EMPLOYEES SATISFACTION WITH NATIONAL HEALTH INSURANCE IN SAROVA HOTELS IN NAIROBI

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DECLARATION

I declare that this is my original work and has never been presented in any other college or examination body.

Signature: ..... Date: 10/11/11

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SUPERVISOR

This research project has been submitted for examination with my approval as the University of Nairobi supervisor.

Signature: ..... Date: 7/11/2011

DEDICATION

This research project is dedicated to my family, friends and relatives.

ACKNOWLEDGEMENT

I thank the Almighty God for seeing me through the entire period. I live for you God.

Thanks to my family for their encouragement and support during this entire period.

Many thanks too to my supervisor for his patience during this entire research period. You gave me the chance to see my best side.

In addition, thanks to my fellow staff members and friends for helping me with typesetting and proofreading of the document. This final document is as a result of your participation and input.

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ABSTRACT

The case for National Health Insurance satisfaction is considered in the light of the fact that only a small percentage of the Kenyan population is employed in the formal sector and could be covered at first. Ostroff, (2001) acknowledges that a larger percent of employers, outside government, spend on average 11% of payroll on health care for their employees. This demonstrates their lack of satisfaction with the National Health Insurance offered by the government health plans. Nevertheless, those who can readily be covered by insurance are making considerable use of the more expensive health services. The government has been in most cases concerned with ensuring the safeguard and protection of policyholder's interests by ensuring that the insurers and schemes are financially solvent and that policy holders are not exposed to loss by underwriters by being not able to meet their obligations, but not to create the atmosphere for the growth of the industry and encourage it to respond to the prevailing needs of the society in general. The objective of the study was to establish the employees' satisfaction levels with National Health Insurance in Sarova hotels in Nairobi.

The research design used in this study was the case study design. Case studies involve collection of empirical data generally from one or a small numbers of cases. It usually provides rich details about those cases, of a predominantly qualitative nature. The population comprised employees of The New Stanley and The Panafric Hotels in Nairobi which were the only hotels under Sarova chain of hotels in Nairobi County. Simple random sampling technique was used to select respondents. The data was collected through a structured questionnaire administered on a drop and pick basis which had both open and close-ended questions. Descriptive statistics data analysis was done by use of measures of central tendency which included frequencies, means and percentages. Qualitative data was analyzed by comparing responses and merging those which were alike usually in a textual or narrative form. The information was presented in tables and charts.

A total of 69 questionnaires were filled from the two hotels. Sarova Panafric was very collaborative and filled 42 questionnaires while Sarova Stanley staff filled 27. Both cases met the required threshold number of respondents. The male respondents were 52 % while the female respondents were 48%. Increasing National Health Insurance customer satisfaction requires providers to pay attention to some factors that consumer's consider important. These factors include the price of the policy, enough information about the policy coverage, quality of customer service, proximity to the insurance centers, and the past corporate image of the health insurance provider. The study found out that in Sarova hotels in Nairobi employees were not generally satisfied with the service NHIF was offering with only 17% of the respondents very satisfied and 3% extremely satisfied. The female respondents were found to be more informed about the National Health Insurance scheme compared to male respondents and used the NHIF services more frequently than males. Respondents revealed that NHIF had not thoroughly conducted enough trainings and awareness programmes. Level of education of the respondents was an influential factor in determining the level of employees' awareness of the services and subsequently the overall satisfaction levels. The general perception about NHIF as an organization is average and need to be improved to increase service satisfaction. Finally, the study found out that the overall satisfaction levels of the services offered by NHIF to the respondents were slightly below average.

Some recommendations given by the respondents included, the scheme to cover not only the inpatients but also the outpatient employees, scheme should also cater for the non formal sector and the unemployed citizens who are highly pressed by the medical bills, to improve the service efficiency within the current system and have a variety of health insurance packages. The study called for further study in the employees' perception towards Health Insurance concept, trends in modern Health Insurance schemes in the world and further study that will determine factors that attract employers to private Health Insurance providers.

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

According to Harter (2002), there is a wide variety of health care systems around the world, with as many histories and organizational structures as there are nations. In some countries, health care system planning is distributed among market participants. In others, there is a concerted effort among governments, trade unions, charities, religious, or other co-ordinated bodies to deliver planned health care services targeted to the populations they serve. However, health care planning has been described as often evolutionary rather than revolutionary. Health insurance is a cover against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care expenses among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement. The benefit is administered by a central organization such as a government agency, private business, or not-for-profit entity (Iaffaldano, 2000)

Organ (1998) cites that comprehensive health insurance pays a percentage of the cost of hospital and physician charges after a deductible (usually applies to hospital charges) or a co-pay (usually applies to physician charges, but may apply to some hospital services) is met by the insured. These plans are generally expensive because of the high potential benefit payout and because of the vast array of covered benefits. Scheduled health insurance plans are not meant to replace a traditional comprehensive health insurance plans and are more of a basic policy providing access to day-to-day health care such as going to the doctor or getting a prescription drug.

According to Srivastava (2001), these plans have taken the name mini-med plans or association plans. The term "association" is often used to describe them because they require membership in an association that must exist for some other purpose than to sell insurance. These plans may provide benefits for hospitalization and surgical, but these benefits will be limited. Scheduled plans are not meant to be effective for catastrophic events. These plans cost much less than comprehensive health insurance. They generally

pay limited benefits amounts directly to the service provider, and payments are based upon the plan's "schedule of benefits". Compulsory health insurance is a system by which medical and hospital care would be available to all who desire it, the cost being paid by employers, employees and, possibly, government. Compulsion would stem from the fact that everybody would be required to pay taxes regardless of whether or not he sought medical care. Cash sickness benefits refers to a system by which those covered would be entitled to weekly benefit payments in case of illness (Ejiofor,1996).

In Kenya, (Ostroff , 2001), found that the poorest of the poor category makes 16 hospital visits every year but use Sh1,637 every year to pay for their health care services. The "rich" make the lowest number of hospital visits averaging 9.6 and use Sh2,704 on average per visit. In between the two groups are the "lower middle" income group who visit 14 times and pay Sh3,565 per visit. The "middle income" make 10.4 visits and pay Sh3,073 each time, while the "second rich" makes 10 visits and pays Sh3,635 for each. The study was being done to inform government plans to launch a National Social Health Insurance Fund (NSHIF) which would have imposed a social tax on the employed in order to provide universal health care to all Kenyans.

1.1.1 Employee health insurance satisfaction

Employee's health plan satisfaction varies widely among some insurers across the world due to various factors. Contacting members regularly and increasing their understanding of plan details can lead to more consistent and positive satisfaction ratings, more renewal business and additional sales of services to members (Debue, 2001). Majority of health plan members rate their insurer lowest for the communications and information that are provided to help them understand their plan. About 45 percent of members fully understand how to use their health insurance coverage and member services. Enhancing member understanding with critical plan details—such as prescription coverage, co-pays, how to locate physicians and how to appeal coverage denials—can lead to higher satisfaction ratings for insurers (Organ, 1998). Health insurer performance fluctuates greatly—even among different regional plans from the same insurance company—and this lack of service consistency can present a real challenge for human resources

executives attempting to select the best health benefits for their employees working in multiple regions across the country (Ryan,1996). With increasing healthcare costs and an aging workforce that needs additional services, businesses have less and less tolerance for insurers that are not consistently engaging members and helping them manage their own health care and the associated costs. However, those plan members who are most engaged by their insurer through effective communication better understand how to use their plans and have particularly high satisfaction levels. Higher satisfaction scores translate into better retention rates and more positive recommendations for the plan (Srivastava, 2001).

A study carried out in New England (Mishra, 2000) revealed that there is a significant decline in overall satisfaction and this is partially driven by a lack of members' understanding of their plan services and benefits and how to successfully access them. Despite the overall decrease in satisfaction, some plans perform particularly well, mainly because of their focus on building relationships through member education, communication and reliable, consistent delivery of health insurance products and services. According to the study, health plan members in Pennsylvania, Michigan and New England remained the most satisfied with their health plan experience overall, although the average satisfaction score in each region has decreased significantly in 2010, compared with 2009. Member satisfaction continues to improve in the Illinois-Indiana region—the only region to experience an increase (Mishra, 2000).

1.1.2 National Health Insurance Fund in Kenya

National Health Insurance is covered by National Hospital Insurance Fund (NHIF) which is a State parastatal that was established in 1966 as a department under the Ministry of Health. The original Act of Parliament that set up this Fund in 1966 has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. NHIF's core function is to collect contributions from all Kenyans earning an income of over Ksh 1000 ($12) and pay hospital benefits out of the contributions to members and their declared dependants (spouse and children) (www.nhif.go.ke).

Whilst ensuring that Kenyans of all walks of life have access to quality and affordable healthcare, NHIF operates under the social principle that "the rich should support the poor, the healthy should support the sick and the young should support the old." (www.nhif.go.ke).

1.1.3 The Sarova chain of hotels

The term hotel chain traits back its origins to the 1920s where a great trend began which shifted individual ownership of hotels to corporate ownership as a result of increasing costs of building and operating hotels. As the corporate world took over the hotel business, they did not believe in a single hotel at a single location but a chain of hotels at different locations with the same name but not necessarily with the same capacity and product range. Chain operations of 'hotels allows for efficient management through the use of mass purchasing, central reservations and billings, and extensive advertising and promotion campaigns. Today about 30 percent of all American hotels and motels are affiliated with chains or franchised groups. (Dante, 1998).

Sarova chain of hotels is the leading hotel and lodges chain in Kenya and East Africa it is also one of the most innovative hotel chain, offering guests' diverse experiences. Sarova Hotels currently has over a thousand rooms in eight hotels in East Africa. Their motto "refreshing African hospitality is embraced in the corporate culture of Sarova Hotels and it is evident in the service standards across all the Sarova properties. Sarova Hotels currently has eight affiliates located in different parts of Kenya with only two hotels located at the heart of Nairobi; they include the Victorian age-old elegance of Sarova Stanley and the epitome of neo-Africa at Sarova Panafric hotel which will be used as samples in this study (www.sarovahotels.com)

Hotel workers provide hospitality and other service to travelers. Employees work as room cleaner, maintenance worker or desk clerk etc, and help to ensure that hotel operations run smoothly and meet customers' expectations. But, in order to keep hotel functioning at its best, employer need to insure his workers to stay safe and healthy in the job. The

biggest risk health for hotel workers is normally ergonomic injuries from sprains, strains, and repetitive work (Söderlund, Et al. 2000)

1.2 Research problem

The case for National Health Insurance is considered in the light of the fact that only a small percentage of the Kenyan population is employed in the formal sector and could be covered at first. Ostroff, (2001) acknowledges that a larger percent of employers, outside government, spend on average 11% of payroll on health care for their employees. This demonstrates their lack of satisfaction with the National Health Insurance offered by the government health plans. Nevertheless, those who can readily be covered by insurance are making considerable use of the more expensive health services.

In Kenya, majority of private firms -including hotels- and a few public corporations are turning to private insurance providers as the National Health Insurance services have become weak and ineffective (Wanjohi,2002). According to *Hotel and Club Voice* magazine published in New York City (1998), hotels and clubs in New York City formed their own health insurance program that offered preventive medicine, regular health information program for members of the hotel which had contracts with the health insurance. This program did only serve the hotel members, but their families as well, and received the Health Center's services. Information about the facility is freely disseminated through the monthly newsletters and pamphlets that are distributed at the Health Center and Insurance Fund Office on such subjects as prenatal care, heart disease, overweight, underweight, diabetes, and tuberculosis and Blood Bank services as preventive measures. This significantly increased the satisfaction rating of their health insurance program.

Koima (2003) studied challenges in the regulation of the insurance industry in Kenya. He found out that the government has been in most cases concerned with ensuring the safeguard and protection of policyholder's interests by ensuring that the insurers and schemes are financially solvent and that policyholders are not exposed to loss by underwriters by being not able to meet their obligations, but not to create the atmosphere for the growth of the industry and encourage it to respond to the prevailing needs of the

society in general. Maina (2005) established factors that determine perceived quality of service in the insurance industry in Kenya, the case of Nairobi province. The resulting validated instrument comprised of six dimensions: assurance, personalized financial planning, competence, corporate image, tangibles and technology. Further the results of analytical hierarchy process highlighted the priority areas of service instrument with assurance is the best predictor, followed by competence and personalized financial planning. The study showed that there is ample room for improvement in all the aspects related to service quality. The results will help the service managers to efficiently allocate attention and resources among the dimensions on the differential basis, consistent with the customer priorities. These findings can be transformed into effective strategies and actions for achieving customer satisfaction.

To the researcher's knowledge, none of the studies had been done aimed at establishing the satisfaction level of National Health Insurance. This study seeks to identify the extent to which employees are satisfied with National Health Insurance, factors that have led organizations/employers to obtain the same services offered by National Health Insurance to private firms in Kenya, and through recommendation establish areas of improvement in National Health Insurance plan to ensure improved employee satisfaction with the service.

1.3 Objective of the study

To establish the employees satisfaction levels with National Health Insurance in Sarova hotels in Nairobi.

1.4 Value of the study

The study will make a significant contribution to hotel managers and employees, as it will provide a lot of insight about health insurance satisfaction. National Health Insurance providers (NHIF) will know through this study the areas of improvement and hence improve satisfaction of their clients. Consequently the study will encourage adoption and acceptance of National Health Insurance in informal and formal sectors of economy. This study will also add to the existing knowledge and stimulate further research on health insurance satisfaction.

CHAPTER TWO: LITERATURE REVIEW

2.1 Insurance concept

Insurance companies continue to play an important role in the development of the economy. According to Irukwu (1975), insurance plays two vital roles. First, insurance act as an economic device which is vital to the survival of other businesses. By accepting to bear the financial loss of the insured persons and institutions, insurance provides stability to individuals, industries and commercial undertakings. Secondly, insurance as a financial institution accumulate funds which they invest in the economy, in government and in privately owned industries. According to Ejiofor (1975), insurance plays a role in teaching and motivating people to save and invest and encouraging responsible family headship and property ownership. Ogunlana (1973) suggests that in addition to the conventional roles, African insurance industry should become one of the vital weapons in war against under development as represented in poverty, disease, illiteracy, unemployment, adverse balance trade and similar economic features prevalent in Africa. The insurance industry has an important role in the economic and social development of any country, among the roles as stated by Kibera (1996) include; risk transfer, creation of common pool, peace of mind and business continuity, loss of control, social benefits of pension management and education.

2.2 National Health Insurance concept

National Health Insurance is a system by which medical and hospital care would be available to all who desire it, the cost being paid by employers, employees and, possibly, government. Compulsion would stem from the fact that everybody would be required to pay taxes regardless of whether or not he sought medical care. Cash sickness benefits refer to a system by which those covered would be entitled to weekly benefit payments in case of illness (Iaffaldano, 2000).

Comprehensive health insurance pays a percentage of the cost of hospital and physician charges after a deductible (usually applies to hospital charges) or a co-pay (usually applies to physician charges, but may apply to some hospital services) is met by the insured. These plans are generally expensive because of the high potential benefit payout

and because of the vast array of covered benefits. Scheduled health insurance plans are not meant to replace a traditional comprehensive health insurance plans and are more of a basic policy providing access to day-to-day health care such as going to the doctor or getting a prescription drug. In recent years in the USA, these plans have taken the name mini-med plans or association plans. The term "association" is often used to describe them because they require membership in an association that must exist for some other purpose than to sell insurance. These plans may provide benefits for hospitalization and surgical, but these benefits will be limited. Scheduled plans are not meant to be effective for catastrophic events. These plans cost much less than comprehensive health insurance. They generally pay limited benefits amounts directly to the service provider, and payments are based upon the plan's "schedule of benefits (Iaffaldano, 2000).

In United Kingdom (UK) National Health Service (NHS) is a publicly funded healthcare system that provides coverage to everyone normally the resident. It is not strictly an insurance system because there are no premiums collected, the costs are not charged at the patient level and and costs are not pre-paid from a pool. However, it does achieve the main aim of insurance which is to spread financial risk arising from ill-health. The costs of running the NHS (est. £104 billion in 2007-8) are met directly from general taxation. The NHS provides the majority of health care in the UK, including primary care, in-patient care, long-term health care, ophthalmology, and dentistry. Private health care has continued parallel to the NHS, paid for largely by private insurance, but it is used by less than 8% of the population, and generally as a top-up to NHS services. There are many treatments that the private sector does not provide. For example, health insurance on pregnancy is generally not covered or covered with restricting clauses. (Murphy, 1990).

To maintain the attractiveness of the risk pool to different segments of the population with different expected costs, health coverage providers typically vary premiums based on factors associated with differences in expected health care costs, such as age, gender, health status, occupation, and geographic location. For example, on average the expected health costs of people over age 50 are more than twice as much as the expected health costs of people under age 20. In cases where the individual is paying the full premium for

coverage, health coverage providers will want to charge a higher premium to people who are older to recognize the higher expected costs. If premiums are not varied to account for the differences in expected costs, the pool may attract a disproportionate share of older, more expensive people, raising the average cost in the pool and making coverage in the pool less attractive to younger people (who would have to pay a premium that exceeded their expected average health care costs). This is another form of adverse selection and would lead to a breakdown of the risk pooling. Other examples of underwriting include health coverage providers charging different premiums to small employers based on the industry of the employer or on the employer's prior health claims (Ostroff, 1992).

2.3 Health insurance in Kenya

According to Mutiga (2003), Kenya has had a history of health financing policy changes since its independence in 1963. Recently, significant preparatory work was done on a new Social Health Insurance Law that, if accepted, would lead to universal health coverage in Kenya after a transition period.Questions of economic feasibility and political acceptability continue to be discussed, with stakeholders voicing concerns on design features of the new proposal submitted to the Kenyan parliament in 2004. For economic, social, political and organizational reasons a transition period will be necessary, which is likely to last more than a decade. However, important objectives such as access to health care and avoiding impoverishment due to direct health care payments should be recognized from the start so that steady progress towards effective universal coverage can be planned and achieved.

Health coverage providers pool the health care risks of a group of people in order to make the individual costs predictable and manageable. For health coverage arrangements to perform well, the risk pooling should result in expected costs for the pool that are reasonably predictable for the insurer and relatively stable overtime (e.g., the average level of health risk in the pool should not vary dramatically from time to time, although costs will rise with overall changes in price and utilization)(Wong, 1999). To accomplish this, health coverage providers strive to maintain risk pools of people whose health, on average, is the same as that of the general population. Said another way, health coverage

providers take steps to avoid attracting a disproportionate share of people in poor health into their risk pools, which often is referred to as adverse selection. For obvious reasons, people who know that they are in poor health will be more likely to seek National Health Insurance than people who are healthier. If a risk pool attracts a disproportionate share of people in poor health, the average cost of people in the pool will rise, and people in better health will be less willing to join the pool (or will leave and seek out a pool that has a lower average cost).A pool that is subject to significant adverse selection will continue to lose its healthier risks, causing its average costs to continually rise. According to Wong (1999), this is referred to as a "death spiral."In practice, health coverage providers often have multiple risk pooling arrangements. They may establish separate arrangements for different markets (e.g., individuals who buy on their own, small businesses, and trade associations) and for different benefit plans within markets (e.g. plans with different levels of deductible).

In part, this product differentiation protects the health coverage provider because problems in one risk pooling arrangement will not have a direct effect on people participating in another pooling arrangement. Health coverage providers use underwriting to maintain a predictable and stable level of risk within their risk pools and to set terms of coverage for people of different risks within a risk pool. Underwriting is the process of determining whether or not to accept an applicant for coverage and determining what the terms of coverage will be, including the premium. As discussed below, both state and federal laws circumscribe the ability of health coverage providers to reject some applicants for coverage or to vary the terms of coverage (Stanton, 1994).

A primary underwriting decision involves whether or not the health coverage provider will accept an applicant for coverage. Health coverage providers typically underwrite each person seeking to purchase coverage in the individual insurance market (where people buy insurance on their own), reviewing the person's health status and claims history. If an applicant is in poor health, a health coverage provider (subject to state and federal law) may decide not to offer coverage. However, in most states, a health coverage provider also may choose to accept the applicant but vary the terms of coverage -- they

may offer coverage at a higher than average premium (called a substandard rate), exclude benefits for certain health conditions or body parts (called an exclusionary rider), or do both. As discussed below, state and federal laws generally require health coverage providers to accept small employers applying for coverage, so the underwriting decisions are more limited to determining the premium and other terms of coverage (though these actions are also limited by law in many states).

2.4 Factors affecting National Health Insurance satisfaction

Increasing insurance customer satisfaction requires providers to pay attention to a few factors that consumers consider important. For example, customers tend to rate providers based on the price of the policy, because most people want the lowest prices possible. They also tend to want good information coverage, through which most informal sector customers will consider whether the policy meets their needs before they commit to it. Consumers also typically choose a company that makes it easy to contact customer service representatives and the proximity to the insurance branch, leading insurance customer satisfaction also have relied on the past corporate image on National Health Insurance provider. These factors have been compressively discussed below (Srivastava, 2001)

2.4.1 Awareness on National Health Insurance

The organizational efforts of the informal sector's operators themselves are the principal means whereby informal sector workers will be able to bring about changes in their working and ling conditions. While protective approaches cannot significantly change the social situation, they can dramatically reduce its pernicious effects on informal sector workers allowing them to perform safer tasks under healthy and protected conditions innovative means to prevent occupational accidents and diseases and environmental hazards need to be developed through cost-effective and sustainable measures at the work-site level. There have been limited attempts to deal with the informal sector in the area of health promotion and protection, although, never with a comprehensive strategy. However, evidence suggests, that with the appropriate support, informal sector workers can move from a situation of mere survival to a stronger economic position enhancing

their contribution to economic growth and social integration, as well as participating in the improvement of their own working and living conditions (Francis, 2005).

The level of a person's education may determine his/her ability to understand the benefits of risk management and savings. A higher level of education might therefore increase an individual's level of risk aversion. Education may also increase the demand for pure death protection by lengthening the period of dependency, as well as increasing the human capital of, and so the value to be protected in the primary wage earned (Halawani et al, 2000) find a positive relationship between health insurance penetration and the level of education. National Health Insurance penetration should rise with the level of income, for several reasons. First, an individual's consumption and human capital typically increase along with income. This can create a greater demand for insurance (mortality coverage) to safeguard the income potential of the insured and the expected consumption of his/her dependents. Second, health insurance may be a superior good, inasmuch as increasing income may explain an increasing ability to direct a higher share of income towards retirement and investment-related insurance products. Finally, the overhead costs associated with administrating and marketing insurance make larger size policies less expensive per Shilling of insurance in force, which lowers the price of health insurance policies. Höfter (2006), Holley et al (2004), Truett and Truett (1990) and ILO (2000) have all shown that the demand for health insurance is positively related to income, using both aggregate national account data and individual household data.

Maina (2003) conducted a research on factors that determine perceived quality of service in the Insurance Industry in Kenya. The study established that the factors that customers consider important when judging quality of service in the insurance industry were efficiency, fast action on complaints and prompt service. On the other hand, the factors considered unimportant are confidentiality, communicating at least once a year and employee discretion in solving customer problems. The IRA Report (2008) acknowledges that the insurance industry suffers from poor image which can be reversed through public education and campaigns on insurance and insurance products. While as the study found that customers have very good knowledge about insurance and the type

of insurance covers, it found that the same customers were not well informed on features of insurance covers: i.e. Bonus, premiums, maturity date and benefits among.

In 2002, the Ministry of Health with the support of donor partners initiated a number of countrywide programs to compact priority problem in preventive health care and promote awareness in health issues. Since then a modest increase in the number of institution and facilities in Kenya has been witnessed. This is illustrated by the growth of the number of private health facilities now standing at 7.1 per cent of the entire health care sector, compared to 2.5 percent in the previous year. There were 481 hospitals, 601 health centres and 3273 dispensaries in the country. A health work environment facilitates optimal physical and mental health in relation to work and adaptation of work to the capabilities of workers in light of their state of physical and mental health.. Educators, managers, employers, learners, parents and stakeholders have a duty of ensuring that the rights and dignity of all affected or infected persons are respected (Jack, 2000).

Learning institutions and work places are therefore encouraged to facilitate access to information on health as well as when and where employees and learners seek treatment promptly for treatment (WHO, 2001). There may be situations where worker wish at their on initiative to be tested including as part of voluntary testing programs. Voluntary testing is normally carried out by community health services and not at workplace. Where adequate medical services exist, voluntary testing may be undertaken at the request and with written information consent of the worker, with advice from the workers representative if so requested. It is performed by suitably qualified personnel with adherence to strict confidentiality and disclosure. Gender sensitive pre-and post-test counseling, which facilitates an understanding on the nature and purpose of the disease tests, the advantages and disadvantages of the tests and the effect of the result upon the worker, should form part of an essential part of any testing procedure (Jütting, 2004). After setting the promotional objectives, an organization must decide on how much to spend. Determining the ideal amount for the budget is difficult because there is no precise method to measure the exact results of spending promotional dollars, (Ekman, 2004; Barrientos, 2000). With promotional pricing, companies will temporally price their

product below list price and sometimes even below cost to create buying excitement and urgency.

Promotional activities forms part of marketing which will become handy in finding out the factors influencing poor uptake of National Health Insurance in informal sector into NHIF. In Uganda most policy holders did not know how much they were paying, what was covered or how to make claims. The insurance agent MFI staff pension also knew little and therefore would be of no much help (Höfter,2006). There are a number of marketing tools that can be used to reach potential members. These would include a few traditional methods like brochures, Newsletters, the occasional exhibition and aggressive public relations effort. He goes on to say that the techniques available have largely been ignored by public organizations because of their distaste for marketing. These organizations that have taken marketing enthusiastically provide excellent examples of just what marketing can achieve by the sensitive tools available. NHIF has engaged in promotion activities according to their marketing department. These activities include show stands in agricultural shows in Kenya, they also distributes brochures and magazines on their products through local radio stations (www.nhif.co.ke)

2.4.2 Payable Premiums on National Health Insurance

In the narrowest sense, (Gaal, 2004) pricing is amount of money charged for a product or service. More broadly, price is the sum of all the values that customers give up in order to gain the benefits of having or using a product or service. Historically, price has been the major factor affecting buyers' choice. In recent decades, non price factors have gained increasing importance. However pricing will remain one of the most important elements determining a firm's market share and profitability. Normand and Busse (2000) cite pricing problems, adverse selection, and moral hazard to explain slow growth of the life insurance market in the USA. In Kenya, observed insurer behaviour also suggests that this market may be characterized by pricing problems. For example, consumers offer evidence that similar life insurance policies are sold at significantly different prices across insurers.

Statistical analysis revealed that income and age had significant influences on the sum assured. The higher an individual's income the greater the amount of insurance he can afford. Age is considered in premium determination hence has a bearing on the size of policy that can be afforded. Most policyholders (63.5%) were of the view that the cover on their lives was just enough while 33.3% felt it was inadequate. On the other hand, most insurance companies (75%) were of the view that most of their clients were inadequately covered with 25% of them being of the opinion that they were covered adequately. No case of over insurance was noted. The low income class in Kenya has continuously increased with 56% of Kenyan earning less than 1 dollar per day, With, 70% of the health care seekers in Kenya going to the alternative health care providers like herbalists, traditional healers and wish doctors due to inability to afford or access main stream health facilities, (RA, 2008). The low and the middle income patients are in dire need of medical health facilities. The Nairobi city council clinics offer medical services at government subsidized rates and serve these lower income earners, who may not afford the medical fees in private hospitals (WHO, 2004). Forty percent of the poor in the unplanned settlement in Kenya do not access to medical care due to poverty (cost versus income level) and absence of health care facilities. According to the second report on poverty 2002, 26.4% do not seek medical care because the illness was minor, 22.2 % purchased drugs over the counter, while 11.4 percent failed to seek medical care due to long distance between themselves and the facilities. In fact, there are few doctors in attendance and drugs are in short supply and thus making health care to the poor a precarious business, (Wiesmann and Jütting, 2000)

The impact on global economic activity should also be limited. First, the depreciation of the dollar has softened the impact of the oil price surge on other consuming countries. Second, the price rise has been driven by sustained strong demand growth rather than supply shortfalls. Third, compared with the oil price surge in the late 1970s, economies today are much less energy intensive. Fourth, in the case of the United States, the low season of gasoline consumption during September –October has so far kept retail gasoline prices comfortably below the highs set in May 2006. Sharp supply-induced rise in oil prices could result in a global slowdown, as income is redistributed to oil- exporting economies, which have a lower propensity to spend than oil-importing economies.

Higher oil prices would also raise the cost of production and put upward pressure on the aggregate price level. This would cause central banks to increase interest rates. Together with the direct impact on production costs, higher interest rates would then further dent economic activity in the short run.

This sector appears as highly commercialized and therefore discourages survivalist (Rondinelli and Kasarda, 1993). The survivalists are in form of people unable to secure regular wage employment or access to economic sector of their choice. These enterprises group appears as small businesses employing between one to four paid employees, they are predominantly in the trade related activities. Despite the gloomy nature of the benefit derivable from globalization by cities in developing countries it is important to note that these cities with Lagos as an example has benefited enormously from this process. This nature of workers and business enterprises are not able to fund the health insurance cost and do not have adequate information on the importance of the National Health Insurance.

2.4.3 Branch network in National Health Insurance

It is not appropriate to identify the formal sector as the "modern" sector, as opposed to the informal sector which is supposed to be "non-modern". As deplorable as it may be, it is a fact that sweatshops producing garments or components for the automobile industry, or assembling printed circuit boards in back alleys in Paris, New York or Macau, are a more "modern" phenomenon than a steelworks (WHO, 2004). The growth of the informal sector since the 1980s has two main causes: the global economic crisis is one; the way production is being organized by transnational capital is another. The world economic crisis is the result of political decisions: it is political decisions which have led to the debt crisis of the so-called developing countries, driven the structural adjustment programs of the IMF and the World Bank and led to the global crisis which started in Asia in 1997, continued in Russia in 1998 and hit Brazil at the beginning of this year. According to an ILO estimate, this crisis destroyed 24m. Jobs in East Asia alone, mostly in the "modern industrial" sector (in the terminology of the report) (Van Ginneken, 1999).

The most important general statement that can be made about informal sector workers, which is valid under any definition and crucial in terms of organizing, is that the majority of them are women workers. A majority of workers expelled from the formal sector by the global economic crisis are women. Women are the principal victims of the precarization of labour and the pauperization created by the crisis and has therefore massively entered the informal sector in the last two years (ILO, 2000). Even before the crisis, however, women constituted most of the informal labour force (child labour is also strongly represented). The very great majority of home workers are women (and home work represents as much as 40 to 50% of labor in certain key export sectors, such as garments and footwear, in Latin America and Asia) women are also the great majority of street vendors in informal markets as indicated by ILO (2000).

Regional variances in mortality experience occur in all countries including the more developed countries. In the less developed countries, however, there is also the glaring urban/ rural disparity so that infant and child mortality rates in the rural areas are about a third higher than those for cities. In the recent years a further twist has been added to the question of disparities in the form of growing number in settlement in most of large cities. The mortality experience of the urban poor often exceeds that of the villages in spite of the relative proximity of the former to healthcare facilities (Iriart et al, 2001). In Manila the infant mortality rate is three times higher in the squatter area than in rest of the city. Unequal distribution of health facilities resulting in disparities of health care is usually due to political and social economic factors. But disparities also indicate poor planning and management of health resources (Nuri, 2002). Similarly forces also operate at the Regional and District level as at National Level, leading to differences in health experience between communities (Okello and Feeley, 2004). The promise of a networked global market space is that it enables the exchange of goods, services and information from companies anywhere to customer anywhere at any time and at the lowest price.

National Health Insurance has 32 branches in Kenya headquarter being in Nairobi. Location is an important concept and forms one of 4ps in marketing. The placement of channels of distribution elements concerns how products and services are delivered to the markets to make them available for exchange, (Savas et al, 2002). Most products do sell

directly to final consumers. In between them stands a chain of market intermediaries. Many scholars have come up with various definition of distribution. There are classic location factors including availability of raw materials, Transportation, marketing, energy, labor capital, technical knowledge, demand, completion, government influence, tradition, random factors and perception. The extent to which any is important or prioritized varies by industry or individual company management (Sekhri and Savedoff, 2005). NHIF as observed earlier has 32 branches. Also at present there are attempts to increase branches network through introduction of Satellite/window offices. At present there are 42 such offices which are later are to be upgraded to fully pledged offices.

2.4.4 Corporate Image on National Health Insurance

Organization that have good image will attract clients. To achieve that fate, the targeted clientele must have a good perception of the organization concerned. Corporate image is formed in a customer mind through a procedure whereby information is processed and organized into meaning in basis of categories (Sekhri and Savedoff, 2005). It is described as the overall impression made on the mind of customers. It is related to traditional, ideology, and business name, and reputation, Variety of services and to the impression of quality communicated by each person. Reputation is closely tied to image in that it affects customer expectations with regard to quality of service offering (Söderlund and Hansl, 2000).

An image has two components: functional and emotional. Functional component is related to tangible characteristics that can easily be measured, while emotional component is associated with psychological dimensions that are manifested in feelings and altitudes towards a company. Corporate image is therefore the result of an aggregate process by which customers will compare and contrast various attributes of the companies. The measurements of corporate Image in service industries is challenging mainly because of the distinctive features that distinguish services from goods. Intangibility is a well documented features acknowledged in the service marketing literature (Vladescu et al, 2000)

With services consumers are constrained with lack of objective attributed to base their evaluation of image, and in such situation must resort to tangible extrinsic cues from there judgments. To that end the contact personnel along with the tangible cues associated with the physical environment where the service is produced and consumed become silent. Similarly the relationships formed during the services encounter are also central in the customers evaluation of the quality of services received and can affect customer's perception of the image. Zweifel (2005) observes that reputation is considered by growing number of management practitioners and scholars to be an intangible asset that enables the enactment of relationships among the corporation and the public.

A company's reputation is therefore a variable asset yet many companies are relatively an aware of how they are perceived. He further observed that some corporations suffer from serious image problems. In the eyes of many they are seen as exploiters, having cat bosses. Reputation does not originate from corporate communications (office or the marketing plan or individual behavior). Reputation comes from experience, thought process and values of people who see themselves as stakeholders. Reputation according to him leads to liking and disliking and a sense of comfort or concern with what is perceived.

Kenya has previously been a fertile ground for multinational companies selling there drugs at prices not affordable by the middle and lower income groups. With the liberalization of the economy, there has been a huge penetration in Kenya of companies which produce generic pharmaceutical products. This has resulted in a very stiff competition with companies rejuvenating their marketing activities like never seen before. The marketing of patented and generic products is very different and observes that influencing the pharmacist choice between generic marketers. The Kenyan multinational companies, mostly dealing with patented products have targeted the market segment of higher income earners through the channels of private hospitals.

Up to 1995 NHIF has been dogged by image problem arising from fraudulent claim payment to hospitals. In 1995, the Ministry of Health commissioned an investigation into those allegations. The findings led to a major crackdown on the concerned Hospitals and

HHIF officials. This action by the government attracted wide negative publicity among the general public. However, the government has since then put into place measures that have since changed the whole scenario including computerizing its entire operations and putting financial controls in place as well.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Research Design

The research design used in this study was the case study design. Case studies involve collection of empirical data generally from one or a small numbers of cases. It usually provides rich details about those cases, of a predominantly qualitative nature (Yin,2004). Yin (1994) defines a case study as an empirical enquiry that investigates a contemporary phenomenon within its real life context, when the boundaries between phenomenon and context are not clearly evident, and in which multiple sources of evidence is used. A case study generally aims to provide insight into a particular situation and often stresses the experience and interpretations of those involved. It may generate new understandings, explanations or hypothesis. According to Eisenhardt (2003), case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships.

3.2 Population

The population comprised employees of The New Stanley and The Panafric Hotels in Nairobi which were the only hotels under Sarova chain of hotels in Nairobi County. The New Stanley hotel had two hundred employees and thirty four employees in all the seven departments while The Panafric hotel had two hundred and seventeen employees. For this study the employees were homogeneous and therefore the department factor did not matter and the respondents were selected randomly.

3.4 Sample

Simple random sampling technique was used to select respondents. According to Ary, Jacob and Razeria (1992), ten to twenty percent of the sample representation is adequate. The following calculation was used to obtain the minimum number of respondents in each hotel

$$\frac{\text{Number of employee in a hotel}}{100} \times 10$$

That is, in The New Stanley hotel the minimum number of respondents was:-

$$\frac{234 \text{ X } 10}{100} = 23.4 \approx 25 \text{ respondents}$$

In The Panafric hotel the minimum number of respondents was:-

$$\frac{217 \text{ X } 10}{100} = 21.7 \approx 22 \text{ respondents}$$

Least number of respondents expected was be forty seven, twenty five form the New Stanley hotel and twenty two from the Panafric hotel. To ensure the least number of respondents was exceeded, more questionnaires were given out and do adequate follow up.

3.5 Data Collection

The study used primary data. The data was collected through a structured questionnaire administered on a drop and pick basis. The questionnaire had both open and close-ended questions. Questionnaires are more objective in gathering information in a standardized way. The questionnaire had section A and B, with the first section collecting demographic characteristics of the respondents and the later collecting data on the employee satisfaction on National Health Insurance satisfaction. An introduction letter was attached to the questionnaire guaranteeing the respondents their privacy and confidentiality.

3.6 Data Analysis

The data was to be checked for accuracy and completeness of recording of the responses, it was then coded and checked for coding errors and omissions. The researcher used both quantitative and qualitative data analysis techniques for this study because both approaches will complemented each other. Quantitative data analysis included descriptive statistics. Descriptive data analysis was done by use of measures of central tendency which including frequencies, means and percentages. Qualitative data was analyzed by comparing responses and merging those which were alike usually in a textual or narrative form. To present the information, frequency tables, charts, graphs, words and figures were used.

CHAPTER 4: DATA ANALYSIS, RESULTS AND DISCUSSION

4.1 Demographic information

A total of 69 questionnaires were filled from the two hotels. Sarova Panafric was very collaborative and filled 42 questionnaires while Sarova Stanley staff filled 27. Both cases met the required threshold number of respondents. The male respondents were 52 % while the female respondents were 48%. The respondents were from all the departments since the questionnaires were distributed randomly. Level of education varied significantly among the respondents where 16% had their highest level of education being secondary school level, 68% had diploma education, 13% had university education and only 3% had their highest education level as masters' degree level. Length of service among the respondents indicated that there was high staff turnover in the hotel sampled by having 62% of the respondents having worked in their current hotel for a period below 3 years and only 3% had over ten years in their current employment.

4.2 NHIF use frequency

It was noted that a significant number of employees samples (41%) had never used the NHIF services while the majority (45%) indicated that they very rarely use the services, occasionally users were 6% and frequent users were 9%. 74% of the respondents did not use the NHIF services when they last visited the hospital. 26% however consumed the NHIF services the last time they visited the hospital. The big percentage of the respondents who did not use NHIF services the last they visited the hospital may due to the fact that they may be outpatients which the scheme does not cover, this sturdy however did not cover the extent of the sickness whether the respondents were inpatients or outpatient when they last visited the hospital. A trend was noted whereby majority 79% of those who consumed the NHIF services last time they visited the hospital were women. This may because women mostly use the services during the child delivery period.

4.3 Awareness on National Health Insurance

A reasonable number (38%) of the respondents indicated that they were not informed on how to claim or use the National Health Insurance Fund. 32% were slightly informed,

13% somehow informed, 16% were well informed and 1 % claimed to be highly informed. There was some relationship between the level of education and level of awareness of NHIF services. Respondents who had their highest education level of education being a university degree and masters education did not register in not informed. 68% of the respondents who said they were not informed about NHIF services were males. The only respondent to indicate that he was highly informed about NHIF claiming process and services was a female Hr manager in job description with a university degree as the highest level of education. Level of awareness and gender are presented in table below

Table 1: Level of awareness and gender

Level of awareness	Male (%)	Female (%)	Total (%)
Highly informed	--------	1	1
Well informed	6	10	16
Somehow informed	6	7	13
Slightly informed	15	17	32
Not informed	26	12	38

n = 69

The frequency in which the respondents received information about the National Health Insurance scheme faired very poorly where rarely and very rarely where 55% moderately were 26% and frequently were 19%. No respondent indicated that he receives information about National Health Insurance scheme very frequently.

4.4 Payable premiums on National Health Insurance

The majority of the respondents (35%) were ok with the charges that were levied by the health scheme. However, there was a significant number of respondents who felt that they were highly charged (26%) and over charged (10%). 20% felt that the services are slightly cheap while 9% said that National Health Insurance scheme is very cheap. It was noted that that majority (83%) of the respondents who had secondary school as their highest level of education felt highly charged and over charged. This is probably because

they are lower in organizational ranks and may be receiving smaller remuneration that makes them sensitive to any deduction from their salaries.

4.5 Corporate image on National Health Insurance

The general perception and image about the National Health Insurance scheme is generally average (55%) but bending towards below average (23%) and poor (3%)

However a significant number of respondents believes the performance of NHIF have been good (16%) and excellent (3%). This perception was the overall view of the respondents about the NHIF, the study did not however establish the core reason for poor perception. It could have been the perception about the insurance scheme as a whole or due to the running and the management perspectives of the scheme.

4.6 Satisfactions with National Health Insurance Scheme

The satisfaction levels and gender have been summarised by the table below.

Table II: Satisfaction level and gender

Satisfaction level	Male (%)	Female (%)	Total (%)
Extremely satisfied	------	3	3
Very satisfied	7	10	17
Moderately satisfied	13	20	33
Slightly satisfied	24	12	36
Not satisfied at all	7	4	11

n = 69

The satisfaction level among the respondents did not fair very well, neither very bad. Majority (36%) was slightly satisfied and moderately satisfied (33%). A good number (17%) of the respondents were very satisfied and extremely satisfied (3%), never the less, 10% indicated that they were not satisfied at all by the services offered by the NHIF.

Both hotels sampled had subscribed to another private insurance firm to cover medical expenses of their staff. This shows that there was dissatisfaction or insufficiency in the services that the NHIF offered that drive the employer to seek the same compulsory services to a private firm.

CHAPTER 5: SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

The case for compulsory health insurance is considered in the light of the fact that only a small percentage of the Kenyan population is employed in the formal sector and could be covered at first. Ostroff, (2001) acknowledges that it is shown from a survey of larger employers, outside government, that they spend on average 11% of payroll on health care for their employees. This demonstrates their lack of satisfaction with the compulsory health insurance offered by the government health plans. Nevertheless, those who can readily be covered by insurance are making considerable use of the more expensive health services. In Kenya, majority of private and a few public corporations are turning to private insurance providers as the compulsory health insurance services have become weak and ineffective (Wanjohi,2002).

Increasing insurance customer satisfaction requires providers to pay attention to some factors that consumers consider important. These factors include the price of the policy, enough information about the policy coverage, quality of customer service, proximity to the insurance centre, and the past corporate image of the health insurance provider. This study investigated the level of satisfaction of the employees obtaining the national health insurance at the Sarova hotels in Nairobi.

5.2 Conclusion

Insurance industry is one of the vital weapons in war against under development as represented in poverty, disease, illiteracy, unemployment, adverse balance trade and similar economic features prevalent in Africa. Significant preparatory work was done on a new Social Health Insurance Law that, if accepted, would lead to universal health coverage in Kenya after a transition period. Questions of economic feasibility and political acceptability have not yet been tacked. Majority of private firms (including hotels) and few public corporations in Kenya are turning to private insurance providers as the National Health Insurance services have been seen as weak and ineffective.

The purpose of this study was to establish the employees' satisfaction levels with National Health Insurance in Sarova hotels in Nairobi. Factors that determine perceived quality of service of the National Health Insurance industry in Kenya comprised of some validated instrument dimensions including: payable premiums, ease of access, corporate image, and awareness. The results of analysis highlighted the priority areas of service improvement to ensure improved employees satisfaction. In Sarova hotels in Nairobi employees were not satisfied with the service NHIF was offering with only 17% of the respondents very satisfied and 3% extremely satisfied. Reason provided for low satisfaction included, inefficiency in their internal processes leading to excessive delays in service provision that eventually motivates the employers to register with private health insurance providers, lack of variety of insurance packages that forces everyone to single scheme and lack of inpatient cover among other reasons.

The female respondents were found to be more informed about the national health insurance scheme compared to male respondents and used the NHIF services more frequently than males. Probably because they use and update their profile with scheme when they are about to give birth unlike males. Respondents revealed that NHIF had not thoroughly conducted enough trainings and awareness programmes and respondents were confused on how to start the compensation process. The main information about NHIF services is found on their website and on brochures. Many people still do not have easy access to computer and internet while the brochures are not widely distributed. Payable premiums to National Health Insurance are not a major factor that inhibits employees' satisfaction with NHIF services. 35% of respondents said that they were OK with paid premiums, 20% said slightly cheap and 9% said very cheap. Level of education of the respondent was an influential factor in determining the level of employees' awareness of the services and subsequently the overall satisfaction levels. Level of education affect the level of general knowledge and so about the health scheme this was perceived to be caused by lack of information concerning the National Health Insurance.

The general perception about NHIF as an organization is average and need to be improved to increase service satisfaction and increase membership subscription from the

informal sector. The overall satisfaction levels of the services offered by NHIF to the respondents, was slightly below average. The study showed that there was ample room for improvement in all the aspects related to service quality. Those results would help the service managers to efficiently allocate attention and resources among the dimensions on the differential basis, consistent with the customers' priorities. Those findings could be transformed into effective strategies and actions for achieving high customer satisfaction.

5.4 Recommendations

The main objective of any firm is to serve its clients and ensure satisfaction with the services they have rendered. To improve satisfaction of the employees with the National Health Insurance scheme, respondents provided the following recommendations.

The scheme would need to cover not only the inpatients but also the outpatient employees (76%). Females are the frequent users of the service mostly during child delivery time where they are only covered for the boarding facility only. 29% of the sample indicated that they would like the scheme to cover all expenses including the prescription and consultancy expertise. Of the 58% sampled recommended the improvement of the service efficiency within the current system including the provision of the membership cards and obtaining the financial support on time when they are in need.

The NHIF slogan "Young should support the old, and the healthy to support the sick", had not been achieved, and therefore 52% of the respondents recommended that the scheme should extend the medical cover of its members even after their retirement age when they need the monetary support most. Further to this, 19% recommended to the scheme to have a system to cover all citizens of the country, and not only the employees in formal employment. Having a single compulsory package was the single reason cited by respondents for the rare use of the facility since there was no alternative package this prompted the employers to look for alternative medical cover despite having the compulsory one. Another reason cited by the respondents for preferring the private firms was their promptness of services that private firms offer to the clients especially in cases of emergency. In this regard NHIF is recommended to provide such services.

19% of respondents suggested that the scheme should also cater for the non formal sector and the unemployed citizens who are highly pressed by the medical bills. However to cater all the citizens there would be need to increase the contribution and so, 14% of the respondents suggested that the government should support the scheme through funding to complement employees deductions.

5.5 Areas for further research

This study aimed at establishing the level of satisfaction of employees with the National Health Insurance and collected data from the Sarova hotels in Nairobi. There are other studies done in this field including the study by Koima (2003) who studied challenges in the regulation of the insurance industry in Kenya and Maina (2005) established the factors that determined perceived quality of service in the insurance industry in Kenya, the case of Nairobi province. However, study need to be done to establish employees' perception towards Health Insurance concept. This study calls for further study on the trends in Health Insurance schemes in the world. Study needs to be done on the best methods of covering medical expenses in developing countries and finally, this study calls for further study that will determine factors that attract employers to private Health Insurance providers.

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QUESTIONNAIRE

The main objective of this questionnaire is to determine the level of National Health Insurance Satisfaction in Sarova hotels in Nairobi.

Please tick (√) appropriately on the space provided.

SECTION A: DEMOGRAPHIC INFORMATION

1. Gender

   Male ( ) Female ( )

2. Respondents Job title _____

3. Highest level of education

   a) ( ) Secondary Level
   b) ( ) College diploma
   c) ( ) University degree
   d) ( ) Master degree

4. Number of years worked in this hotel

   a) ( ) below 3 Years
   b) ( ) 4 -6 years
   c) ( ) 7- 10 years
   d) ( ) More than 10 years

SECTION B: NATIONAL HEALTH INSURANCE PROVISION

5. How frequent do you use the National Health Insurance services?

   a) ( ) Very Frequently
   b) ( ) Frequently
   c) ( ) Occasionally
   d) ( ) Very Rarely
   e) ( ) Never

6. The last time you visited a hospital, did you pay using your National Health Insurance providers (NHIF) card?

   ( ) Yes ( ) No

7. To what extent do you think you know the process of claiming the benefits of National Health Insurance?

   a) ( ) Highly informed
   b) ( ) Well informed
   c) ( ) Somehow informed
   d) ( ) Slightly informed
   e) ( ) Not informed

8. How often do you receive information (through Media/ Training) about the National Health Insurance?

   a) ( )Very frequently
   b) ( )Frequently
   c) ( ) Moderately
   d) ( ) Rarely
   e) ( ) Very rare

9. How would you rate the monthly charges levied by the compulsory health plan (NHIF) in correspondence to the quality of services they offer?

   a) ( ) Very cheap
   b) ( ) Slightly cheap
   c) ( ) OK
   d) ( ) Highly charged
   e) ( ) Over charged

10. (a) Have your hotel subscribed to another (private) health insurance provider?

   ( ) Yes ( ) No

   (b)If yes, who pays for the premiums?

   a) ( ) Hotel
   b) ( ) Deductions from salary
   c) ( ) Personal arrangement
   d) ( ) Any other (Please specify)

   .....

11. (a) In your opinion, is it necessary for you to acquire the health insurance services from private firms, apart from the compulsory plan?

( ) Yes ( ) No

(b) If your answer above is yes, for what reason would you require another private health insurance services? Please explain.

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12. In your opinion generally, how would you rate the performance of National Health Insurance plan (NHIF) in the last ten years?

a) ( ) Excellent
b) ( ) Good
c) ( ) Average
d) ( )Below average
e) ( ) Poor

13. What is your satisfaction level with National Health Insurance plan (NHIF) in Kenya?

a) ( ) Extremely satisfied
b) ( ) Very satisfied
c) ( ) Moderately satisfied
d) ( ) Slightly satisfied
e) ( ) Not satisfied at all

14. Which are the main areas of improvement would you recommend to the National Health Insurance providers (NHIF) to improve on?

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Appendix 1 – Letter of Introduction to Respondents

UNIVERSITY OF NAIROBI

School of Business

P.O BOX 30197

Nairobi, Kenya

Muchai Peter M.

P.O BOX 12224-0400

Nairobi.

Tel: 0720 672621

Dear Respondent,

RE: **REQUEST FOR YOUR PARTICIPATION IN MBA RESEARCH PROJECT**

I, Peter M. Muchai, am a post graduate student at the School of Business, University of Nairobi pursuing Master of Business administration. I am conducting a research project titled "***Employee satisfaction with National Health Insurance***" in partial fulfillment of course.

Your organization has been selected to form part of this study. Therefore, I kindly request you to assist me to collect data by filling out the accompanying questionnaire.

The information provided will be used exclusively for academic purposes and will be held in strict confidence. A copy of the final paper will be availed to you upon request.

Your cooperation is highly appreciated.

Thank you.

Yours faithfully,

Muchai Peter
MBA Student
University of Nairobi – School of Business

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Supervisor