiences. *International Journal of Hospitality Management*, 3(29):343–352.
- Potrac, P., Jones, R. & Nelson, L. 2014. Interpretivism. In *Research methods in sports coaching*. New York:Routledge, 31–41.
- Prakash, A. & Mohanty, R.P. 2013. Understanding service quality. *Production Planning and Control*, 24(12):1050–1065.
- Preker, A.S., Scheffler, R.M. & Bassett, M.C. 2007. *Private voluntary health insurance in development: Friend or foe?* Washington, DC: World Bank Publications.
- Prentice, C. 2013. Service quality perceptions and customer loyalty in casinos. *International Journal of Contemporary Hospitality Management*, 25(1):49–64.
- PSMI (Premier Service Medical Investments). N.d. *Our history*. Retrieved from <http://www.psmi.co.zw/about-us/our-history/> [Accessed 19 July 2016].
- Psomas, E.L. & Jaca, C. 2016. The impact of total quality management on service company performance: Evidence from Spain. *International Journal of Quality and Reliability Management*, 33(3):380–398.

- Punnakitikashem, P., Buavaraporn, N., Maluesri, P. & Leelartapin, K. 2012. Health care service quality: Case example of a hospital with lean implementation. In *POMS 23rd Annual Conference*. Chicago, IL: Production and Operations Management Society, 1–5.
- Purcarea, V.L., Gheorghe, I.R. & Petrescu, M.C. 2013. The assessment of perceived service quality of public health care services in Romania using the SERVQUAL scale. *Procedia Economics and Finance*, 6:573–585.
- Quinn, J.B., Baruch, J.J. & Paquette, P.C. 1987. Technology in services. *Scientific American Journal*, 257(6):50–58.
- Raajpoot, N.A. 2002. TANGSERV: A multiple item scale for measuring tangible quality in foodservice industry. *Journal of Foodservice Business Research*, 5(2):109–120.
- Rai, A.K. & Medha, S. 2013. The antecedents of customer loyalty: An empirical investigation in life insurance context. *Journal of Competitiveness*, 5(2):139–163.
- Ramanujam, P.G. 2011. Service quality in health care organisations: A study of corporate hospitals in Hyderabad. *Journal of Health Management*, 13(2):177–202.
- Ramseook-Munhurrin, P., Lukea-Bhiwajee, S.D. & Naidoo, P. 2010. Service quality in the public service. *International Journal of Management and Marketing Research*, 3(1):37–50.
- Rao, P.H. 2012. The private health sector in India: A framework for improving the quality of care. *ASCI Journal of Management*, 41(2):14–39.
- Rasheed, M. & Latif, A. 2011. Does technology-enabled service quality affect organizational competencies? *Journal of Public Administration and Governance*, 1(2):58–76.
- Reimer, A. & Kuehn, R. 2005. The impact of servicescape on quality perception. *European Journal of Services Marketing*, 39(7/8):785–808.
- Reitsma-Van Rooijen, M., De Jong, J.D. & Rijken, M. 2011. Regulated competition in health care: Switching and barriers to switching in the Dutch health insurance system. *BMC Health Services Research*, 11(1):95–104.
- Roberts, M.J., Hsiao, W., Berman, P. & Reich, M.R. 2004. *Getting health reform right: A guide to improving performance and equity*. Oxford: Oxford University Press.
- Rönnbäck, Å. & Witell, L. 2008. A review of empirical investigations comparing quality initiatives in manufacturing and service organizations. *Managing Service Quality: An International Journal*, 18(6):577–593.
- Roohi, G., Asayesh, H., Abdollahi, A.A. & Abbasi, A. 2011. Evaluation of clients' expectations and perception gap regarding the quality of primary healthcare service in healthcare centers of Gorgan. *Journal of Jahrom University of Medical Sciences*, 9(3):40–45.
- Ross, K.N. 2005. *Quantitative research methods in educational planning*. International Institute for Educational Planning/Unesco. Retrieved from www.unesco.org/iiep [Accessed 8 May 2014].

- Rousseau, D.M., Sitkin, S.B., Burt, R.S. & Camerer, C. 1998. Not so different after all: A cross-discipline view of trust. *Academy of Management Review*, 23(3):393–404.
- Rust, R.T. & Oliver, R.L. 2000. Should we delight the customer? *Journal of the Academy of Marketing Science*, 28(1):86–94.
- Ryu, K. & Jang, S. 2008. DINESCAPE: A scale for customers' perception of dining environments. *Journal of Foodservice Business Research*, 11(1):2–22.
- Saad, A.M., Yusoff, R.Z. & Islam, R. 2014. Antecedents of service quality in the insurance industry. *Advances in Natural and Applied Sciences*, 8(8):121–131.
- Saini, S. & Singh, R. 2018. Service quality assessment of utility company in Haryana using SERVQUAL model. *Asian Journal of Management*, 9(1):702–708.
- Salovey, P. & Mayer, J.D. 1990. Emotional intelligence. *Imagination, Cognition and Personality*, 9(3):185–211.
- Santos, J. 2002. From intangibility to tangibility on service quality perceptions: A comparison study between customers and service providers in four service industries. *Managing Service Quality*, 12(5):292–302.
- Sanyanga, S. 2014a. *AHFoZ industry overview*. Retrieved from www.ahfoz.org/Presentations/p1.pdf [Accessed 18 December 2014].
- Sanyanga, S. 2014b. *Speech by the Chief Executive Officer of the Association of Healthcare Funders of Zimbabwe, Mrs Shylet Sanyanga at the Annual All Stakeholders Conference, at the Elephant Hills Hotel 2 September – 5 September 2014*. Retrieved from www.ahfoz.org/Presentations/p13.pdf [Accessed 18 December 2014].
- Saunders, M., Lewis, P. & Thornhill, A. 2007. *Formulating the research design: Research methods for business students*. New Delhi: Prentice Hall.
- Saunders, M., Lewis, P. & Thornhill, A. 2009. *Research methods for business students*. Fourth edition. New York, NY: Pearson Education.
- Schneider, B., White, S.S. & Paul, M.C. 1998. Linking service climate and climate and customer perceptions of service quality: Tests of a causal model. *Journal of Applied Psychology*, 83(2):150–163.
- Seddon, N. 2008. Is the future Dutch? *The Lancet*, 372:103–104.
- Sekhri, N. & Savedoff, W. 2005. Private health insurance: Implications for developing countries. *Bulletin of the World Health Organization*, 83(2):127–134.
- Sekhri, N., Savedoff, W. & Thripathi, S. 2005. *Regulation private health insurance: Policy issues for developing countries*. Discussion paper 3-2005. Geneva: World Health Organization.
- Selvakumar, J.J. 2016. Impact of service quality on customer satisfaction in public sector and private sector banks. *Purushartha: A Journal of Management Ethics and Spirituality*, 8(1):1–12.

- Seth, N., Deshmukh, S.G. & Vrat, P. 2005. Service quality models: A review. *Journal of Quality and Reliability Management*, 22(9):913–949.
- Shahin, A. 2006. *SERVQUAL and model of service quality gaps*. Retrieved from <http://www.qmconf.com/Dous/oo77.pdf> [Accessed 6 April 2016].
- Shamu, S., Loewenson, R., Machededze, R., Mabika, A. & Africa, S. 2010. *Capital flows through medical aid societies in Zimbabwe's health sector*. EQUINET discussion paper 82. Grahamstown: Rhodes University.
- Shekarchizadeh, A., Rasli, A. & Hon-Tat, H. 2011. SERVQUAL in Malaysian universities: Perspectives of international students. *Business Process Management Journal*, 17(1):67–81.
- Shostack, G.L. 1985. Planning the service encounter. *The Service Encounter*, 1:243–254.
- Shukla, P. 2008. *Essentials of marketing research*. Retrieved from bookboon.com [Accessed 12 January 2015].
- Siddiqi, K.O. 2011. Interrelations between service quality attributes, customer satisfaction and customer loyalty in the retail banking sector in Bangladesh. *International Journal of Business and Management*, 6(3):12.
- Sigala, M. 2008. Developing and implementing an eCRM 2.0 strategy: Usage and readiness of Greek tourism firms. *Information and Communication Technologies in Tourism*, 2008: 463–474.
- Singh, S., Sirohi, N. & Chaudhary, K. 2014. A study of customer perception towards service quality of life insurance companies in Delhi NCR region. *Global Journal of Management and Business Research*, 14(7):19–32.
- Stafford, M.R., Stafford, T.F. & Wells, B.P. 1998. Determinants of service quality and satisfaction in the auto casualty claims process. *Journal of Services Marketing*, 12(6):426–440.
- Storey, C. & Larbig, C. 2017. *Absorbing customer knowledge: How customer involvement enables service design success*. University of Sussex. Retrieved from <http://sro.sussex.ac.uk/id/eprint/68141> [Accessed 4 November 2017].
- Švárová, M. & Vrchota, J. 2014. Influence of competitive advantage on formulation business strategy. *Procedia Economics and Finance*, 12:687–694.
- Sweeny, J.C., Soutar, G.N. & Mazzarol, T. 2008. Factors influencing word of mouth effectiveness: Receiver perspectives. *European Journal of Marketing*, 42(3/4):344–364.
- Thai, V.V. 2016. The impact of port service quality on customer satisfaction: The case of Singapore. *Maritime Economics & Logistics*, 18(4):458–475.
- Thompson, A., Strickland, A.J. III & Gamble, J.E. 2010. *Crafting and executing strategy: The quest for competitive advantage – concepts and cases*. New York, NY: McGraw-Hill/Irwin.
- Toran, D. 1993. Quality service (quality everything!). *LIMRA'S Market Facts*, 12(2):10–11.

- Tornow, W.W. & Wiley, J.W. 1991. Service quality and management practices: A look at employee attitudes, customer satisfaction and bottom line consequences. *Human Resources Planning*, 14(2):105–115.
- Trocchia, P.J. & Janda, S. 2003. How do consumers evaluate internet retail service quality? *Journal of Services Marketing*, 17(3):243–253.
- Tsoukatos, E. & Rand, G.K. 2006. Path analysis of perceived service quality, satisfaction and loyalty in Greek insurance. *Managing Service quality: An International Journal*, 16(5):501–519.
- Urban, W. 2010. Customers' experiences as a factor affecting perceived service quality. *Economics & Management*, 15:820–826.
- Valmohammadi, C. & Beladpas, M. 2014. Customer relationship management and service quality: A survey within the banking sector. *Industrial and Commercial Training*, 46(2):77–83.
- Van de Ven, W.P.M.M. & Schut, F.T. 2008. Universal mandatory health insurance in the Netherlands: A model for the United States? *Health Affairs*, 27(3):771–778.
- Van Iwaarden, J., Van der Wiele, T., Ball, L. & Millen, R. 2003. Applying SERVQUAL to web sites: An exploratory study. *International Journal of Quality and Reliability Management*, 20(8):919–935.
- Van Looy, B., Gemmel, P. & Dierdonck, R. 2003. *Services management: An integrated approach*. London: Pearson Education.
- Varca, P.E. 2009. Emotional empathy and frontline employees: Does it make sense to care about the customer? *Journal of Services Marketing*, 23(1):51–56.
- Vargo, S. & Lusch, R.F. 2004. The four service marketing myths: Remnants of a goods-based manufacturing model. *Journal of Service Research*, 6, May: 324–335.
- Wang, R., Lin, Y.H. & Tseng, M.L. 2011. Evaluation of customer perceptions on airline service quality in uncertainty. *Procedia - Social and Behavioral Sciences*, 25:419–437.
- Warraich, K.M., Warraich, I.A. & Asif, M. 2013. Achieving sustainable competitive advantage through service quality: An analysis of Pakistan's telecom sector. *Global Journal of Management and Business Research*, 13(2):39–46.
- Weber, J.M. 2013. Defining the constructs of making, enabling, and keeping promises: A focus group application. *Journal of Services Research*, 13(2):117–130.
- Wendel, S., De Jong, J.D. & Curfs, E.C. 2011. Consumer evaluation of complaint handling in the Dutch health insurance market. *BMC Health Services Research*, 11(1):310–318.
- White, W.D. & Chao, S. 2014. *Mass customisation for management of healthcare*. U.S. patent no. 8,799,023. Washington, DC: U.S. Patent and Trademark Office.
- Whyte, G. & Bytheway, A. 2017. The V-model of service quality: An African case study. *European Journal of Marketing*, 51(5/6):923–945.

- Wieseke, G., Geigenmuller, A. & Kraus, F. 2012. On the role of empathy in customer employee interactions. *Journal of Service Research*, 15(3):316–331.
- William, O., Appiah, E.E. & Botchway, E.A. 2016. Assessment of customer expectation and perception of service quality delivery in Ghana Commercial Bank. *Journal of Humanity*, 4(1):81–91.
- Woods, D. 1997. *The future of the managed care industry: And its international implications*. London: Economist Intelligent Unit.
- Wu, H.-L., Liu, C.-Y. & Hsu, W.-H. 2008. An integrative model of customer perceptions of healthcare services in Taiwan. *The Services Industries Journal*, 28(9):1307–1319.
- Yadav, M.K., Rai, A.K. & Srivastava, M. 2014. Exploring the three-path mediation model: A study of customer perceived value, customer satisfaction service quality and behavioral intention relationship. *International Journal of Customer Relationship Marketing and Management*, 5(2):1–20.
- Yamaguchi, S., Akiyoshi, R., Yamaguchi, Y. & Nogawa, H. 2015. Assessing the effects of service quality, past experience, and destination image on behavioral intentions in the spring training camp of a Japanese professional baseball team. *Journal of Convention & Event Tourism*, 16(3):228–252.
- Yavas, U., Karatepe, O.M. & Babakus, E. 2011. Efficacy of job and personal resources across psychological and behavioral outcomes in the hotel industry. *Journal of Human Resources in Hospitality & Tourism*, 10(3):304–314.
- Yesilada, F. & Direktor, E. 2010. Health care service quality: A comparison of public and private hospitals. *African Journal of Business Management*, 4(6):962–971.
- Yousapronpaiboon, K. 2014. SERVQUAL: Measuring higher education service quality in Thailand. *Procedia - Social and Behavioral Sciences*, 116:1088–1095.
- Yuen, K.F. & Thai, V.V. 2015. Service quality and customer satisfaction in liner shipping. *International Journal of Quality and Service Sciences*, 7(2/3):170–183.
- Zeithaml, V.A. 1981. *How consumer evaluation process differ between goods and services*. Retrieved from https://www.researchgate.net/profile/Valarie_Zeithaml/publication/279912843_How_Consumers_Evaluation_Process_Differ_for_Products_and_Services/links/559d8a4108ae04e36508f5f6.pdf [Accessed 20 August 2016].
- Zeithaml, V.A., Bitner, M.J. & Gremler, D.D. 2009. *Services marketing: Integrating customer focus across the firm*. New York, NY: McGraw-Hill, Irwin.
- Zeithaml, V.A., Parasuraman, A. & Berry, L.L. 1990. *Delivering quality service: Balancing customer perception and expectations*. New York, NY: Simon & Schuster.

- Zeithaml, V.A., Parasuraman, A. & Malhotra, A. 2002. Service quality delivery through web sites: A critical review of extant knowledge. *Journal of the Academy of Marketing Science*, 30(4):362–375.
- Zhang, M., Xie, Y., Huang, L. & He, Z. 2013. Service quality evaluation of car rental industry in China. *International Journal of Quality and Reliability Management*, 31(1):82–102.
- Zhu, Z. & Nakata, C. 2007. Re-examining the link between customer orientation and business performance: The role of information systems. *Journal of Marketing Theory and Practice*, 15(3):187–203.
- Zigora, T. 1996. *Current issues, prospects, and programs in health insurance in Zimbabwe: Sustainable health care financing in southern Africa*. Washington, DC: The World Bank.

APPENDIX 1: QUESTIONNAIRE

UNIVERSITY OF KWAZULU-NATAL SCHOOL OF MANAGEMENT, IT & GOVERNANCE

Dear Respondent,

Researcher: Tsitsi Mufudza Mobile Telephone no: +263 772 721 561

Supervisor: Dr Vannie Naidoo Office Telephone no: +27 31 260 8080

Research Office: Mariette Snyman Office Telephone no: +27 31 260 8350*

I, a PhD student in Management, in the School of Management, IT & Governance, of the University of Kwa-Zulu Natal (UKZN), invite you to participate in a research project entitled:

Customer perceptions and expectations of service quality in medical insurance companies in Zimbabwe.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above.

Sincerely

Investigator's Signature :

Date : 02-02-16

UNIVERSITY OF KWAZULU-NATAL
SCHOOL OF MANAGEMENT, IT & GOVERNANCE

Supervisor: Dr VannieNaidoo Office Telephone no:+27 312608080

Researcher: TsitsiMufudza MobileTelephone no: 263 772 721 561

Research Office:MarietteSnyman Office Telephone no: +27 312608350

Title of Study:

Customer perceptions and expectations of service quality in medical insurance companies in Zimbabwe.

The purpose of this survey is to:

- Establish the perceptions of medical insurance customers on quality variables with respect to tangibles, reliability, responsiveness, assurance and empathy;
- Determine medical insurance customers' expectations of quality service offerings made by medical insurance companies with respect to tangibles, reliability, responsiveness, assurance and empathy;
- Measure the quality gaps that medical insurance clients experience in Zimbabwe; and
- Come up with strategies on how companies in the medical insurance industry can improve service quality.

This questionnaire comprises four sections:

- **Section A:**Demographic Data
- **Section B:** Customer Expectations of services offered by medical insurance companies.
- **Section C:** Customer Perceptions of services offered by medical insurance companies.
- **Section D:** General Questions about medical insurance companies in Zimbabwe and how service quality can be improved in these companies.

How to complete the questionnaire:

- You can mark each response by making a tick (✓) or a cross (X), or by encircling each appropriate response with a PEN (not a pencil), or by filling in the required words or numbers.
- Please remember to choose an answer on the scale from 1 to 5 for Section B & C
 - 1 being an answer to a statement that you **Strongly Disagree** with.
 - 5 being an answer to a statement that you **Strongly Agree** with.

Remember to answer **ALL** the questions even if they are not directly relevant to your experience. The aim is to understand how you perceive the services you are provided with.

SECTION A: DEMOGRAPHICS

Please provide only ONE option per question below in the space provided.

1. What is your age group?

| | |
|-------|--|
| <20 | |
| 21-30 | |
| 31-40 | |
| 41-50 | |
| >50 | |

2. What is your gender or sex?

| | |
|--------|--|
| Male | |
| Female | |

3. Name of Medical Insurance Company you subscribe to.

| | |
|-------------------|--|
| PSMAS | |
| CIMAS | |
| First Mutual Life | |
| Fidelity | |
| Altfin | |

4. Which sector of the economy are you employed in?

| | |
|------------------------|--|
| Private Sector | |
| Public Sector | |
| State-Owned Enterprise | |

5. Period of membership of the medical insurance company

| | |
|-------------------|--|
| 0-1year | |
| 2-3years | |
| 4-5years | |
| More than 5 years | |

6. Have you ever switched between medical insurance companies?

| | |
|-----|--|
| Yes | |
| No | |

7. If Yes to 6 above, what was the reason for switching?

| | |
|-----------------------|--|
| Poor service Delivery | |
| Change of Job | |
| Other (Specify) | |

SECTION B: CUSTOMER EXPECTATIONS OF A MEDICAL INSURANCE COMPANY

The following 22 statements will analyse what you think an ideal medical insurance company should do for you.

The scale is as follows:

| | 1 | 2 | 3 | 4 | 5 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly disagree | Disagree | Undecided | Agree | Strongly agree |
| SECTION B: EXPECTATIONS | | | | | |
| TANGIBLES | | | | | |
| 1. An ideal medical insurance company should have modern equipment. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. An ideal medical insurance company should have visually appealing facilities (buildings, counters, computers etc). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Its employees should be well-dressed, neat and have a professional appearance. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. An ideal medical insurance company has visually appealing materials associated with the service (website, brochures, and display posters). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| RELIABILITY | |
|--|--|
| 5. An ideal medical insurance company provides all medical benefits as promised in their plans. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 6. An ideal medical insurance company provides its services at the time it promises to do so. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 7. When the customer has any query, employees should be dependable in solving it. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 8. The company should perform the service right the first time. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 9. An ideal medical insurance company maintains error-free records. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| RESPONSIVENESS | |
| 10. An ideal medical insurance company keeps customers informed about when services will be performed. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 11. An ideal medical insurance company provides prompt service to customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 12. Its employees are always willing to help customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 13. It has employees who are always ready to respond to customers' requests. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

| ASSURANCE | |
|---|--|
| 14. An ideal medical insurance company has employees who instil confidence in customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 15. Its employees should make customers feel safe in their transactions. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 16. Its employees should be consistently courteous. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 17. An ideal medical insurance company has employees who have the knowledge to answer customers' questions. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| EMPHATHY | |
| 18. An ideal medical insurance company has employees who give customers individual attention. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 19. An ideal medical insurance company has employees who deal with customers in a caring manner. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 20. An ideal medical insurance company has employees who have the customers' best interest at heart. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 21. An ideal medical insurance company has employees who understand the specific needs of their customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 22. An ideal medical insurance company provides convenient business hours. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

SECTION C: PERCEPTIONS

The following 22 statements deal with the perceptions of service experienced in your health insurance company.

The scale is as follows:

| | 1 | 2 | 3 | 4 | 5 |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly disagree | Disagree | Undecided | Agree | Strongly agree |
| SECTION C: PERCEPTIONS | | | | | |
| TANGIBLES | | | | | |
| 1. My health insurance company has modern equipment. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. My health insurance company has visually appealing facilities. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. My health insurance company's employees are well dressed, neat and have a professional appearance. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. The materials associated with the service (website, brochures, and display posters) are visually appealing. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| RELIABILITY | |
|--|--|
| 5. My health insurance company provides all the medical benefits services as promised. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 6. My health insurance company provides services at the promised time. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 7. My health insurance employees' are dependable in handling customers' service problems. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 8. My health insurance company provides services right the first time. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 9. My health insurance company maintains error-free records. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| RESPONSIVENESS | |
| 10. My health insurance company has employees who keep customers informed about when services will be performed. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 11. My health insurance company provides prompt service to customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 12. The company's employees have a willingness to help customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 13. Employees are always ready to respond to customers' requests. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

| ASSURANCE | |
|--|--|
| 14. My health insurance company has employees who instil confidence in customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 15. My health insurance company has employees that make customers feel safe in their transactions. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 16. My health insurance company has employees who are consistently courteous. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 17. My health insurance company has employees who have the knowledge to answer customers' questions. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| EMPATHY | |
| 18. My health insurance company has employees who give customers individual attention. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 19. Its employees deal with customers in a caring manner. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 20. My health insurance company has employees who have the customers' best interests at heart. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 21. My health insurance company has employees who understand the needs of their customers. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 22. My health insurance company provides convenient business hours. | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

SECTION D: GENERAL QUESTIONS ABOUT HEALTH INSURANCE COMPANIES IN ZIMBABWE AND HOW SERVICE QUALITY CAN BE IMPROVED.

| | 1 | 2 | 3 | 4 | 5 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| | Strongly disagree | Disagree | Undecided | Agree | Strongly agree |
| SECTION D: GENERAL QUESTIONS | | | | | |
| | | | | | |
| 1. Health insurance services are quite beneficial to the people in Zimbabwe | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Health insurance in Zimbabwe enables patients to obtain healthcare when needed. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. There is need to improve service delivery in most health insurance companies in Zimbabwe. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. My health insurance company has proactive and not reactive customer service and retention programs. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. If health insurance companies built alliances with service providers (Doctors, Pharmacies etc), quality will be compromised. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. If health insurance companies built alliances with service providers (Doctors, Pharmacies etc) quality will be improved. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | |
|--|--|
| <p>7. Health insurance companies in Zimbabwe have customised service packages which enable them to build long term relationships with customers.</p> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <p>8. Health insurance companies in Zimbabwe can use technology to improve service quality.</p> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <p>9. Employees in my health insurance company are trained to serve customers to the best of their ability.</p> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| <p>10. The quality standards are uniform in all health insurance companies in Zimbabwe that Insurance companies have to adhere to.</p> | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |

Thankyou for your time !

APPENDIX 2:LETTER OF INFORMED CONSENT

UNIVERSITY OF KWAZULU-NATAL SCHOOL OF MANAGEMENT, IT & GOVERNANCE

Dear Respondent,

PhD in Management Thesis

Researcher: TsitsiMufudza Mobile Telephone no: +263 772 721 561
Supervisor: Dr VannieNaidoo Office Telephone no: +27 31 260 8080
Research Office:Ms P Ximba Office Telephone no: +27 31 260 3580

I, a PhD student in Management, in the School of Management, IT & Governance, of the University of Kwa-Zulu Natal (UKZN), invite you to participate in a research project entitled:**Customer perceptions and expectations of service quality in medical insurance companies in Zimbabwe.**

The aim and purpose of this research is to establish the expectations and perceptions of customers in respect of quality variables namely tangibles, reliability, responsiveness, assurance and empathy; to measure quality gaps and to come up with strategies on how service quality can be improved in medical insurance companies in Zimbabwe.

Your participation in this project is voluntary. You may refuse to participate or withdraw from the project at any time with no negative consequence. Confidentiality and anonymity of records identifying you as a participant will be maintained by the School of Management, IT & Governance, UKZN.

If you have any questions or concerns about completing the questionnaire or about participating in this study, you may contact me or my supervisor at the numbers listed above.

The survey should take you about 10 minutes to complete. I hope you will take the time to complete this survey.

Sincerely



Investigators Signature : T Mufudza

Date : 02-02-16

CONSENT

I _____ (*Name: Optional*) the undersigned have read and understand the above information. I hereby consent to participate in the study outlined in this document. I understand that participation is voluntary and that I may withdraw at any stage of the process.

Participant 's Signature _____

Date _____

APPENDIX 3: GATEKEEPERS' LETTERS



CLINICAL DIRECTOR
FOR your
attention.

5 February 2016

Dear Sir/Madam

Assistance in Conducting Survey in Hospitals in Zimbabwe



20/2

To whom it may concern

It is a requirement of our PhD qualification that the student completes a thesis based on research in a specific field of study. In this way students are given the opportunity to creatively link and discuss the theoretical aspects of the programme to the practical issues facing organisations in real life settings. Typically a thesis necessitates data gathering and the student is using questionnaires specifically.

Student name: **Tsitsi Mufudza (Student No. 214578505)** has chosen to do a research project entitled: **Customer Perceptions and Expectations of Service Quality in Medical Insurance Companies in Zimbabwe.**

Your assistance in permitting access to your organization for purposes of this research is most appreciated. Please be assured that all information gained from the research will be treated with the utmost confidentiality. The confidentiality of information and anonymity of personnel will be strictly adhered to by the student.

I trust that you will look favorably upon her application and provide her with a Gatekeeper's letter that assist her in conducting her research at hospitals in Zimbabwe.

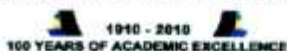
Should you need any further information or confirmation, please contact me by e-mail (naidoo@ukzn.ac.za) or by telephone at 031-2608080.

Yours faithfully,

Dr. Vannie Naidoo

Lecturer: Management and Entrepreneurship
School of Management, IT and Governance
College of Law and Management Studies
University of KwaZulu-Natal
M Block, Room M1-202, University Road, Westville Campus
Cell : +27 722566626
Email : naidoo@ukzn.ac.za

School of Management, IT & Governance



Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

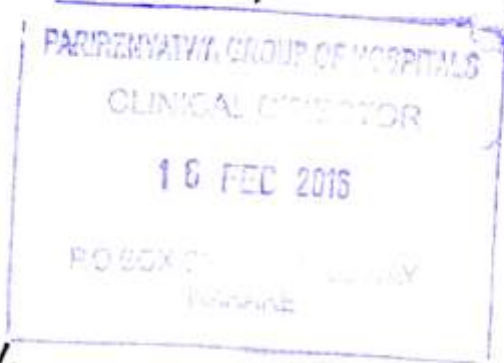
Gatekeeper's Consent

I NOAH MADZINA in my capacity as CLINICAL DIRECTOR
PARIRENYATWA HOSP hereby give permission
to Student name: Tsitsi Mufudza (Student No. 214578506) to conduct research in my organization.

The student MAY/~~MAY NOT~~ (delete whichever is not applicable) use the name of the organisation in the dissertation.
mmalpsa

Signature of Manager/Owner/Gatekeeper: *mmalpsa*

Company Stamp:



Date: 19/02/16

Gatekeeper's Consent

I Cwata PF..... in my capacity as Operations Director..... hereby give permission to **Student name: Tsitsi Mufudza (Student No. 214578506)** to conduct research in my organization.

The student MAY/MAY NOT (delete whichever is not applicable) use the name of the organisation in the dissertation.

Signature of Manager/Owner/Gatekeeper:.....



Company Stamp:



Date:

Gatekeeper's Consent

I P. MAKABELO in my capacity as CLINIC MANAGER hereby give permission to **Student name: Tsitsi Mufudza (Student No. 214578506)** to conduct research in my organization.

The student MAY/MAY ~~NOT~~ (delete whichever is not applicable) use the name of the organisation in the dissertation.

Signature of Manager/Owner/Gatekeeper: _____

Company Stamp:



Date: 16/02/16

NB: To see patients before their admission into the Wards.

Gatekeeper's Consent

I BRIGHTON TADDERERA in my capacity as GROUP HUMAN RESOURCES MANAGER hereby give permission to Student name: Tsitsi Mufudza (Student No. 214578506) to conduct research in my organization.

The student MAY/MAY NOT (delete whichever is not applicable) use the name of the organisation in the dissertation.

Signature of Manager/Owner/Gatekeeper: 

Company Stamp:



Date: 16/02/2016

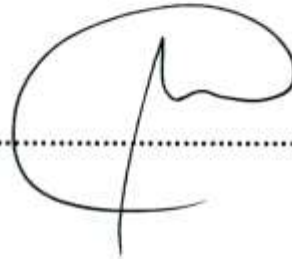
Gatekeeper's Consent

I Dr Mazvuru..... in my capacity as Head of Practice..... hereby give permission to **Student name: Tsitsi Mufudza (Student No. 214578506)** to conduct research in my organization.

The student MAY/MAY NOT (delete whichever is not applicable) use the name of the organisation in the dissertation.

Signature of Manager/Owner/Gatekeeper:.....

Company Stamp:



DR A MAZVURU & PARTNERS
DENTAL SURGEONS
3rd Floor Medical Centre
52 Baines Ave, Harare
Tel: 250975/7, 0772 113627
mazvuru@yahoo.co.uk

Date: 16-02-16.....

APPENDIX 4: ETHICAL CLEARANCE APPROVAL



19 April 2018

Mrs Tsitsi Mufudza (214578506)
School of Management, IT & Governance
Pietermaritzburg Campus

Dear Mrs Mufudza,

Protocol reference number: HSS/0309/016D

Project title: Customer perceptions and expectations of Service Quality in the Medical Insurance Sector in Zimbabwe

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 22 March 2018 has now been approved as follows:

- Change in Title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for period of 3 years from the date of original issue. Thereafter Recertification must be applied for on an annual basis.

Best wishes for the successful completion of your research protocol.

Yours faithfully

.....
Professor Shenuka Singh (Chair)

/ms

cc Supervisor: Dr Vannie Naidoo
cc Academic leader Research: Professor Isabel Martins
cc School administrator: Ms Angela Pearce

Humanities & Social Sciences Research Ethics Committee

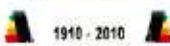
Professor Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4809 Email: ximbap@ukzn.ac.za / snymernm@ukzn.ac.za / motumpo@ukzn.ac.za

Website: www.ukzn.ac.za

 1910 - 2010
100 YEARS OF ACADEMIC EXCELLENCE

Founding Campuses  Edgewood  Howard College  Medical School  Pietermaritzburg  Westville

APPENDIX 5: ENGLISH LANGUAGE EDITING CERTIFICATE

Jackie Viljoen
Language Editor and Translator
16 Bergzicht Gardens
Fijnbos Close
STRAND 7140

Accredited member of the South African Translators' Institute
No APSTrans 1000017
Member of the Professional Editors' Group (PEG)

☎ +27+21-854 5095 📠 082 783 0263 📠 086 585 3740
Postal address: 16 Bergzicht Gardens, Fijnbos Close, STRAND 7140 South Africa

DECLARATION

I hereby certify that the thesis by **TSITSI MUFUDZA** was properly language edited but without viewing the final version.

The track changes function was used and the author was responsible for accepting the editor's changes and for finalising the reference list.

Title of thesis:

CUSTOMER PERCEPTIONS AND EXPECTATIONS OF SERVICE QUALITY IN THE MEDICAL INSURANCE SECTOR IN ZIMBABWE

The editor did not write or rewrite any part of the thesis on behalf of the client, including passages that may have been plagiarised. The academic content is the sole responsibility of the client as author of the work. The editor could not and did not test definitively for plagiarism, nor is there any explicit or implicit guarantee that the content that was edited contained no material used without consent. The editor accepts no responsibility for any failure on examination of the thesis by the university.



JACKIE VILJOEN
Strand
South Africa
28 June 2018

APPENDIX 6: TURNITIN REPORT

Customer perceptions and expectations of service quality in the medical insurance sector in Zimbabwe

ORIGINALITY REPORT

10%

SIMILARITY INDEX

8%

INTERNET SOURCES

4%

PUBLICATIONS

5%

STUDENT PAPERS

MATCH ALL SOURCES (ONLY SELECTED SOURCE PRINTED)

3%

★ Submitted to University of KwaZulu-Natal

Student Paper

Exclude quotes On

Exclude matches < 10 words

Exclude bibliography On
