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Factors Influencing Civil Servants' Perceptions of National Health Insurance Schemes: A Case Study of the Tanzania Industrial Research and Development Organization (TIRDO), Tanzania

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ABSTRACT

In today's world of modern and ever-changing competitive business environment, workers' health is central to every organization. This study aimed to assess factors affecting civil servants perception towards national health insurance at Tanzania Industrial Research and Development Organization (TIRDO) in Tanzania with a sample of 50 respondents from five departments with a total population of 200 people. The study was guided by gap model of service quality as its theoretical framework. A descriptive design was employed using quantitative data collection methods including questionnaires. The study used simple random sampling and purposive sampling to select participants to give answers and explanations concerning the study. Data was analyzed quantitatively using the Statistical Package for Social Sciences (SPSS). The responses from both questionnaires was assessed and the tool evaluated for reliability and consistency of responses/answers, the number of participants lost in understanding the meaning of the questions was informed the quality of the testing tool. The findings revealed that factors such as waiting time before offered service, hospital visiting frequency, modality of admission, clients' attitude towards the service providers, tangibility, reliability and responsiveness highly affected the perception of respondents towards health insurance schemes. It was recommended that civil servants should have an option to choose a health insurance scheme of their choice. There is also a need to establish permanent functional structures of insurance to constantly engage the scheme management, health care providers and subscribers in order to minimize the mistrust and improve uptake of service delivery. The study concluded that factors affecting perception of NHIF users should be worked upon to create good working environment for employees and their wellbeing in general as when they are healthy, then they become productive as they do not have to worry of health circumstances.

Keywords: National Health Insurance, Economic Growth, Perception

I. INTRODUCTION

Globally, over 1.3 billion people lack access to quality health care because the majority of household are financially unstable. Health insurance is a tool that enables people to guard against the high cost of illness by sharing risks through payroll deductions from employees' employers and an equity fund with the ultimate goal of achieving universal health coverage. Moreover, a significant portion of those who do seek out and pay for medical care risk bankruptcy and improve fitment (Fatima et al, 2019), those who are under privilege financially or who don't use health services at all. While many others may opt to forego some services or have less severe cost ramifications owing to health issues, people of all income levels want protection from financial risks connected with disease in 2005, the member states of the World Health Organization (WHO) adopted a resolution acknowledging this and asking countries to establish finance systems in order to achieve universal health coverage (WHO, 2020).

The debate among historians over the reasons for the repeated failures of national health insurance (NHI) proposals in the United States is complex and multifaceted. Several key factors contribute to these failures. Firstly, the issues surrounding national health insurance are highly complex involving intricate policy details and far-reaching implications for the economy and society. Secondly, there are significant ideological differences among political leaders and policymakers with divergent views on the role of government in providing health care. Additionally, the lobbying power of special interest groups particularly those representing the private insurance and pharmaceutical industries has played a major role in obstructing national health insurance initiatives. These groups have invested heavily in campaigns to influence public opinion and policy decisions in their favor (Shewamene et al , 2021).

Moreover Sui et al, (2021) asserts that the leadership has often been weakened in its ability to push through comprehensive health reform either due to political opposition, lack of support from congress or other factors that limit presidential power. The decentralization of congressional power also complicates the passage of national health legislation, as it disperses authority across many lawmakers, making it difficult to build the necessary consensus for such sweeping reforms. Despite these challenges, the American public has consistently shown support for the goals of

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universal health care and government involvement in health financing as evidenced by opinion polls dating back to the 1930s. This public support highlights a disconnect between the desires of the population and the actions of policymakers.

On a global scale particularly developing countries are facing severe crises in funding their public health services. This crisis is characterized by a decline in the availability of low-cost, high-quality health services which disproportionately affects the poor. As governments struggle to maintain adequate funding for public health services, the quality and accessibility of these services deteriorate leading to increased health disparities and unmet health needs among the most vulnerable populations (Zhang et al, 2022).

Okafor et al (2021) emphasizes that there are two approaches to the problem of ensuring that people have adequate access to health care. The first approach is for the government to attempt to gradually nationalize all health care services ultimately ending with fully taxpayer found state- owned health services. The second approach is to establish a health care environment in which private care funds and provision can rapidly serving an increasing percentage of the population to the point where all health services are privately provided .Numerous studies conducted across the globe have identified a range of factors that significantly influence insurance coverage, particularly in the context of health insurance. These factors encompass economic, social, and administrative dimensions, each contributing in various ways to the extent and quality of insurance coverage available to a population.

One of the primary factors identified is the level of income within a country alongside its rate of economic growth. In nations where income levels are higher and the economy is growing steadily both individuals and the government possess a greater capacity to prepay for insurance. This enhanced financial ability enables broader access to insurance coverage as citizens can afford premiums, and the government can subsidize or directly fund insurance programs, thereby expanding coverage (Alex & Mwamfupe 2020).

Alawode and Adewole, (2021) insists that the structure of a country's economy is another crucial determinant. In countries with a predominantly formal sector, where most individuals are employed in regular, wage-earning jobs, insurance coverage tends to be higher. This is because formal employment often comes with structured benefits, including health insurance, as part of employment contracts. In contrast, in countries with large informal sectors, particularly in developing regions, many individuals do not have formal, stable income. As a result, these individuals are less likely to have access to insurance leading to lower overall coverage. The disparity is especially pronounced in developing countries, where informal employment is widespread, and social safety nets are often weaker.

Population distribution also plays a significant role in influencing insurance coverage. Ampaw et al,(2020) highlights that highly populated urban areas, residents are more likely to have easier access to insurance services due to the concentration of healthcare facilities, insurance providers, and infrastructure. Urban centers typically have better connectivity, making it easier for people to enroll in insurance schemes and access healthcare services. On the other hand rural areas with dispersed populations face greater challenges. The lack of infrastructure, lower density of healthcare facilities, and logistical difficulties in reaching remote areas contribute to lower insurance coverage in these regions.

Social solidarity within a society is also an influential factor. Solidarity refers to the willingness of individuals within a society to support one another particularly in the context of health insurance. According to Frichi et al (2019), in societies with a high level of innate solidarity, there is a greater acceptance of cross-subsidization, where healthier or wealthier individuals contribute more to support those who are less healthy or financially disadvantaged. While policymakers can enforce solidarity through laws and policies, such as mandatory insurance schemes, the success and sustainability of these initiatives often depend on the underlying social cohesion. Without a sufficient degree of solidarity, it becomes challenging to maintain the cross-subsidization required for schemes like social health insurance to function effectively.

Effective government leadership is essential in launching and guiding the process toward achieving compulsory health insurance for all. McIntyre et al, (2018) insists that a transparent and open political environment where debates on health insurance are encouraged and financial information is readily available helps build trust among the population. This trust is crucial for the successful implementation of social health insurance as it encourages citizens to participate in and support the system. The confidence of the population in the government and other agencies involved in the implementation of national health insurance is pivotal to its success.

Finally all of these factors economic conditions, population distribution, administrative capacity, social solidarity, and government stewardship have a direct or indirect impact on the quality of care provided by different insurance schemes and health providers. They also affect employment rates, public awareness, and knowledge about health insurance, as well as the overall educational status of individuals within a society. Numerous studies have shown that these elements are critical in determining not just the extent of health insurance coverage, but also the effectiveness and sustainability of that coverage in improving health outcomes for the population (Kiyoya, 2019: Lidofsky et al, 2019). Understanding and addressing these factors can help developing countries such as Tanzania, shape and improve their

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national health schemes to be flexible and suitable to their citizens and hence develop positive perception towards the schemes.

1.1 Statement of the Problem

In today's world of modern and ever-changing competitive business environment, a healthy society is a wealthy nation in term of resources and productivity. As a result, every nation looking to grow economically should work to enhance the health of its people so that they can support that growth (Douthit et al, 2015). Achieving universal health coverage through affordable health care is the goal of the third sustainable Development Goals (SDGs) agenda. Closing the gap in access to medical care is the goal. Despite its good intentions, affordability and uncertainty remain as the key challenges in fulfilling this agenda.

In order to guarantee that their citizens have universal access to basic and high-quality healthcare, nations all over the world have implemented a variety of health financing strategies, such as social health insurance. While developed nations like Australia and Canada have effectively funded their citizens' health needs through a combination of public and private health insurance systems. Despite that, socio-economic obstacles in developing nations continue to restrict access to health care through health insurance (Kagaigai, 2021).

The challenges associated with health insurance both globally and in developing countries like Tanzania, are multifaceted and deeply rooted in both financial and non-financial factors. These challenges significantly hinder the effectiveness and accessibility of health insurance coverage particularly in regions where the economic and social infrastructure is underdeveloped (Howick et al, 2020).

Amani et al. (2020) highlights that cost of insurance is one of the primary challenges in fulfilling an effective health insurance scheme. In many developing countries, the high costs associated with health insurance pose a significant barrier to widespread coverage. The economic situation in these countries exacerbates this issue as many individuals cannot afford to pay for insurance. This is especially true in countries like Tanzania where the rate of unemployment is very high, limiting people's ability to contribute to insurance schemes. When large portions of the population are unemployed or underemployed, the financial resources needed to support national or community-based health insurance systems are insufficient. Consequently, these systems struggle to provide comprehensive coverage to the entire population.

Beyond the issue of poverty, there are several non-financial factors that also contribute to the lack of adequate health insurance coverage. One such factor is the general perception of health insurance, particularly in its early days of introduction. In many communities, especially in developing countries, there was and sometimes still is a negative perception of health insurance. This skepticism can stem from a lack of understanding of how insurance works, cultural beliefs, or past negative experiences with insurance providers. This early resistance has had a lasting impact, making it difficult to achieve broad acceptance and enrollment in health insurance schemes (Fatima et al , 2019).

Kiyoya, (2019) emphasizes on how drug shortages pose a challenge to insurers. These shortages can occur due to supply chain issues, inefficiencies within the health system, or even mismanagement by insurance agents or service providers. When insured individuals are unable to access the necessary medications due to these shortages, their trust in the insurance system diminishes. This lack of trust further discourages people from enrolling in or continuing with health insurance plans thereby limiting coverage.

The absence of adequate infrastructure, such as pharmacies and health facilities, also contributes to the challenges of health insurance in developing countries. Even when people are insured, the lack of accessible healthcare infrastructure means they may not be able to fully utilize the benefits of their insurance. This gap in infrastructure is particularly pronounced in rural areas, where healthcare facilities are sparse and often under-equipped. Without the necessary infrastructure to support the effective delivery of healthcare services, the value of health insurance is significantly diminished, leading to underutilization and dissatisfaction among the insured (Girma,2020).

Generally the challenges facing health insurance in developing countries like Tanzania are deeply intertwined with both economic conditions and systemic issues within the health system. The high costs of insurance combined with widespread poverty and unemployment, create significant financial barriers to coverage. At the same time non-financial factors such as negative perceptions of insurance, drug shortages, lack of infrastructure, fraudulent activities, and systemic inefficiencies further complicate the situation. These challenges collectively limit the effectiveness of health insurance schemes and hinder their ability to provide comprehensive, accessible healthcare to all segments of the population (George, *et al*., 2021).

1.2 Research Objective

To determine factors influencing perception of civil servants towards national health insurance schemes. A case study of TIRDO in Tanzania.

II. LITERATURE REVIEW

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2.1 Theoretical Review

In 1985, Parasuraman, Berry and Zeithaml postulated the gap model of service quality (Parasuraman et al., 1985). According to the model, it explains on how different gaps between customers' expectations and perceived services affect service quality of health services and insurance coverage. For instance a gap between management's view and what customers expect. This is the discretionary between what patients' desire and what the healthcare provider believe they require. This arises when the management does not correctly analyze what the customer wants. This is not a unique notion about services. The needs of the customer may not always be properly seen by management simply because insurance schemes do not properly communicate customer needs to health facilities hence limited or ineffective service delivery (Martin,2016).

The model is applicable to the study as it useful to insurance providers to evaluate customers experience and identify areas of improvement. It has proven itself to be an ideal tool for the management of customer satisfaction. It tackles the difference between what the customers expect and what they perceive was delivered.

2.2 Empirical Review

Bhaisare and Rangari (2019) conducted a survey in Maharashtra to gauge the knowledge and familiarity of health insurance beneficiaries with the state health insurance system. According to the report, insurance members required more expensive hospital services as a result of the agency's subpar treatment. These findings simply that a mandated insurance scheme will boost government health workers' productivity in order to retain their clientele. Still the majority of Tanzania's public hospitals offer better services now than they did a few years ago. Additionally, many public and private health facilities in Tanzania accept health insurance through the NHIF, providing members with greater access to high-quality care from any facility of their choosing.

Shewamene et al. (2021) conducted a study on the variables affecting health insurance quality. Even with South Africa's strong economic position, the country's health insurance system still appears to be subpar when compared to other countries with similar economic standing. We found in this study that beneficiaries were not adequately involved in the creation of healthcare policies. Consequently, those who get insurance are valuable customers who ought to be involved in the creation of policies. Based on the kind of packages they receive; this study will assist you in determining the extent to which healthcare providers accurately comprehend the services to which they are entitled from medical facilities.

75% of patients in a study by Douthit et al. (2015) in the United States of America using a case study methodology to assess patients' opinions of health coverage were found to be quite satisfied with the effectiveness of health insurance programs. Never less, prior to the Civil Rights Act 1965, which instituted a number of reforms, the problem in America was the unjust insurance service provided too racially and ethnically mixed communities, with white residents being disproportionately wealthy.

A study by Spaan et al. (2012) in Asia and Africa found that employee donations are a liability to lower class civil servants because they do not receive the same level of service as higher-ranking employees. The study used a survey design to find out consumer views of health services. The latter can always access these facilities at any hospital. On the other hand, studies reveal they while insurance facility costs are the same, a shortage of medical professionals occurs in many rural and semi urban areas. Applying this to Tanzania, the government of the late president Dr. Magufuli has done a fantastic job of bolstering the infrastructure and medical facilities, even though the problem of subpar health services in outlying areas unavoidable.

A study on patients' perceptions of the caliber of medical care provided in public healthcare institutions was conducted in Mbeya by Tungu et al. (2020). The findings showed that 56.8% of respondents thought public hospitals provided insufficient services. The main causes of this agreement were the absence of new facilities, the overall conduct of healthcare personnel, the hospital's operation hours, a lack of qualified medical staff and insufficient communication networks. Because the study participants were patients at different Mbeya health institutions, the conditions of the participants at the time had a significant impact on the study's outcomes. This has helped to explain why beneficiaries who will be healthier by the time they participate in the study rather than patients are being used in it to void any potential emotional reactions.

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III. METHODOLOGY

3.1 Research Design

The study employed descriptive survey design which comprises describing, observing and explaining individuals' behavior of a subject. This design was beneficial since it is constructed at a single case study. According to Kombo and Tromp (2006), descriptive research design was helpful to save time and resources by letting the researcher gather information from one place and respondent only once in a time. The selected research design was employed also is sought to be useful in realizing the individual employee feelings and perceptions in regard the subject matter under study.

3.2 Study Population and Sample Size

The population for this study comprised of all employees from TIRDO including every department so as to obtain a vast knowledge on how the understand how health national insurance operates and how willing are they joining these schemes. This has made a researcher critically analyze on they perceive these schemes and propose ways of improving them. According to Tanzania Industrial Research and Development Organization Staff registers, the total number of the available population in the study area is 200 working employees under five departments.

The list of employees from each department was selected randomly by using playing cards method to ensure simple random sampling of the respondents from the study area therefore 50 respondents were selected to participate in questionnaire method of data collection.

Table 1

Showing Number of People Taken as the Sample from each Department

TIRDO Departments	Total number of Workers	Estimated sample size
Top management	24	6
industry and research	38	10
ICT and technology	34	8
Engineering	28	7
HR	40	10
Finance	36	9
Total	**200**	**50**

3.3 Data and Collection

Data for this study were collected using questionnaires. Questionnaires were employed to gather structured information from a diverse group of respondents, including employees and heads of departments. These questionnaires featured both closed and open-ended questions, allowing for a comprehensive understanding of the participants' views (Kothari, 2004).

3.4 Data Analysis

After data collection process, data analysis process takes place. Primary data was verified for accuracy after the data gathering activity before being coded, entered, and verified for analysis. For proper data administration, organization, and housekeeping, Ms. Excel was used. This enabled the researcher to establish relationships between the variables used in the study. In the data analysis process simple percentages, descriptive analysis and explanations was used. The simple quantitative classifications of data, distribution and the measures of dispersion were used in measure of the variables under the study.

IV. FINDINGS & DISCUSSION

4.1 Demographic Characteristics

Basically, this part focused on questions related to the respondents' age, sex and level of education. Also, working experiences of respondents were collected. These were found to be important in helping to draw an analysis and conclusion.

4.1.1 Gender of Respondents

The distribution of gender among participants in the table 2 shows that 62% were male and 38% were female. This indicates a higher gender imbalance, with more males participating in industrial sectors compared to females. This

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finding may imply that at TIRDO which was the population chosen for the study has potential disparities in participation and decision-making processes between male and female as the number of male is way greater than female.

Table 2
Gender of Respondents

Gender	Frequency	Percent
Male	31	62.0
Female	19	38.0
Total	50	100.0

4.1.2 Age

The age distribution of participants in the table 3 showed that the majority fall within the age range of 36-45 years (38%), followed by those aged 26-35 years (32%), 46-55 years (24%), 18-25years (4%) and 56 years and above (2%). This distribution suggests that a significant proportion of respondents are within the mid-career stage which may have implications for leadership development, succession planning, and knowledge transfer within the organization.

Table 3
Age Level of Respondents

Age Level	Frequency	Percent
18-25	2	4.0
26-35	16	32.0
36-45	19	38.0
46-55	12	24.0
56 and above	1	2.0
Total	50	100.0

4.1.3 Education Level

The findings also presented education levels, the data in the table 4 indicated that 52% of respondents hold a bachelor's degree, followed by postgraduate qualifications (36%), diploma (6%), certificate (4%) and standard seven (2%). This distribution highlights the relatively high educational attainment among respondents which could signify a well-educated workforce within the study area at TIRDO. However, it also raised questions about inclusivity and diversity in decision-making processes, considering the underrepresentation of individuals with lower educational qualifications therefore their perceptions towards national health insurance cannot be seen and analyzed to get important details.

Table 4
Education Level of Respondents

Education Level	Frequency	Percent
Standard seven	1	2.0
O level	2	4.0
Diploma	3	6.0
Bachelor	26	52.0
Master's degree and above	18	36.0
Total	50	100.0

4.1.4 Working Experience

On examining working experience table 5 reveals that a significant proportion of participants have between 16 and above years 17(34%), followed by those with 11-15 years 15(30%), 6-10 years 7(14%), and 5 years and below 10 (20%). This distribution suggests a mix of early-career professionals and mid-career experts' respondents in the study, indicating a potential blend of fresh perspectives and seasoned insights during discussions.

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Table 5
Working Experience of Respondent

Working Experience of Respondent	Frequency	Percent
5 years and below	10	20.0
6 – 10 years	7	14.0
11 – 15 years	15	30.0
16 and above years	17	34.0
5	1	2.0
Total	50	100.0

4.2 Factors Influencing Perception of Civil Servants towards National Health Insurance Schemes

This objective of the study aimed at assessing factors influencing perception of civil servants towards national health insurance schemes. As indicated in table 5, respondents revealed their views on factors influencing perception of civil servants towards national health insurance schemes by measuring variables such as waiting time before offered service, hospital visiting frequency, modality of admission, clients' attitude towards the service providers, tangibility, reliability and responsiveness.

Table 5
Factors Influencing Perception of Civil Servants towards National Health Insurance Schemes

No	Variable	Scale	Frequency	Percentage
1	Waiting time before offered service	Below an hour More than an hour	20 30	40 60
2	Hospital visiting frequency	Once More than once	15 35	30.6 69.3
3	modality of admission	Referred Un referred	8 42	15.2 84.8
4	Clients attitude	Positive attitude Negative attitude	5 45	10 90
5	Tangibility	Health reception Amenities Communication equipment	28 15 8	55 30 15
6	Reliability	Wards hygiene Availability of pharmaceuticals	38 12	75 25
7	Responsiveness	Inpatients Outpatients	30 20	60 40

4.2.1 Waiting Time Before Offered Service

Respondents revealed that waiting time before service below an hour was 40% and more than an hour was 60% to get treatment for health service which made NHIF beneficiaries very dissatisfied to wait for long to get treatment. Also respondents who visited the hospital more than once were more dissatisfied than those who visited once.

4.2.2 Hospital Visiting Frequency

Data findings indicated that 69.3% declared to be dissatisfied after frequent visits compared to 30.7% who visited once. This creates negative perception towards NHIF as customers find out weaknesses in different important departments that have been neglected.

4.2.3 Modality of Admission

Moreover, 15.2% of referred clients are dissatisfied with treatment compared to 84.8% un referred patients this simply because referred client do not get the services that they expected to be served at accredited facilities. Sometimes shortage of equipment and health workers make NHIF beneficiaries develop negative attitudes towards the scheme.

4.2.4 Clients' Attitude towards the Service Providers

90% of clients had negative attitudes towards health providers because of frequent bad customer care they received; this made them become highly dissatisfied with time. Moreover some health providers had negative attitudes towards NHIF beneficiaries simply because the scheme always delayed to initiate payments on time so they neglected to serve NHIF clients. This made respondents to regard the scheme as disorganized and even fail to encourage others to enroll because of disruptions now and then.

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4.2.5 Tangibility

55% of respondents declared to be pleased with the health reception as it is welcoming and directive towards services while 30% were also pleased with amenities such as clocks, chairs and benches that were available to serve the customers and only 15% were satisfied with communication equipment such as displays and speakers that give information to patients of whom is going to be serve next. However some facilities lacked such devices that made respondents develop bad perception as they failed to get information on time and do a follow up. The local method of shouting by heath service providers is noisy and very unprofessional.

4.2.6 Reliability

The reliability of wards hygiene consisted only 75% of respondents that were pleased but 25% of them were unhappy with the cleanliness of toilets especially male wards and congestion of some wards. Moreover 25% were satisfied with the availability of pharmaceuticals as most of the medicines were not reliable either out of stock or not covered by the scheme of which this created discomfort when attending health services probably fearing to opt for out of pocket during treatment.

4.2.7 Responsiveness

In addition to that only 40% of inpatients declared to be satisfied with staff responsiveness compared to 60% of outpatients that used NHIF scheme for treatment. Data findings showed that some health staff were overwhelmed when serving in patients who needed maximum care and attention and long assistance so they get tired and fail to be efficient compared to serving outpatients.

4.3 Discussion

The study highlights various factors influencing perception of civil servants towards national health insurance schemes at Tanzania Industrial Research and Development Organization (TIRDO).

Data findings indicate that that NHIF users 'satisfaction with health services is significantly influenced by the length of time they must wait for a service. The health service NHIF beneficiaries at authorized health care facilities were divided into two main groups as those who received care in less than 60 minutes and those who received care in more than 60 minutes. In spite of this, the study gathered various claims from NHIF beneficiaries regarding the types of services and departments indicating significant challenges in providing prompt responses to clients' demands.

The results of the study also demonstrate that NHIF recipients' satisfaction levels are significantly influenced by the rate of recurrence to the health care especially in public hospitals. In other words, NHIF recipients' can readily compare the current situation with the state of service at the time of the most recent visitation. The study findings revealed that 69.3% were dissatisfied with NHIF services after frequent visits compared to 30.6% who were satisfied. Also respondents who visited once health centers' were more satisfied than those who attended frequently. These findings correspond with a study by Kiyoya, (2019) who assessed NHIF beneficiaries' satisfaction in accredited facilities.

The study's findings showed that NHIF beneficiaries' satisfaction levels were significantly influence by their attitudes towards service providers. The study's findings indicate 90% of the 50 patients who expressed dissatisfaction with the medical staff were not satisfied while only 10% of NHIF beneficiaries' were satisfied and had a positive attitude towards the service providers. In addition to that even Amani et al, (2020) emphasizes on how service providers can make patient feel glad to be served by them or not. It is how they are taken care of and handled that can persuade more NHIF beneficiaries to recommend a certain health facility or to crush it and not convince others to be treated there.

Similarly, it was discovered that in authorized healthcare facilities, the mode of admission was highly statistically significant predictor of the NHIF beneficiaries. According to study findings, NHIF beneficiaries who were referred were far more dissatisfied than those who were not. The results showed that only 46.6% of beneficiaries who were not referred were deemed to be dissatisfied with the standard treatment provided at authorized health care institutions, 84.8% of NHIF beneficiaries who were referred were not happy. This is because most of the NHIF users who were referred were not likely to be directed to institutions that were accredited which created a psychological impact on them.

Data results indicated that outpatients were dissatisfied with the way some accredited health facilities looked upon their arrivals. This included things like installed TVs, chairs, benches and wall clocks. In contrast, inpatients were found to be content with how their rooms looked. Data findings revealed that there were no comfortable seats in the reception area. There was only one bench and tall, wooden chairs that appear to be shorter than five individuals sitting together on average.

These findings correspond with findings by Christmals (2020) who also noted the lack of proper amenities at public health facilities including wall watches, shortage of chairs, ineffective channels for health attendants and patients to communicate about treatment protocols such as speakers or a flowing display that can be used to indicate who will

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visit the doctor next. These results demonstrated that the hospital has to upgrade the current benches and address the shortage of reception seats in the department.

However the results also showed that outpatient NHIF recipients were dissatisfied with furniture and equipment in the reception area which creates a welcoming environment for patients to converse with hospital staff. The hospital is adequately sized and its design is not too intricate so as to facilitate communication between medical staff and patients. The presence of equipment related to service providers such as computers and wheelchairs was deemed satisfactory by the NHIF beneficiaries. The results of the study indicated that in comparison to inpatients, the restroom settings of outpatients were not pleasant. While most inpatient NHIF beneficiaries were content with the ward's restrooms, this caused unhappiness among outpatients.

Data findings noted that hygiene in some wards was heavily complained by patients especially in male wards who were not happy with the cleanliness. Some hospitals have inadequate infrastructure and a small receiving area for NHIF patients. The insured people's receiving space is too small and does not have enough room for everyone. Due to network issues, some patients are compelled to wait more than an hour for their responses which causes congestion in the NHIF patients reception area.

Although outpatient appear to have neither too many nor too few wards at authorized health institutions, inpatients said that they are dissatisfied with the size of the wards which means that it does not meet the needs of NHIF beneficiaries. The NHIF beneficiaries have expressed satisfaction with the courteousness of the medical staff which includes nurses and physicians. Most respondents declared to be happy and get respectful care from doctors and nurses. The length of time beneficiaries of the NHIF had to wait for services did not satisfy them. Most outpatients expressed dissatisfaction with the length of time they had to wait for the medical attendant to address their concerns, this prolonged duration made it difficult for them to complete their entire course of treatment and as a result they delay returning to their homes.

Data findings indicated that respondents expressed dissatisfaction with the availability of pharmaceuticals. Most of the respondents stated that they were told to purchase medications from outside medical stores. The majority of NHIF beneficiaries viewed this as a major disruption because they are unfamiliar with the costs and are unsure about the quality of the medication guaranteed by out of shops. In a similar vein, Spaan et al. (2012) showed how NHIF users become dissatisfied when they fail to access medications using their cards or when pharmacies are out of stock and they are required to opt for out of pocket payment which makes them angry, unhappy and stressed.

Study results also showed that inpatient NHIF beneficiaries were aware of and pleased with the way attendants handle critically ill patients by giving them priority care and showing full commitment. However in contrast to outpatient NHIF beneficiaries, majority were very dissatisfied and unhappy. Moreover outpatient accounted for the majority of doctors' time in accredited health facilities compared to inpatient NHIF beneficiaries. Thus, it was discovered that although inpatients were dissatisfied with the way doctors listened to their problems compared to outpatients. In line with these findings, a study by Modest and Katalambula (2021) insisted that there was bias between schemes clients and out of pocket clients in health facilities' as out of pocket clients received more concern and attention than schemes clients due to long procedures.

V. CONCLUSIONS & RECOMMENDATIONS

5.1 Conclusions

Factors affecting perception of NHIF users should be worked upon to creating a good working environment for employees and their wellbeing in general as when they are healthy, then they become productive as they do not have to worry of health circumstances. In addition to that administrative costs associated with insurance schemes should be improved regardless of the population distribution. This is because urban areas with good infrastructure and communication networks tend to get better health services than rural areas hence it even simplifies the logistics of enrolling individuals, collecting contributions and delivering health services making civil servants who work in rural areas develop negative attitudes towards the scheme because of limited coverage.

Employer's policy should be flexible to civil servants and their families so as to allow frequent adjustments to match their needs. Moreover national health policies and schemes should be designed to fit other vulnerable groups and informal sector so as they can also be able to access health care services. It has been so obvious for schemes to enroll people with formal employment because they are secured to contribute to insurance fees with added advantage of employer's policy to contribute for health insurance of their employees.

Moreover perceived poor quality of services at accredited facilities has made civil servants dissatisfied, loose trust towards the scheme and develops negative attitudes. When quality care provided under insurance schemes is substandard, they do not see the value of enrolling and their healthcare needs are not met so they become discourage and may even decide to opt for other options that are better.

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5.2 Recommendations

Basing on the findings, the study recommends registering individuals in the informal sector through existing groups and associations. This will help to increase insurance coverage and expand competition among health schemes so as to make them perform better in ensuring effective health delivery. This can also help to collect premiums on installment basis making insurance more affordable and accessible for low income individuals who may struggle with lump sum payments. Additionally, quality health care should also be available in rural and underserved areas so as to achieve universal health coverage by including all necessary segments of the population. Policy makers should address targeted interventions through improving administrative capacity and fostering a stronger sense of solidarity so as to build a strong government stewardship of the health system for successful insurance coverage in the country.

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