Impact of service quality on medical insurance firms and its effect on member satisfaction and loyalty: The case of CIMAS

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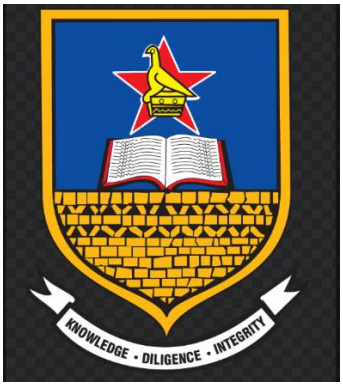
February 2020



Supervisor: Dr Noel Muzondo

Dissertation submitted in part fulfilment of the Master of Business Administration degree to be awarded by the Graduate School of Management of the University of Zimbabwe

DECLARATION

Student's Declaration - I, Ellen N. Sande, do hereby declare that this dissertation is the result of my own investigation and research, except to the extent indicated in the acknowledgements, references and by comments included in the body of the study, and that this dissertation is therefore my original work and has not been presented in part or in full for any other degree at any other University for any academic credit.

Signature…… Date……

NAME: ELLEN SANDE

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Supervisor Declaration- I, Noel Muzondo, confirm that the work reported in this dissertation was carried out by the candidate under my supervision as the University supervisor. This dissertation has been submitted for review with my approval as University Supervisor.

Signature……. Date……

NAME: DR.N. MUZONDO

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DEDICATION

I dedicate this project to my beloved family, that is, my husband Richard and children, Ryan, Rica and Riley, and my workmates. To CIMAS management, I hope this study will help you improve the customer service levels currently in use to survive in the business environment.

ACKNOWLEDGEMENT

I hereby recognise the unmerited favour of God who gave me health and strength upon my accomplishment of this dissertation. It is too long to mention all people who have contributed in one way or another to make this dissertation possible, but I wish to acknowledge the following people who have played their central role to this accomplishment.

I would like to thank my kind and lovely husband, Richard, who was supportive during the study and so encouraging that he strengthened me. A special thanks goes to my parents Mr and Mrs Shamba for their support and prayers.

My sincere gratitude and appreciation go to my supervisor, Dr N. Muzondo, whose invaluable supervision and encouragement guided me successfully to carry out this project. A special thank you to the University of Zimbabwe Graduate School of Management for providing a conducive learning environment that enabled students to fully interact with each other and share experiences. This contributed not only to my academic achievement, but also to my professional and social development.

ABSTRACT

The main objective of this research was to determine the impact of service quality determinants on customer satisfaction and loyalty in the medical insurance industry in Zimbabwe using CIMAS as a case study. In today's competitive and fast paced environment, customer loyalty has often been cited as a significant factor. Customer loyalty is beneficial to a company's performance, medical aid societies like CIMAS included. The delivery of quality services leads to customer satisfaction hence enabling customer loyalty. This study focused on determining the service quality levels of companies in the medical insurance industry in Zimbabwe.

The study used primary source of data which was gathered through questionnaires and analysed by Statistical Package for the Social Sciences (SPSS) SPSS is a software package used for statistical data analysis. It followed the qualitative approach which is exploratory in nature. The research used a inductive approach. A combined survey and case study research strategy and a questionnaire research method were employed to gather data from a random sample of 218 drawn from CIMAS members who visited its two branch offices in Harare, Zimbabwe.

Seven determinants of service quality were extracted from the dataset with exploratory factor analysis and their impacts on customer satisfaction was measured with confirmatory factor analysis. All the factors remained important. Thereafter, the relationship between customer satisfaction and customer loyalty in CIMAS was measured with structural equation modelling. It was found there is a positive and significant correlation between customer satisfaction and customer loyalty.

Recommendations drawn from the findings were for CIMAS management to adopt the gap model and implement strategies that will help in closing the gaps. CIMAS need to improve on the turnaround times in all areas. Finally, CIMAS need to maintain its loyal customer by recognizing them.

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Chapter One Introduction

1.1 Introduction

Customers are the backbone of every organization that exists and more so in the service industry. The gurus Deming, Juran, Crosby and Feigenbaum (1988) developed the total quality management (TQM) philosophy in a bid to create a powerful management tool that provides quality service with the available resources. Customer satisfaction is the basis of success for businesses in the service industry. Many businesses fail to look to one of these key factors in achieving their customer satisfaction goals which is the role of the service providing employee.

Today, customer service not only has become the rhetoric for business but has also taken a distinguished position in every discourse. This view is supported by Doyle and Stern (2006), who assert that without customer satisfaction and loyalty, no company can survive in today's competitive environment. Similarly, no organisation can generate high sales without meeting the customers' needs. Customer service plays a vital role in building a strong and ever lasting relationship between customers and organisations and it is a two-way flow of value.

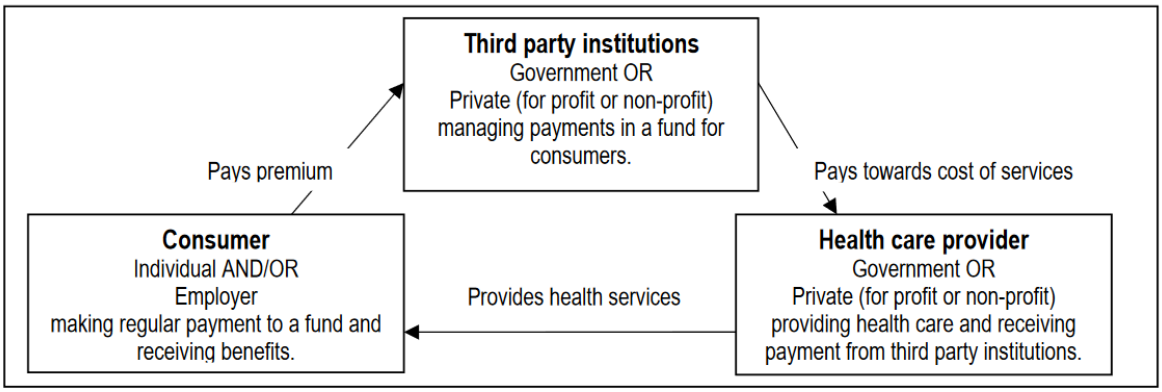
Though firms know that customer service need to be improved for them to upgrade customer satisfaction, there has been no capacity building in this area .One way of achieving effective customer service and satisfaction is through adoption of the service quality model. Service quality must be applied in the medical insurance industry given the fact that the products which are offered to clients are similar. Each medical insurance company would want to meet some of its objectives such as improved business performance and increased market share.

The growing global competition, coupled with the dynamic and complex nature of international business, increases both the need and the means for closer ties with customers. This is pointed out by Cateora, et al. (2010) who further on noted that, with quality becoming the cornerstone of global competition, companies are requiring assurance of standards conformance from suppliers, just as their customers are requiring the same from them. An argument put forth by Zeithaml, Bitner and Gremler (2012), is that companies offering superior customer service achieve higher than normal market share growth and that quality influences profits through increased market share.

1.2 Background of the study

A medical aid society is a pool of funds put together by a group of people who share a common objective of having their medical costs paid for in the event of any of its members falling sick. The running of a medical aid society is internally governed by its constitution and the members are legally the owners of the society (Statutory Instrument 35 of 2004). The members contribute at agreed regular intervals and will expect their medical bills to be paid as and when they lodge claims from medical service providers across the country. Below is the model used by medical aid insurance companies in Zimbabwe.

Figure 1.1: Generic model of Zimbabwean Medical Aid Societies



Source: Conn and Walford, 1998.

Since the medical insurance is a service industry, there is need to adopt service quality models that work for the survival of the medical aid societies in Zimbabwe.

1.2.1 A brief review of Service Quality Models

Several models of service quality exist in the literature (Gronroos, 1984; Parasuraman et al., 1985, 1988; Rust & Oliver, 1994; Kang, 2006). Gronroos (1984) published his service quality model which consisted of expected quality, perceived quality and experienced quality. Under the experienced quality, Gronroos suggested that customer formed an image of the quality service what he called technical quality (what) and functional quality (how).

SERVQUAL is the mostly used and tested method to measure customers' perceptions of service quality (Bateson & Hoffman, 2011:334) the SERVQUAL, conceptualised service quality as a gap between customer 'expectations and perceptions (Parasuraman et al., 1985).

The discrepancies in the consumer evaluation of service quality are largely defined by gaps. The Gap Model of Service Quality is used to analyse these gaps. The basic gap is the Consumer gap, which emerges as the discrepancy between customer expectation regarding service and customers perception of the service delivery in service industry.

Gap 1: refers to consumer expectations and the perception of management towards them. The service providers do not always understand what requirements connote excellence of quality for consumers.

Gap 2: is the specification of the quality of the services defined by the translation of perceptions that management has of the expectations of users. This discrepancy is due to the lack of specification of the offer, adjusted to the wishes of the consumers.

Gap 3: relates to the actual performance of service in the face of previously established specifications.

Gap 4: relates to the service provided and external communications (service specifications announced in the media or other communication channels).

Gap 5: This was established as a function of the four previous shortcomings, namely Gap 5 = f [gap 1, gap 2, gap 3, gap 4].

Rust and Oliver (1994) developed the two dimension, namely functional and technical quality further into three component model which constitutes the service, the service delivery, and the service environment.

Gronroos's (1984,1988) functional quality incorporates both tangibles (environment) and the service delivery, but tangibles are identified by Rust and Oliver (1994) as a dimension on its own.

1.2.2 Industry and CIMAS Background

Traditionally, the public sector has been the main provider of public health services in most countries (World Health Organisation, 2002). Interestingly, there is now a paradigm shift

towards the involvement of private health care providers resulting in a multiplicity of health funders and providing agencies. Zimbabwe, like many other countries, has acknowledged and implemented such co-existence (World Health Organisation, 2002).

Zimbabwe's health sector is divided into public and private sectors. Government owns around 70% of health facilities in the country, while the private sector owns about 30% (AHfoZ, 2018). Most workers in the country cannot afford private hospitals and clinics, so they are cared for at state and mission hospitals and clinics, which are less expensive.

1.2.2.1 Features of the Medical Insurance sector

The enactment of the Medical Aid Societies Statutory Instrument 330 of 2000 paved way for the establishment of more medical aid societies in the country. Gonye as cited in The Newsday (July 7, 2018) in an article entitled 'Unique medical aid schemes launched' states that in an effort to ease the situation and ensure that everyone has access to health care, medical aid societies have mushroomed providing almost the same services to the public. Both public and private employers provide medical insurance through participation in medical aid societies. These are non-profit organisations that collect premiums from business and/or government organisations and use that money to pay health care providers for services provided to beneficiaries. Medical insurance money, whether for public or private facilities, is deducted each month from workers' salary. Medical aid schemes in workplaces in Zimbabwe are voluntary, dealing directly with employers and consumers and avoiding broker costs. But they can limit an employee's choice of society. Benefit packages are clearly specified but are segmented. There are different levels of cover, which apply to the different income groups of beneficiaries.

The treatment levels determine how the members should contribute per month. Zimbabwe has 31 registered medical aid societies, Association of Health Funders of Zimbabwe (AHfoZ, 2018). Medical aid societies are legally required to register with the Ministry of Health and Child Welfare (Statutory Instrument 330 of 2000). Out of the 31 registered medical societies, not all of them are open to the public. Whilst major brands like CIMAS, First Mutual, Generation Health and Masca can accept any application from the public, some medical aid fund like Railmed, Kwekwe City council medical aid societies are closed funds where membership is restricted to benefit their employees and their immediate family members only.

The private medical industry in Zimbabwe is small (owns 30%) but plays a significant role in most workplaces and is the biggest player in the private sector. Medical aid societies cover a tenth of the country's population and provide 80% of income to private health care providers in Zimbabwe.

However, the medical insurance industry is now facing a crisis likely to lead to its demise as evidenced by the closure of five medical aid societies, namely, Galaxy, Shelter, ZimPapers, Access and Green card (AHfoZ, 2018).Although the medical aid industry is indeed adding value to healthcare delivery in Zimbabwe, there are a myriad of challenges emerging and derailing performance of the medical aid societies. The industry faces serious challenges in the working relationships between medical aid societies and providers of health care services particularly doctors as represented by Zimbabwe Medical Association (ZiMA)

In a Ministerial Statement of 23 June 2016, the then Minister of Health and Child Care Dr David Parirenyatwa, highlighted that the fulcrum of the working relationship challenges emanate from issues which include disagreements over tariffs, delays in payment for services rendered, conflict of interest by insurers, unfair and crippling taxation and recovery practices by ZIMRA, charges by providers that are way beyond what the insures can afford and demands by providers to patients for cash payment upfront while the clients are holding valid insurance cards. An article entitled "Medical aid crisis: saving health sector from greed and abuse" on the source blog (Lex Vambe, June 23, 2016) sum the challenge of service delivery saying "Zimbabwe's healthy industry has been locked in a crisis for some years now, mainly due to a standoff between health funders and providers of medical services over tariffs, service delivery among other contested matters……" The crisis has resulted in the membership for medical aid funders falling by 31 percent due to lack of confidence in the system, absence of guarantee of payments and poor debt control (Lex, Vambe, 2016). There are challenges faced by the medical aid societies that are affecting the service delivery and are threatening their survival. Some of the challenges are as below:

1. Failure to provide products and or services that cater for low income earners

Medical aid societies in Zimbabwe cover only a tenth of the population where about 80% of income to private health care providers in the country comes from medical aid societies; and contribute more than 20% of the country's health expenditure (Shamu et al., 2010). The tenth of the population covered by medical aid societies are formally employed people who are urban

residents. The medical aid societies are failing to spread their coverage amongst the rural and poor populations.

2. Failure to pay claims from medical service providers

There has been a rise in claims costs in an environment that is largely described as turbulent. Medical aid societies responded to the economic decline and hyperinflationary environment of the 2000s by acquiring related industries to manage the costs of doctors, specialists and pharmacists (Shamu et al., 2010).

3.Failure to meet customer expectations

Consumers of medical aid products have been demanding more in terms of benefits. One of the highly demanded benefit not there in the medical aid society is lack of pay back sums to those customers who would have not claimed for a certain period (Shamu et al., 2010). This has resulted in stiff competition amongst medical aid societies and health insurance companies.

1.2.2.2 CIMAS Background

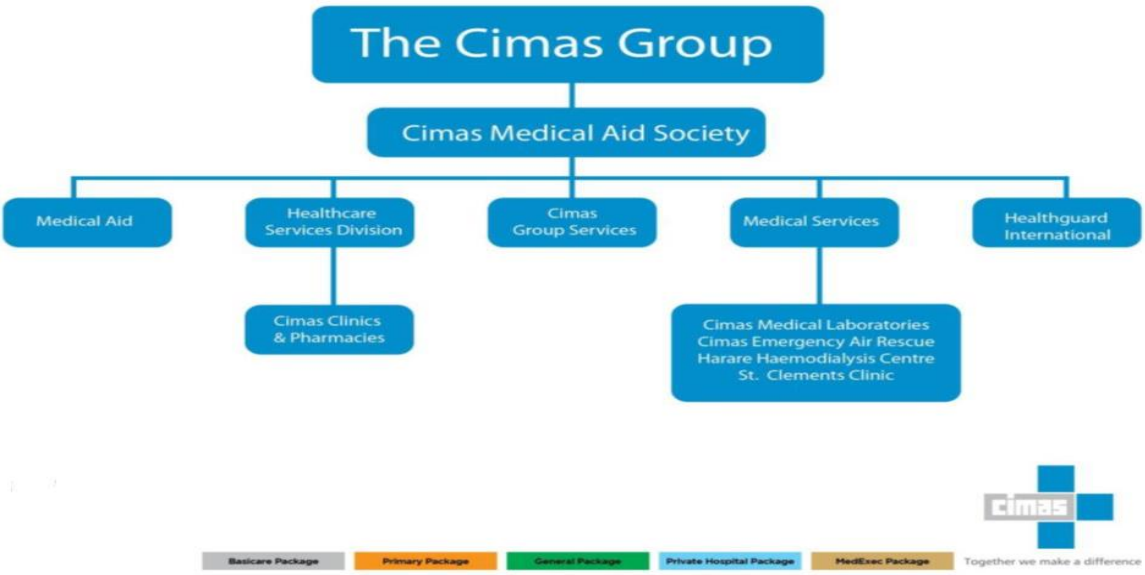
CIMAS Medical Aid Society was established in October 1945. It was formed after the municipalities of the two major towns of Salisbury (now Harare) and Bulawayo had introduced a medical aid benefit fund. The Salisbury (now Harare) Chamber of Commerce realized that those who were in the commercial industry throughout the country were not being catered for in terms of the medical aid cover. At that time, members of the civil service were already covered by a medical aid society which is still in existence today. The Society was named Commercial and Industrial Medical Aid Society (CIMAS).

CIMAS is largely owned by its members. It is in partnership with Health guard International RSA which is a comprehensive healthcare package that allows members access to healthcare facilities within Sub Saharan region. These affiliations allow members to get worldwide recognition and get treatment in any destination of their choice during holidays and other business trips. (CIMAS marketing strategic plan 2016-2020)

CIMAS Organisational Structure

CIMAS Medical Aid Society has five major divisions which are Medical Aid, Medical services, Healthcare, Health guard International, Shared Services.

Figure:1.2 CIMAS Group Organogram

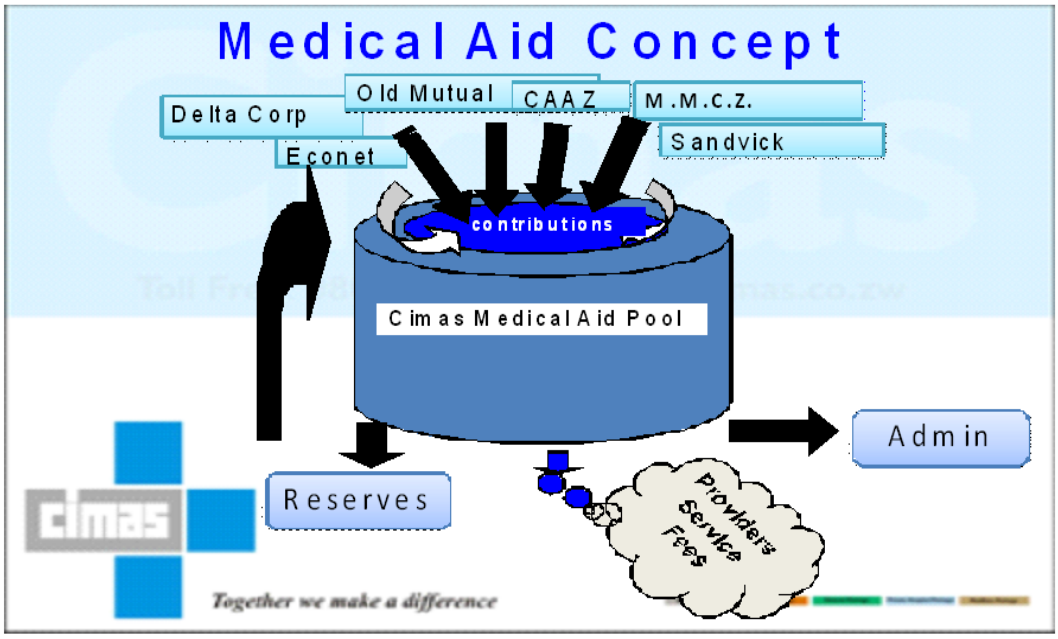


Source: CIMAS marketing strategic plan 2016-2020

Medical Aid Concept

CIMAS uses a business model called the Medical Aid Concept since its commencement in October 1945.

Figure 1.3: Medical Aid Concept



Source: CIMAS marketing strategic plan 2016-2020

As illustrated by the diagram different members whether individuals or companies contribute to the society and get financial assistance whenever they require medical attention. Medical aid concept is a process of sharing risk. It is all about pooling of resources and risk sharing. Medical aid concept strives on cross-subsidization, whereby those healthier members subsidize for those sickly and may be vice versa in the future. This concept is there to share financial health risk and reduce the burden on an individual. This means that those who are not ill will enjoy the benefit of being covered and peace of mind and those who are sick will benefit financially. The more members the society has; the lower the risk in the pool of funds and likeliness to be wiped out (CIMAS internal document).

CIMAS SWOT Analysis

Table 1.1: CIMAS SWOT

STRENGTHS	**WEAKNESSES**
Qualified and experienced workforce	Affordability
Innovation	Centralization
Large market share	Poor communication channels
Own healthcare facilities	Not flexible to changes
OPPORTUNITIES	**THREATS**
Developing markets for informal sector	Political and economic instability
Take over struggling medical aid societies	Deregulation of the medical aid industry
Joint venture	Increased competition from local and international players
Diversification	Service providers' bargaining power

Source: CIMAS marketing strategic plan 2016-2020

The products in the industry remain highly undifferentiated, and competition is based mainly on service provider awards, acceptability of membership cards and service Excellency. The CIMAS Medical Aid numbers reached an all-time high of 209 359 in 2014 since dollarization and have been on a downward trend as at November 2016. Resignations have mainly been as a result of retrenchments and firms moving to competition. (CIMAS Annual Report, 2017)

The government has failed to control some medical aspects; this has affected all medical aids. This has led to providers charging exorbitant fees which are resulting in large sums of shortfalls. Due to these disarrangements people are now reluctant to join medical aid since it is resulting in huge shortfalls which they will pay on their own since it is not covered by medical aid. Due to these disarrangements' the market share of the organization has reduced. The organisation has been affected also by company closures and declining disposable incomes. There has been a significant decline in CIMAS membership from November 2016. The CIMAS Laboratory patient numbers have -also been on a downward trend since 2013 in line with the decline in the medical aid membership figures.

CIMAS is failing to maintain one of its pillars of customer centricity as it used to recognize itself as the giant in medical aid provisions, henceforth there is a mentality amongst the decision makers that they know what the people like. This is a dangerous approach in the modern-day business world where there is much competition.

CIMAS' policies are always changing and sometimes it makes the society lose customers. On 16 March 2015 CIMAS just decided not to register individual members and introduced a policy that does not allow waiving of waiting periods. At the same time this year it has introduced a policy that individuals are to be registered only under 2 packages. Also, the society has changed its policy on pensioner status whereby one has to apply to qualify yet before it was automatic for those above 60 years with 10 years of continued membership.

Also, the society is not communicating with its members as expected. The society makes use of emails, letters and press to inform members about any change. But however, some of the members are technologically challenged up to an extent that they are not able to use emails, and some are not able to buy newspapers hence distorting communication flow.

In his statement the CEO, confirmed that the persistent economic decline reflected the business unit's performance. The liquidity crunch continues to affect members. Active members decreased by 6 % from 2015 translating to a decrease in revenue. (Annual report,2016).
The chairman also confirmed that the private health sector has been hard hit by dual pricing that became more prevalent in the last quarter of 2018. Many local health service providers are demanding payment in hard currency and where they accept the RTGS/ZWL equivalent, it is often at rates well above the official bank rate. (Annual report, 2018).

1.3 Statement of the problem

As reflected in the background above, a crisis in the medical aid industry emerged with evidence from an article by Lex Vambe, June 23, 2016 depicting a decline in the membership of medical aid firms by 31 percent. There has been lack of confidence in the system, absence of guarantee of payments, failure to meet customer expectations, lack of products that cater the

poor and rural community (Lex Vambe, June 23, 2016). The crisis had been seconded by the statements from the CEO and Board chairman of CIMAS.

Thus, this crisis in the medical aid industry has indeed emerged as a problem worth being addressed through research. The researcher is therefore determined to critically assess the validation of the service quality models for the medical insurance industry with CIMAS being the case study.

1.4 Research objectives

1.4.1 Main research objective

The main research objective was to identify the determinants of service quality in CIMAS and ascertain their impact on member satisfaction and loyalty.

1.4.2 Secondary objectives

i. To identify the determinants of service quality in CIMAS.
ii. To confirm the identified determinants of service quality in CIMAS.
iii. To measure the impact of the identified determinants of service quality on customer satisfaction in CIMAS.
iv. To assess the impact of the customer satisfaction on customer loyalty in CIMAS.

1.5 Research Questions

1.5.1 Main research questions

The main research question was: What are the key determinants of service quality in CIMAS and how do they impact on member satisfaction and loyalty in the medical aid society?

1.5.2 Secondary research questions

i. What are the key determinants of service quality in CIMAS?
ii. Can all the identified determinants of service quality in CIMAS be confirmed?
iii. What is the impact of the identified determinants of service quality on customer satisfaction in CIMAS?
iv. Does customer satisfaction have a positive impact on customer loyalty in CIMAS?

1.6 Research Hypothesis

In view of the above theoretical discussion and the literature reviewed in Chapter 2, especially around the conceptual framework of determinants of service quality, customer satisfaction and loyalty in CIMAS, the study tested the following hypotheses:

H_1: Tangibility has a positive and significant correlation with customer satisfaction.
H_2: Reliability has a positive and significant correlation with customer satisfaction.
H_3: Responsiveness has a positive and significant correlation with customer satisfaction.
H_4: Empathy has a positive and significant correlation with customer satisfaction.
H_5: Assurance has a positive and significant correlation with customer satisfaction.
H_6: Product has a positive and significant correlation with customer satisfaction.
H_7: Price has a positive and significant correlation with customer satisfaction.
H_8: Customer has a positive and significant correlation with customer loyalty.

1.7 Scope of the study

These days a lot of different companies are present and competing in the market for medical aid funders. The aim of this study is to identify the determinants of service quality in CIMAS and ascertain their impact on member satisfaction and loyalty. The study will be completed in a period of 6 months and will be limited to subscribing members of CIMAS accessing services at Borrowdale and Jason Moyo offices. CIMAS subscribers will be the population for the research.

1.8 Significance of the study

The aim of the study is to design and validate the Service Quality model for medical insurance companies focusing on CIMAS as case.

1.8.1 Benefits to Management

This study will focus on how to improve on the current operations of the organisation and how management can turn the already successful strategies into competitive strategies that result in the organisation competing better in the marketplace.

Therefore, the study enables management to compare their organisations strategies against those of their competitors and adopt the best practices for the organisation's benefit to improve on where they are falling short.

1.8.2 To other Researchers

The research sought to establish a starting point for other researchers who may be directly involved or are interested in the industry since the topic or subject has so far not been dealt with conclusively and satisfactorily especially in Zimbabwe. In this respect the researcher formed a primary and preliminary platform for further study along the same lines of the topic. It forms a source of literature review for future students. The research adds on to already held researches by the university.

1.8.3 To the Customers /Members

The success of an organisation depends on its competitive strategies and how they influence customers' perception towards the organisation and its service offerings. Medical aid societies benefit economically if members and potential members have confidence in the industry.

The study can also be beneficiary to the customers or members of the society. Members' needs are better met through the reliability of a wider variety, affordable differentiated products and they can recommend the society to friends and relatives.

1.8.4 To the Nation

The research will also benefit the nation through quality health service delivery by its efforts to improve service delivery which will result in a healthy nation. More jobs can be created through the expansion of branch networks as a result of improved financial stability and growth in market share.

1.8.5 To the Researcher

It is also intended primarily to enrich, both academically and in a practical sense the author. Being a scholar and medical aid administrator by profession, the researcher will benefit by understanding the issues around medical aid societies' products and performance with a view to advice on improvements. It will also improve the researcher's analytical skills which are important in carrying out work tasks

The research will also assist the researcher in sharpening her research skills and scope which is vital for any further educational studies. The research also marks as a basis for obtaining a

master's degree in Business Administration as it is conducted in partial fulfilment of the program.

1.9 Structure of the dissertation

The study consists of five chapters. This research aimed at identifying the determinants of service quality in CIMAS and ascertain their impact on member satisfaction and loyalty. The result of this research, therefore, lead to a deeper understanding of how service quality affects CIMAS' performance. Chapter 1 has provided the problem and its setting.

Chapter 2 has provided a review of the literature on service quality model and its dimensions. This section mainly covered what authorities have contributed with emphasis on service model - customer expectations, customer loyalty and customer satisfaction.

Chapter 3 dealt with the research methodology that was used for the field-based examination to explore the service quality on the performance of CIMAS Medical aid. In this section, the researcher focused on the research design, population sampling techniques and data collection, presentation and analysis procedures that were employed in the study.

Chapter 4 presented findings of the research that were conducted on CIMAS as well as data analysis. The chapter, therefore, incorporated general and cross tabulation analysis through tables, frequency distributions, pie charts, bar graphs and diagrams in presenting the findings.

The last section, chapter 5, communicated the conclusions and recommendations noting the main points in the analysis of the primary and secondary data by highlighting areas for future improvement.

1.10 Chapter Summary

Chapter one explored the introduction of the entire study, background of the research, review of service quality models. It also highlighted the industry's background and that of CIMAS medical aid society. Also, the problem statement, research questions and objectives, significance of the study as well of the scope. It noted that the study would be limited to CIMAS medical aid, mainly Harare branches.

Chapter Two

Literature review

2.1 Introduction

According to Paula (2010) the major benefit of a literature review is that it ensures the research ability of a topic before proper research commences. By reviewing the available literature, this will assist the researcher in understating the topic and even develop it further and by so doing existing gaps are identified (Forxall, 2003). Literature review is also being used to defend some of the professional practices (Arlene, 2005).

Key areas covered in this chapter

This chapter reviews work done by other researchers who carried out research in the same field of study. The review focuses on theoretical review, empirical review, conceptual framework, research gaps and summary.

Through the years, service quality has progressively become more imperative in a challenging and contemporary service industry as a means of attaining sustainable profitable business. The service industry is highly competitive with many firms seeking to engage more customers to grow their market shares and establish a long-lasting relationship with their customers. Organisations like CIMAS must prove to their customers that they provide quality services that are customer focused (Shahin & Samea,2010). Service quality is perceived differently among customers depending on how well the delivered service meets their needs.

THEORETICAL LITERATURE

2.2 Definition and benefits of service quality, customer satisfaction and customer loyalty in service organisations

2.2.1 Service and Service Quality

2.2.1.1 Service

According to Hoffman, a service is deed, effort or performance. Kotler et al (2009) define services by combining the acts-based and ownership definitions. According to them, a service is any act or performance one party can offer to another that is essentially intangible and does not result in the ownership of anything. A service is a process consisting of a series of intangible activities that normally, but not necessarily always, take place in interactions between customer, service employee and or physical resources and systems that provide solutions to customer problems (Gronroos ,2007).

Quality is a powerful weapon in every sector of the market as it enables firms to grow their market share and competitiveness while increasing customer satisfaction and loyalty levels (Demir et al.,2015). This has led to many organisations embracing a culture of quality, as such CIMAS must adopt. Chodzaza and Gombachika (2013) recognized service quality is a forbear of customer satisfaction, retention, operational efficiency, and profitability.

2.2.1.2 Service Quality

Service quality plays a significant role in conventional and service industries. Customer satisfaction in the service industry depends on the quality of service and overall experience. Organisations with a satisfied customer base have a competitive edge over others (Arokiasamy &Huam, 2014). Medical aid societies are key institutions in the health sector. In the corporate world, service quality plays an important role in creating differentiation and a satisfied customer base. A satisfied customer base also helps in increasing market share (Khan & Mariam,2014) Many leading firms focus on providing quality services for creating differentiation and competitive advantage. CIMAS must also adopt that as it leads to a stronger brand image. The SERVQUAL model has been used extensively by marketers for measuring customer satisfaction (Arokiasamy &Huam,2014). According to Brown and Bitner (2007), the rapid growth and competition in many industries has made it imperative for firms to measure and evaluate service quality.

2.2.1.3 Customer satisfaction

Customer satisfaction is a psychological state. Customers are highly satisfied when service quality exceeds their expectations (Paul et,.al,2016a). it is believed that satisfied customers keep a sustainable relationship with the company by regularly purchasing its products and services (Kashif, et al,.2015). A high-quality service leads to competitive advantage, satisfied customer base and improved bottom-line for the company.

According to Huang and Feng (2009), the performance of a company regarding the quality of its services leads to satisfaction. Agbor (2011) states that the main reason for providing quality service is to satisfy customers. Gera (2011) also established that quality of service greatly impacts customer satisfaction and value perceptions in a positive manner. The best way to determine if services are good or bad and whether they will satisfy customers is through measuring service quality (Agbor,2011).

2.2.1.4 Customer Loyalty

According to Carter (2014), customer loyalty occurs when a customer chooses to transact with a certain firm or procures a specific service constantly. He further states that customer loyalty occurs when a customer holds an emotional connection with an insurer's services and is willing to uphold a relationship with them in the long run.

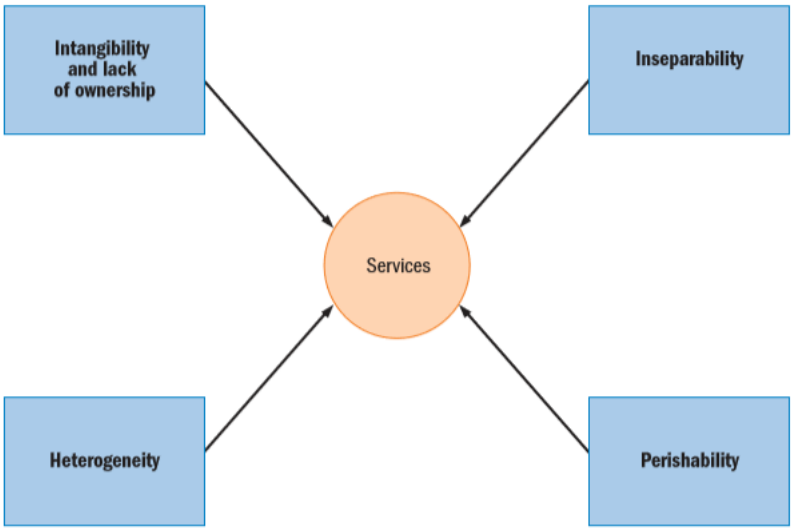
Both consumer and customers are seeking a relationship, one they can engage in and extract value (Manatt,2014). A research done by Harvard Business Review shows that loyal customers are usually much more profitable than new customers. Running a successful business necessitates loyal and repeat customers. They keep your business open and the customers will advocate for your brand (Eklund, 2016).

Some organisation have recognized that to survive and grow , they have to find and then keep profitable customers (Ganiyu, Uche & Adeoti,2012) loyal customers don't usually check prices and compare them to competition as diligently as other customers because they trust your services(Airas,2015). Loyalty is truly achieved when a customer can not only be a repeat buyer but also a champion of your product or service to his or her family and friends. Customers don't just tell their acquaintances and friends about bad experiences, they especially like to share the great experiences they may have had (Airas,2015).

2.3 Characteristics of services and how they affect service delivery and customer satisfaction

For services marketing, the distinguishing features or characteristics of services are important in the design of an appropriate marketing mix. (Gilmore, A, 2003)?? The identification of these characteristics was the concern of much of the earlier research and conceptual development of services marketing. The core characteristics are now widely recognised as intangibility, inseparability, perishability and heterogeneity (Gilmore, A, 2003) these are defined below:

Figure 2.1: Service Characteristics



Source: Wouter de Vries jr, 2012

Intangibility

A service is an Even though many services include tangible aspects, the service performance leading to customer's experience is intangible. The benefits of buying a product are based on its physical characteristics, whereas the benefits of buying a service are from the nature of the performance. The intangible nature of services often means that customers have difficulty in evaluating and comparing services (Gilmore, A, 2003). The buyer does not have any opportunity to touch, smell and taste the services. While selling or promoting a service one

must concentrate on the satisfaction and benefit a consumer can derive having spent on these services (Gilmore, A, 2003).

Inseparability

Because services are processes, deeds or acts, customers are involved in the production of a service (Gilmore, A, 2003). For most services both the buyer and the seller need to be at the same place at the same time for the service to occur. For example, a dentist is the actual service provider and must be physically present along with the consumer when the service is produced and consumed (Gilmore, A, 2003). The behaviour and attitude of other consumers may impact upon the nature and experience of a service.

Perishability

Given the intangible nature of services, they cannot be inventoried, stored or warehoused or reused. Like in CIMAS' case a doctor cannot store part of his or her knowledge for others to use while he is away (Gilmore, A, 2003). Thus, the availability of enough opportunities for service delivery at relevant times is important for service managers.

Heterogeneity

The intangible nature of services means that standardisation and quality are difficult to control. Given the fact that people are involved in providing the actual services in most sectors and that people are unlikely to operate as reliably and constantly as machines, it is often difficult to measure and control quality (Gilmore, A, 2003).therefore it may be difficult for customers to evaluate quality and for employers to measure and control quality. In this case evaluations often depend largely on attitude, opinions and expectations of customers and potential customers (Gilmore, A, 2003).

The same service cannot be sold to all the consumers even if they pay the same price, consumers rate the services in different ways. This is due to the difference in perception of individuals at the level of providers and users. Heterogeneity makes it difficult to establish standards for the output of service firm (Gilmore, A, 2003).

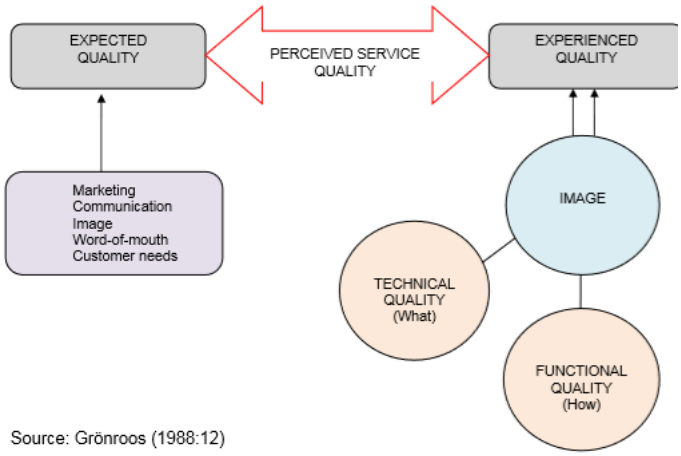
2.4 Service quality models

There are several service quality models in existing literature, will of which may be drawn to measure customer satisfaction. Among others those models include model of service quality (Gronroos, 1984), The three components by Oliver and Rust, 1994, The service marketing mix Vijaywargia 2012SERVQUAL by Parasuraman et a l., (1986), The Gaps model of service quality by Parasuraman et al., 1985).

2.4.1 The Gronroos Model of Service Quality

Gronroos (1984:36) one of the leaders in the Nordic school of thought regarding the service literature, states that a proper conceptualisation of service quality should be customer -based. The customer's perceptions of service quality model and secondly, the determinants of what influence service quality are also included.

Figure 2.2: The Gronroos Model of Service Quality



Source: Grönroos (1988:12)

The model in the above figure emphasises that the interaction between the buyer and the seller in a service setting is as important as the eventual outcome. The basic principle in his model is that service quality is dependent on the comparison of two variables being: the expected service from customers and the actual service as perceived by them (Gronroos, 1984:36)

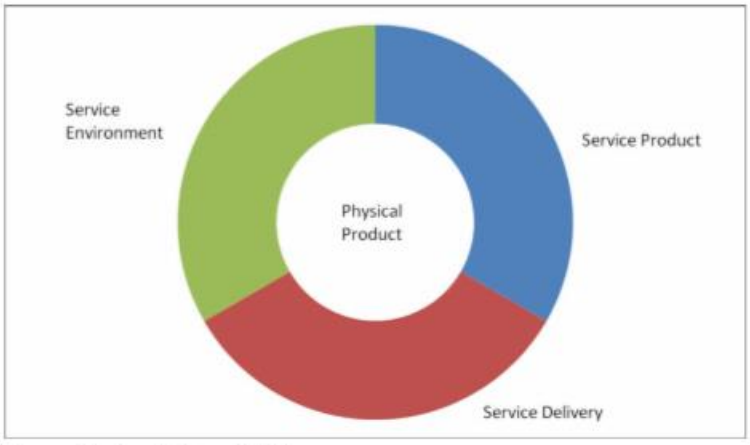
Gronroos (1988:11) suggests that performance evaluations comprise of two dimensions, namely technical (outcomes) and functional (performed service). It will not only be the outcome of a service but also the way a service is performed that exert an influence on the customers perception of a service.

Gronroos believes that a third dimension namely a corporate image exerts an influence on perceived service quality. There are several factors that can influence the corporate image like the technical and functional quality, price, communication, physical location, site appearance, competence and behaviour of employees.

2.4.2 The three-component model of Rust and Oliver

Rust and Oliver (1994) developed the two dimensions, namely functional and technical quality further into a three-component model as depicted by the figure below.

Figure 2.3: The three-component model of Service Quality



Source: Rust and Oliver (1994)

-The service product (the service as it is designed to be delivered-similar to technical quality)
-The service delivery (the sequence of events and service provider role expectations like functional quality)
-The service environment (physical ambience of the service setting)

Gronroos's (1984,1988) functional quality incorporates both tangibles (environment) and the service delivery, but tangibles are identified by Rust and Oliver (1994) as a dimension on its own.

2.4.3 Service marketing mix

This is a marketing tool used by managers when making decisions and company strategies. Hoffman et al 2009.states that elements of the model can be controlled and used to used satisfy or communicate with customers. The service marketing mix is also known as an extended marketing mix and is an integral part of service blueprint design (Vijaywargia, T (2012). It consists of 7p's as compared to the traditional 4p's o a product marketing mix in which the added 3p's are required for optimum service delivery (Vijaywargia, T (2012).

According to the Chartered Institute of Marketing, successful marketing depends upon addressing several key issues. These include:

Product-What the company is going to produce

Price-How much is it going to charge

Place-How the company is going to deliver its products and/or services

Promotion-How the company is going to tell its customers about its products and /or services.

People-Who is going to interact with the customers?

Processes-What are the processes involved when interacting with the customers?

Physical Evidence-What are the tangibles of the company?

Figure 2.4: The Service Marketing Mix Model

Source: Vijaywargia, T (2012).

Product

The product in service marketing mix is intangible in nature. Like physical products service products cannot be measured. At the same time service products are heterogenous, perishable and cannot be owned and thus must be designed with care (Vijaywargia, ~~T~~ (2012).

Price

Pricing in case of services is rather more difficult than in case of products. Service pricing involves taking into consideration labour, material costs and overhead costs. A product is only worth what customers are prepared to pay for it (CIM,2009). CIMAS contributions need to be competitive but this doesn't necessarily mean the cheapest. It means CIMAS must add extra services or details that will offer customers better value for money.

Place

The product must be available in the right place at the right time, in the right quantity while keeping costs to an acceptable level (CIM, 2009). For CIMAS services must be appropriate and convenient for the customers. The healthcare services like clinics, laboratories hospitals and pharmacies must always be available and widespread across the nation.

Promotion

Promotion is the way a company communicates what it does and what it can offer customers. This includes activities such as branding, advertising, corporate identity, sales management and exhibitions (CIM, 2009). CIMAS must use promotions that are appealing, gain attention and tell a consistent message. Above all it must give the customer a reason to choose CIMAS rather than competitors products. Good promotion also must communicate the benefits that a customer obtains from a product and not just the features of that product (CIM, 2009).

People

This include the all the human actors who play part in service delivery and thus influence the buyer's perceptions (Hoffman et al,.2009). People define a service thus in case of service marketing, people can break or make an organisation (Vijaywargia, ~~T~~ (2012). How these people dress, their personal appearance, their attitude and behaviours all have impact on how customers perceive service. Hoffman further added that customers not only influence their own service outcomes, but they can impact other customers as well.

Process

Service process is the way in which a service is delivered to the end customer. The process of giving a service and the behaviour of those who deliver are crucial to customer satisfaction (CIM, 2009). It is also a critical component in the service blueprint for CIMAS define exactly what should be the process of the service product reaching the end customer. The issue of turnaround times, the information given to customers and the helpfulness of the staff are all vital to keep customers satisfied.

Physical evidence

This the environment in which the service is delivered and where the firm and the customers meet for interactions and any tangible components that facilitate performance or communication of the service (Hoffman et al., 2009).

For CIMAS, these include brochures, letterheads, business cards, signage, equipment and physical facility like offices, clinics and labs where the service is offered.

2.4.4 SERVPERF Model

One of the better-known alternatives to SERVQUAL is the SERVPERF instrument (Cronin & Taylor, 1992) which measures experiences only and respondents about expectations. As a result, SERVPERF uses only the perception part of the SERVQUAL scale. The model states that service quality predicted by perceptions and expectations as suggested by Parasuraman et al. (1988). Cronin and Tailor (1992) do not disagree with the definitions of service quality that regard it as the difference between expectations and the perceptions of customers. Although SERVPERF gained popularity, it has not reduced SERVQUAL's usage among researchers. Andronikidis & Bellou (2010:579) found that SERVPERF is both theoretically and empirically Superior to SERVQUAL.

The SERVPERF was created as a contrast proposal to the SERVQUAL model and the basic assumption was to improve the service quality. Cronin and Taylor found out that we cannot examine customer expectations because the expectations belong to the ambiguous and variable category (Stoma, 2012). The SERVPERF is easier to use and less time-consuming compared to the SERVQUAL method (Gilmore,2003).

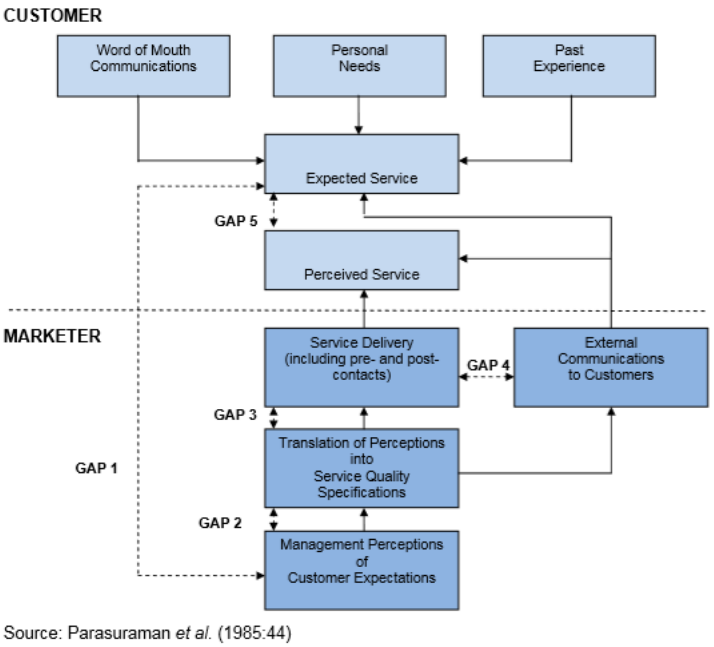
2.4.5 Service quality (SERVQUAL) model

This research will use SERVQUAL model to analyse the gap between perceptions and expectations of the customer, concerning with the service in the medical insurance sector. The SERVQUAL by Parasuraman et a l., (1986) model is mostly found in most service quality articles and textbooks. it is used to measure customers' perceptions of service quality (Bateson & Hoffman,2011:334). The SERVQUAL scale was developed after an exploratory study was conducted which led to the conclusion that there are discrepancies called gaps between what management and what customers believes what service quality constitutes.

The set of gaps was the major obstacle in attempting to deliver a service which customers perceive as being high quality (Parasuraman et al.,1985:44). The gaps are depicted by the figure below.

2.4.6 Gaps model of service quality

Figure 2.5: Service Quality- Gaps Analysis



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

Gap 1: Customer expectation-management perception gap

Managers of service organisations may not always understand what features indicates high quality to customers. They also fail to understand what features a service must have in order to

meet customers' needs and what the level of performance on those features should be to deliver high quality service. This has led to inconsistencies between customer expectations and management perceptions. As a result, customers' service quality perceptions may be affected (Parasuraman et al., 1985:44).

Gap 2: Management perceptions – service quality specification gap

the gap between management perceptions of customer expectations and the actual specifications established for a service may occur as a result of resource constraints, market conditions and lack of management commitment to service quality. This gap affects the service quality perceptions of customers (Parasuraman et al., 1985:44).

Gap 3: Service quality specifications – service delivery gap

Firms may have formal standards or specifications for maintaining service quality, however it may be difficult to adhere to these set standards because of variability in staff performance and this affect service quality from the customer's point of view. (Parasuraman et al., 1985:45).

Gap 4: Service delivery- external communications gap

The gap is the discrepancies between service delivery and what the firm promises through external communications or the absence of information about service delivery aspects may affect customer perceptions of service quality (Parasuraman et al.,1985:46).

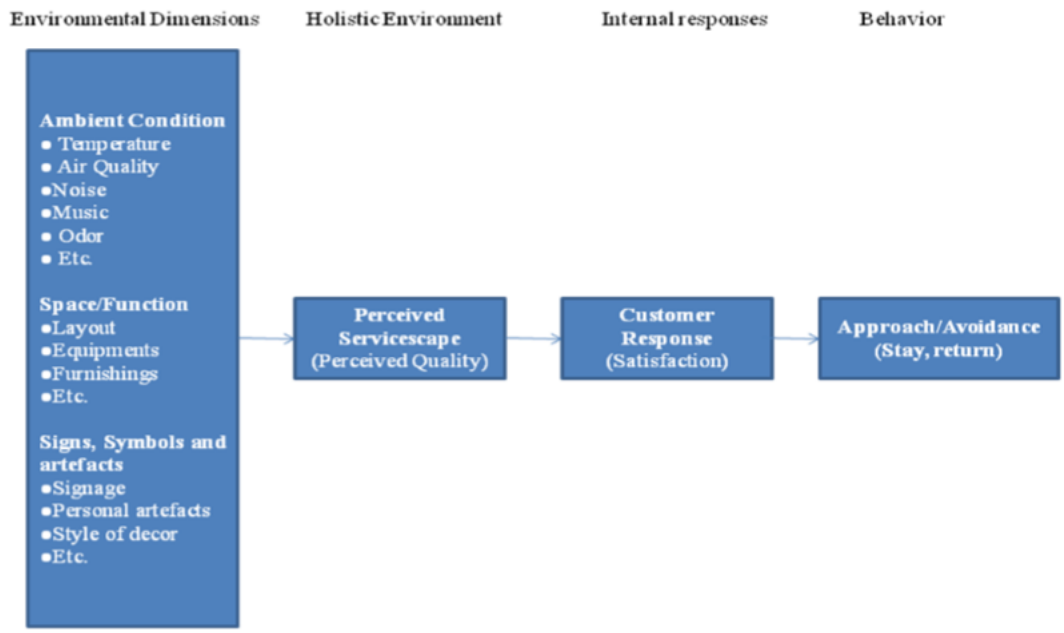
Gap 5: Expected service -perceived service gap

This is the most important gap which is regarded as a function of the first four gaps and Parasuraman et al. (1985:46) argue that there is indeed a relationship between Gap 5 and the first four gaps. The quality that a customer perceives and perceived service (Parasuraman et al.,1985:46).It is important to manage the gaps that exist between expectations and perceptions on the part of management, employees and customers in order to manage service quality (Zeithaml& Bitner,2003:25).By using the gap model, CIMAS must work on closing Gap 5 but in order to do so, the four other gaps that inhibit delivery of quality service within the organisation should be closed (Bateson& Hoffman, 2011:328).

2.4.7 Services capes model

Booms, et al., define Servicescape as the environment in which the service is assembled and in which seller and consumer interact, combined with tangible commodities that facilitate performance or communication of the service. According to Hoffman et al., the term services cape refers to the use of physical evidence to design service environments. He further states that due to inseparability, the model recognizes that the firm's environment is likely to affect consumers and employees alike.

Figure 2.6: The Servicescape Model.



Source: Bitner 1992.

The three important aspects of services cape are suggested by Bitner, are as follows:

1. Ambient conditions
2. Space/function
3. Signs, symbols and artefacts

1.Ambient conditions

These are the conditions surrounding the employees and customers that can be sensed through humans five senses like eyes, ears, nose, tongue and skin. These include temperature, air quality, noise, music, odour etc. (Hoffman al.,2009).

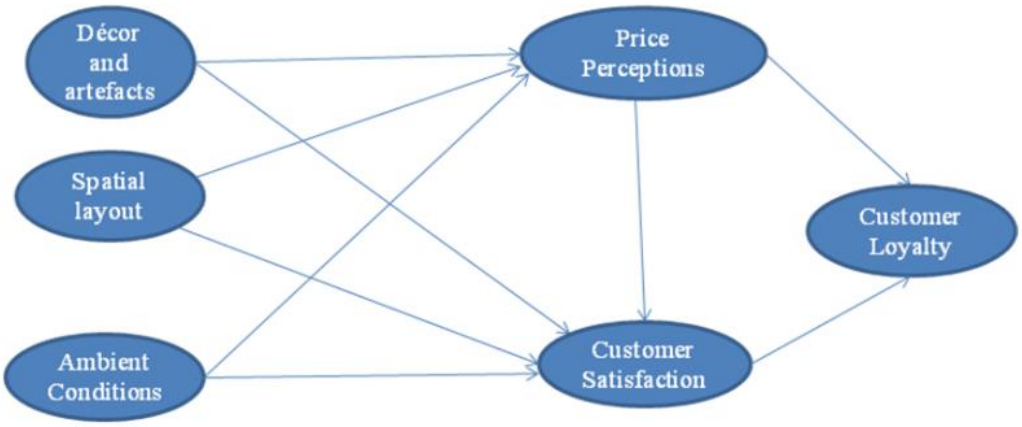
2.Space function

This includes the environment dimensions like the layout of the facility, equipment and furnishings of the firm (Hoffman al.,2009).

3.Signs, symbols and artefacts

This include the environmental physical evidence like signage to direct the flow of the service process, personal artefacts to personalise the facility and the style of décor (Hoffman al.,2009). Rafaeli &Vilnan-Yavetz (2006) coined the term virtual Servicescape. They said that due to the advancement of technology and changing lifestyle, customers do not want to restrict themselves in the environment which is away from the internet technology or modern media.

Figure 2.7: Relationship between Servicescape elements, price perception, loyalty and satisfaction.



Source: Han and Ryu (2009)

Han and Ryu (2009) concluded that the three factors of the physical environment strongly influence how customers perceived price, and this price perception in turn enhanced customer satisfaction level also influences customer loyalty.

2.4.8 Servuction model

The model consists of four factors that directly influence customers' service experiences, and these are:

- Servicescape(visible)
- Contact personnel/service providers(visible)
- Other customers(visible)
- Organizations systems(invisible)

The Servicescape

It involves all the non-living features that comprise the service environment (Hoffman, et al., 2009). Because the service is intangible, customers often have challenges in evaluating the quality of service objectively. Consumers will then rely on the physical evidence that surrounds them to derive their evaluations. Services vary per industry and regardless of the variation, all service firms need to recognize the importance of managing the service scape due to its role in the following:

- Packaging the service
- Facilitating the service delivery process
- Socializing customers and employees
- Differentiating the firm from its competitors

Contact Person/service provider

The contact personnel are the employees who interact with the customers like parking attendants, receptionists and security personnel.in contrast the service providers are the primary providers of service like dentists, physicians, opticians and pharmacists (Hoffman, et al., 2009).

Other Customers

The success of many service encounters depends on the effectiveness of the firm in terms of clientele management. The influence of other customers can be active or passive.

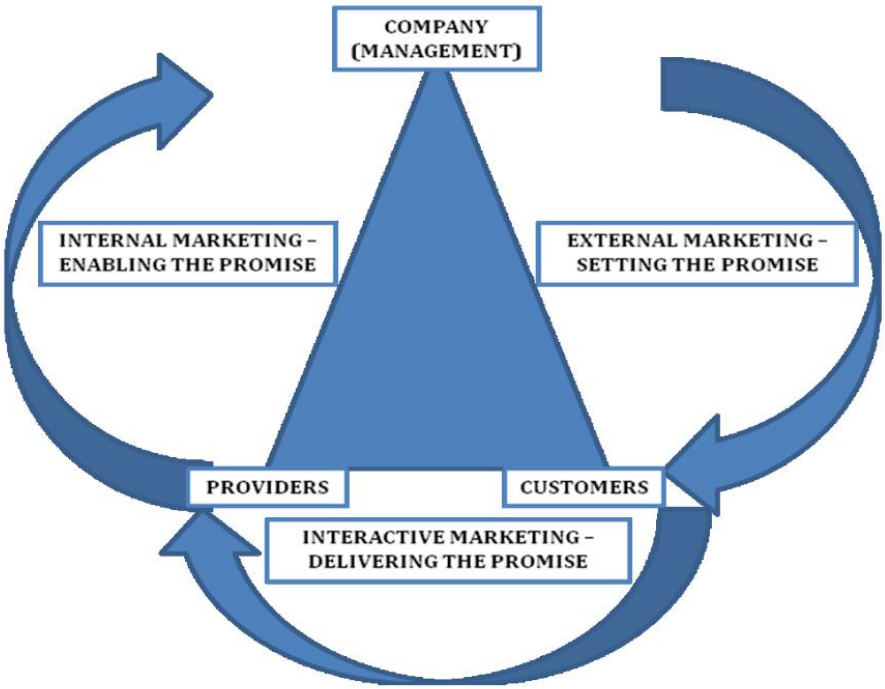
Organisations and Systems

The visible components of service firms cannot exist in isolation, they are supported by invisible components. (Hoffman, et al., 2009). The invisible organisation and system reflect the rules, regulations and processes upon which the organisation is based. Despite their invisibility to customers, they have a profound effect on the consumers' service experience.

2.4.9 Service triangle

The triangle is a framework that supports change in philosophy. It consists of six key relationships between the service strategy (company management), the customers and the employees who are the service providers.

Figure 2.8: The Service Triangle



Source: Dabhade, N et al. (2013).

The first relationship is between the firm's strategy and the customers. The firm's service strategy must be communicated to its customers (Hoffman, et al., 2009). If superior service is the focus of the organization and the key point of differentiation by which it distinguishes itself from competitors, the customer needs to be made aware of its firm's commitment to excellence (Hoffman, et al., 2009). Likewise, CIMAS must engage its members when strategizing. It will make them feel part of the organization and have that sense of ownership. This is the stage when CIMAS is setting the promise and involves price strategy, promotional activities and all communication with the members. It is performed to capture the attention of the market and arouse interest in the service (Dabhande, N et al, (2013).

The second relationship is between the company strategy and the employees. The service strategy needs to be communicated to the firm's employees. good service starts from top flowing to the bottom staff and management must lead by example (Hoffman, et al., 2009). If top management lacks commitment to the process, front line employees who interact with the firm's customers will be ineffective at best. At this stage CIMAS is enabling the promise by training the staff, teamwork programs and motivational activities. This will enable the employees to perform the service effectively and keep up the promise made to the customer. (Dabhande et al, (2013).

This last and most important relationship is the customer and service provider interaction. The systems of an organization should flow logically from the service strategy and enhance the service encounter for employees and customers alike (Hoffman, et al., 2009). At this stage CIMAS is now delivering the promise to its members. These interactions represent the moments of truth incidents. The quality of this interaction is often the driving force in customer satisfaction evaluations (Hoffman et al., 2009).

2.5 Determinants and variables of service quality

Since service quality is considered as a multi-dimensional construct, Parasuraman et al., (1985:46-47) also identified ten key service determinants as depicted in the below figure.

Table 2.1: Determinants of service quality

Determinant	Example of evaluative criteria
Tangibility	Appearance of physical facilities and personnel
Reliability	Performing services right the first time
Responsiveness	Willingness and ability to provide prompt service
Communication	Explaining service to customers in a language they can understand
Credibility	Trustworthiness of customer-contact personnel
Security	Confidentiality of transactions
Competence	Knowledge and skill of customer-contact personnel
Courtesy	Friendliness of customer-contact personnel
Understanding/ Knowing customers	Making an effort to ascertain a customer's specific requirements
Access	Ease of contacting service

Source: Parasuraman *et al.* (1986:6-7)

Of the above determinants, tangibles and credibility can be known in advance of purchase there by indicating that the number of search properties is few. Only when the customer is purchasing or consuming the service, can each of the other properties known to them Parasuraman et al., (1985:48).

Parasuraman et al. (1988) redefined their exploratory research done in 1985 with the subsequent scale named SERVQUAL for measuring customers' perceptions of service quality. The ten determinants were collapsed into five determinants namely reliability, responsiveness, assurance, tangibles and empathy and this are shown in the table below.

Table 2.2: Redefined Determinants of service quality

Determinant	Examples of evaluative criteria
Reliability	Ability to perform the promised service dependably and accurately
Responsiveness	Willingness to help customers and provide prompt service
Assurance	Knowledge and courtesy of employees and their ability to convey trust and confidence
Tangibility	Appearance of physical facilities, equipment, written materials and personnel
Empathy	Caring, individualised attention the firm provides its customers

Source: Parasuraman *et al.* (1986:14-15)

Reliability

Reliability reflects a company's consistency and certainty in terms of performance. Reliability is the most important dimension for the consumer of service. It entails if the company is reliable in providing the service and if it provides it as promised. This determinant is consistently shown to be the most important determinant of perceptions of service quality (Wilson et al., 2008:85).

Responsiveness

It is responsible for measuring company and employee receptiveness towards clients. It also emphasis on the attentiveness and promptness in dealing with customer request, questions, complaints and problems. This includes the turnaround times, answers to questions or attention to problems. Notion of flexibility and ability to customise the service to customer needs. The determinant reflects customer's point of view, not companies (Wilson et al.,2008:85).

Assurance

This looks if the employees are well-informed, educated, competent and trustworthy and inspires trust and confidence. This dimension is important when customers perceive as high risk or feel uncertain about their ability to evaluate outcomes. As such CIMAS must thrive to build trust and loyalty between key contact people and customers (Wilson et al., 2008:86).

Tangibility

Since there is no physical element to be assessed in service, clients often trust the tangible evidence that surrounds it when making their assessment. The tangibles include the service providers' physical installations, equipment, people and communication material. CIMAS must provide physical representation or images of its services that customers will use to evaluate quality, to enhance good image, provide continuity and signal quality (Wilson et al., 2008:86).

Empathy

This is the capacity of a person to experience another's feelings. CIMAS will achieve this by treating customers as individuals. Also, if it provides careful and personalised attention. Every customer wants to feel important and understood by firms that provide a specific service. It would be a good strategy for CIMAS to know its customers by name and build relationships that reflect their personal knowledge of their requirements and preferences.

Critique the literature

Notwithstanding its popularity and widespread application, the SERVQUAL has been subjected to several theoretical and operational criticisms (Cronin and Taylor,1992) Parasuraman et.al's measure of service quality was based on Oliver's disconfirmation of performance model. The model had proposed that satisfaction is a function of the disconfirmation of performance from expectation. Also, there is confusion and sometimes boring on the administration of expectations (E) and perceptions (P) versions of SERVQUAL.

Research gap

The researcher recommends research on the role of internal service quality, customer satisfaction and internal loyalty. Also, the measure of service quality, customer satisfaction and customer loyalty using the empirical model. The two studies will form a basis for further research. She also included the product and price on the determinants of service quality, and these have been excluded from previous studies.

Empirical Evidence

A myriad of similar researches to the one being undertaken have been carried out globally. An empirical literature provides more insight on benefits of customer satisfaction for organisations. Below are some of the researches carried out and the evidence from the researches is significant for the prevailing research.

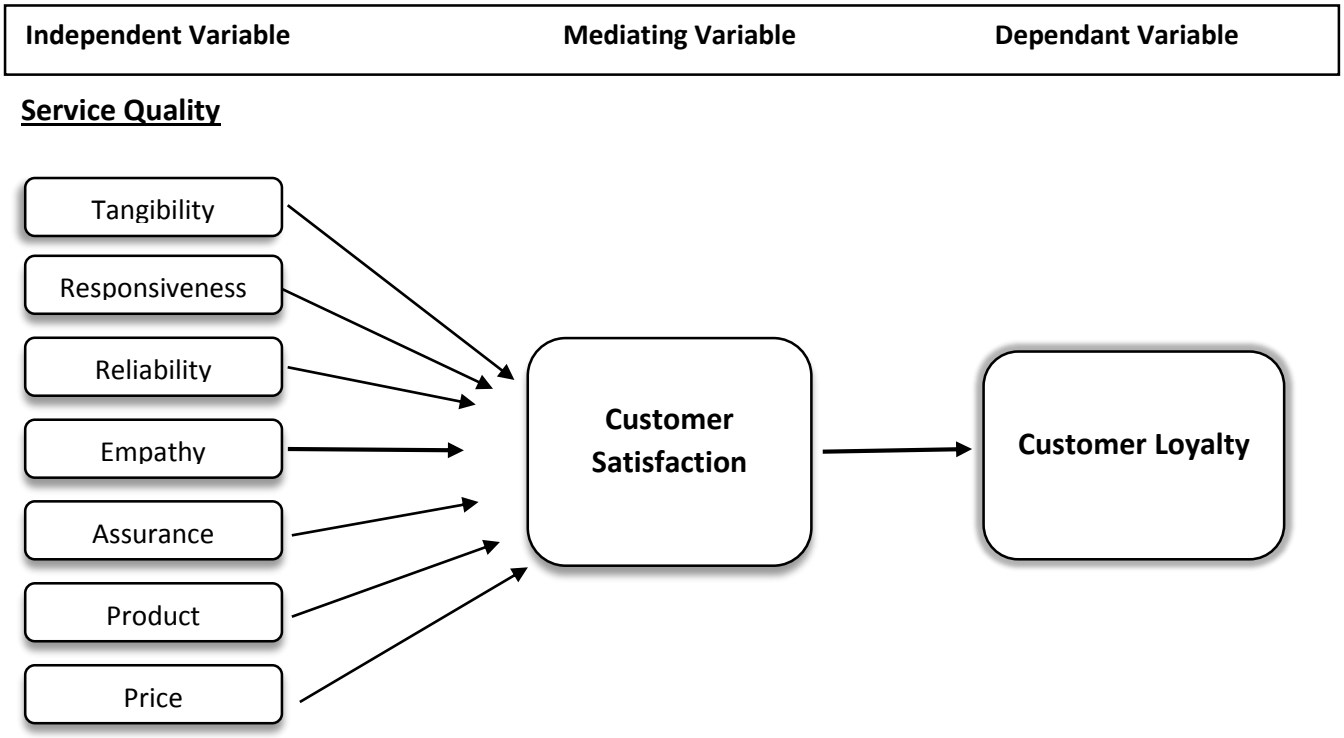
The study carried out by Mugwagwa et al (2017) emphasized on the linkage amongst healthcare providers, healthcare funders and the members (customers) as value addition to the healthcare in Zimbabwe. Empirical evidence from the local research benefits the researcher in acknowledging the importance of impact of customer service in the health care system.

Alegre and Cladera, 2009 quoted service quality among the main causes of customer loyalty. This has been supported by Eshghi et al.,2007. Empirical evidence from this research found the basis of satisfaction being a predecessor of loyalty on evidence that by satisfying customers, they are very likely to remain loyal to the organisation.

2.6 Conceptual Framework

Conceptual framework refers to a system of concepts, expectations, beliefs, assumptions and theories in which a researcher operationalizes to support and inform a research (Robinson 2011).The theoretical part of this research will cover the customer retention, customer satisfaction by meeting customer expectations, customer loyalty and these will lead to service quality.

Figure 2.9: A conceptual framework of association among service quality, customer satisfaction and loyalty



Source: Own compilation

A positive correlation between quality of service performed and loyalty of customers exists with satisfaction acting as a mediator (Chodzadza & Gombachika, 2013). Deviations in the quality services create deviations in customer satisfaction that ultimately form deviations in customer loyalty. (Auh& Johnson,2005). According to Montserttat et. al (2012) a satisfied customer is usually less price sensitive, not attentive to competing brands, spreads good messages about the firm.

Excellence in the quality of service and the subsequent level of customers' satisfaction is constantly related to the customers' loyalty (Shambachew,2015). A company may be offering quality services but does not necessarily meet expectations of the customer, but the customer stays anyway due to behavioural loyalty.

2.7 Chapter Summary

The chapter focuses on literature review. The literature review highlights previous researchers and theories from previous writers. It looked at the service quality models in relation to medical insurance industry. It has been shown that for a company to meet customer expectations, it must offer products and services that excel well in their perceptions. this must be in line with responsibility of the form, tangibility of products and services, security as well as empathy of staff members. Medical aid societies must adopt models that will enhance them to operate well and meet their expected roles.

Chapter Three

Research Methodology

3.1 Introduction

This chapter explains the research methodology the researcher used. The methodology helped to draw answers to the research questions or to fulfil research objectives. Research methodology involves the theoretical frameworks and learning of the various techniques that can be used in the conduct of research and the conduct of tests, experiments, surveys and critical studies (Saunders, Lewis and Thornhill, 2016). The researcher adapted the research onion model proposed by Saunders et al. (2016) to explain her research methodology. The research onion is a tool that helps to organize a research and develop research design following the layers of an onion step-by-step. It comprises five concentric rings – research philosophy, approach to theory development, methodological choice, [research] strategy or strategies, time horizon, data collection and data analysis – hence its name. This list of the concentric rings or parts of the onion is silent on the population and sampling although Saunders et al. (2016) explain these elsewhere in their research methodology textbook. In this chapter, the population, sampling procedure and sample size are explained in between the research strategy and time horizon of the research onion.

3.2 Research philosophy: Pragmatism with bias towards positivism

A classical research methodology is based on a certain philosophical theory which implies strategies and techniques of the research (Nweke & Orji 2009; Saunders et al., 2016). Whether one is aware of or not, at every stage of the research one will make several types of assumptions (Burrell and Morgan, 2016). These include assumptions about the realities encountered in the research ontological assumptions such as how one sees study objects (Saunders et al., 2009) that may include the individuals' working lives, organisational events and artefacts; the epistemological assumptions (Burrell and Morgan 2016; Gabriel et al., 2013), which look at human knowledge ranging from numerical data, textual data, visual data to opinions and narrative stories; and, lastly, the axiological assumptions that focus on the researcher's values and ethics through the research process (Saunders et al., 2019; Heron, 1996).

The researcher investigated how members of CIMAS felt about the medical aid society's quality of service and whether that led to (*dis*)satisfaction and (*dis*)loyalty. To fulfil this key objective of the dissertation, she chose a research philosophy from among those suggested in the research onion of Saunders et al. (2016)—pragmatism, post-modernism, interpretivism, positivism, and critical realism. She settled for the pragmatism philosophy biased towards a positivist philosophy in which she combined ontology and epistemology to produce a research methodology that dealt with the reality in CIMAS. Pragmatism is an approach which asserts that concepts are only relevant where they support action (Kelemen and Rumens,2008) Positivism is the philosophical stance of the natural scientist and it entails working with an observable social reality to produce law-like generalisations (Saunders et al., 2019) The researcher adopted the positivism so as to yield pure data and facts uninfluenced by human interpretation or bias.

3.3 Approaches to theory development: Abduction biased towards deduction

Saunders et al. (2016) distinguish three main approaches to theory development—deduction, induction and abduction. This study used the abduction approach, which is a mix of the deductive and inductive approaches, but in this case biased towards a deductive research approach. Saunders et al. (2012) argue that abduction entails collecting data to examine a phenomenon, identify themes and explain patterns to create a new or amend a current theory, which is subsequently tested. A deductive research logic is referred to reasoning moving from general rule to a specific law-like inference and is usually used for theory testing (Bryman and Bell, 2015; Blaikie 2010) and is aligned with the positivist philosophy (Saunders et al., 2019). The researcher settled for the abductive approach leaning towards a deductive approach because she started with theory developed from reviewing academic literature and then developed a research design to test the theory. Among the hypotheses on service quality and/or customer satisfaction she had two (H_6 and H_7) that had not been tested in previous studies—based on the influence of product and price on customer satisfaction.

3. 4 Research design

A research design is a plan for a study, providing the overall framework for collecting data(Leedy and Ormrod, ,2010) According to Durrheim (2004), research design is a strategic framework for action that serves as a bridge between research questions and the execution, or implementation of the research strategy. It encompasses research philosophies, research strategies, research methods, sampling, data collection and data analysis.

3.4.1 Research strategy: Case study and survey

Presenting research strategies, Saunders et al. (2016) suggest experiment, survey, archival research, case study, ethnography, action research, grounded theory and narrative inquiry to be the main strategies for research. Research strategy can be referred to as a general way which helps the researcher to choose main data collection methods or sets of methods in order to answer the research question and meet the research objectives. This study adopted the case study and survey strategies. In terms of time horizon, this study adopted the cross-sectional research instead of the longitudinal research because it lasted only six months and gathered data from respondents in the sample only once. A cross sectional research is one which captures a snapshot of the status quo in a research subject or issue as opposed to recording events over a long period of time for analysis (Saunders et al. 2009). The time horizon suited the survey strategy as questionnaires were administered over a short period of time.

3.4.1.1 Case Study

A case study is a strategy for doing research which involves an empirical investigation of a contemporary phenomenon within its real-life context using multiple sources of evidence (Saunders et al., 2009:145). The case study strategy makes use of such data collection techniques like interviews, observation and documentary analysis. This study was a case study in the sense that instead of having gathered data from a cross section of medical aid societies in Zimbabwe, it focused on CIMAS because the researcher was constrained by resources: time, money, people and materials. Case studies can be multiple and single case and this one was a single case. Case study research strategy is used in qualitative and quantitative studies (Kumar, 2014) hence is employed by interpretivists and positivists (Collis & Hussey, 2014).

3.4.1.2 Survey

A survey is a research strategy that is mainly used in deductive studies to answer who, what, where and how much type of questions concerning a study (Saunders et al, 2009). This study

used the survey strategy where a sample was chosen from members of CIMAS in Harare where data was collected from members visited the Borrowdale (CIMAS head office) and Jason Moyo (town office) branches. This enhanced the achievement of objectives of the study through using data collected via surveys in CIMAS. Advantages of using a survey include its cost effectiveness, less time consuming, easy to administer and it can collect data from a large number of respondents.

3.5 Population and sampling

3.5.1 Study population

Frankel and Wallen (2006) highlight that a study population is made up of targeted individuals whom the researcher targets to get information from and results will be generalized from the given information. A population is simply defined as a group of individuals of importance to the researcher's investigation (Yin, 2003). For this study, CIMAS has 190 000 members nationwide of which Harare alone constitutes 60% of those members. The target population in this research was made up of all CIMAS members across the packages that were estimated to use the two Harare customer service offices, in the city centre and in Borrowdale. This population enabled the researcher to conduct a quantitative research.

3.5.2 Sampling technique and sample size

A sample is a subgroup of the total population which is chosen to represent the population (Burn, 2004). A sampling frame is a complete list of all the cases in the population from which a sample is drawn (Saunders et al. 2009). Use of the entire population is not possible in research hence the choosing of a reasonable sample size is vital. In this study a sampling frame was made up of CIMAS members who are users of the Borrowdale and Jason Moyo customer service offices. Given the size of the population a census approach was feasible due to limitations of time and resources. Researchers can adopt a census if it is possible to collect data from every case in the population. Thus, the researcher collected data from a sample. The Cochrane's sample size determination criterion, normalized for large population sizes, was used to calculate the sample (Bryman and Bell, 2015; Warner, 2012). The respective formula used to achieve this was:

$$n=N_x/((N-1)\ E^2 + x)$$

Where: $x=Z(c/100)2r(100-r)$

And, where E=Sqrt [(N- n) x/n(N-1)]

Where *N* is the population size, *n*, is the sample size, and Z(c/100) is the critical value for the confidence level. In this regard, a 5% margin of error was considered together with a 95% confidence level. Factoring in the average population size of all walk-ins per month to be 1600, a subsequent sample size of 310 was computed.

There are two broad sampling methods probability (random) and non-probability (non-random) sampling in research methodology literature (Alvi, 2014; Saunders et al., 2016; Malhotra and Dash, 2011). In this study the researcher used both probability and non-probability sampling, name cluster and convenience sampling, because of time limitations and other resources. The sampling strategy fits the pragmatist (combined positivist and interpretivist) research philosophy and abduction (combined deductive and inductive) research approach she adopted. This in line with Saunders et al. (2009:109) who argue that the reality is that a particular research objective seldom fit neatly into only one philosophical domain as suggested in the 'onion' hence researchers are encouraged to think in a more flexible manner about the research approach and methods they adopt.

In probability sampling, also called representative sampling, every member of the population has a known probability of being included in the sample (Alvi, 2014). The researcher adopted probabilistic sampling in respect of deciding the sample and the cluster of focus. She also adopted non-random sampling in respect of deciding who exactly participated in the study. Non-probability sampling is also called judgement or non-random sampling where every unit of population does not get an equal chance of participation in the investigation. Under probability there is simple random, systematic, stratified, cluster and multistage sampling. Volunteer, convenient, quota, snowball and purposive all fall under the non-probability sampling.

The researcher also used cluster sampling in which she chose members from the same geographical area, in this case Harare. The population was divided into two clusters being Jason Moyo branch and Borrowdale branch. This had an advantage of reduced costs, time, efforts because instead of going from place to place over a widely spread area for randomly selecting elements, the elements were found in one geographical region. The researcher then employed convenience sampling**,** a sampling technique used for non-random sampling where she selected

those cases that were easiest to work with (Saunders et al. 2009) from the two research sites, Harare Jason Moyo and Harare Borrowdale branches. The advantages for using the convenient sampling is that it is less time consuming as the sample size is easy and quick to attain, inexpensive and consumes fewer efforts. Thus, data were gathered from those CIMAS customers who visited the two research sites in the three weeks data were gathered and agreed to participate in the study. While simple random sampling technique was more ideal to select members, who visited the two branches during the data collection period, the sample would still not have been truly random given that some prospective respondents declined the invitation to answer the questionnaire.

3.5.3 Methodological choice: Questionnaire and its structure

In their research onion, Saunders, Lewis and Thornhill (2016) list the following research methods that they call methodological choices: mono method qualitative, mono method quantitative, multi-method qualitative, multi-method quantitative, multi-method simple, and multi-method complex. There are several methods through which primary data can be gathered such as questionnaire, interview guide, focus groups, and observation. Thus, the methodological choices are the items or tools that are used to get relevant data for the research project. Questionnaires can be used to collect data in case study and survey research designs (Saunders, Lewis & Thornhill, 2012:179; Muzondo, 2018; Collis and Hussey, 2014).

A questionnaire is a research tool that comprises a series of questions and other prompts in order to gather information from respondents (Best, 2004). It is a list of questions which are given to respondents so that they complete in written form and return them to the researcher. Wisniewski (2004) defines a questionnaire as an instrument used in raw data collection and consisting of a set of questions which are meant to address specific objectives. Questionnaires are an efficient and relatively affordable mechanisms for efficient collection of certain kind of information. The researcher used a questionnaire to collect primary data from CIMAS members. Thus, her methodological choice was mono-method quantitative (Saunders et al., 2016). The questionnaire had three sections.

Section 1 of the question sought to establish the demographics of the respondents. The demographic data collected included the package where the member is registered under, the period of membership and whether the member is a principal or dependant. Section 2 carried all the key questions relating to the key objective of the study hence was informed by the

study's conceptual framework explained in Chapter 2 of this dissertation. The questionnaire requested respondents to tick off their responses on a 5-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree. At the bottom of this section, respondents were also asked to write any other comments on service quality that they had that related to CIMAS. So, the study collected quantitative and qualitative data but with more of the former type. This is consistent with the pragmatist and abductive research philosophy and approach adopted in this study respectively.

The third, and last, section of the questionnaire asked respondents to suggest the cut-off point or threshold below which they would not be satisfied with the performance of CIMAS and also below which they would not be loyal to the medical aid society. Both the minimum satisfaction and loyal points were measured on a 5-point scale ranging from 1 = Lowest Performance to 2 = Highest Performance.

3.5.4 Face validation and pilot study

Three experts, including the researcher's supervisor, checked the face validity of the final draft questionnaire. Face validity is an "agreement that a question, scale, or measure appears logically to reflect accurately what it was intended to measure" (Saunders et al., 2009:592). Some changes were made to the questionnaire as a result of this procedure. Subsequently, the researcher pre-tested the questionnaire on 10 respondents to see if they consistently and correctly interpreted the questions asked. A few more changes were effected to the questionnaire because of the pilot. Pilot testing helps to check if a questionnaire has some level of validity and reliability (Saunders et al., 2012).

3.5.5 Data gathering and ethical considerations

A total of 310 questionnaires were distributed of which 200 were given to the Jason Moyo Road CIMAS branch in the city centre and 110 were given to the Borrowdale CIMAS head office branch. The branches were given two weeks to administer the questionnaires to prospective respondents who visited their offices between early to mid-February 2020. The questionnaires were spread over three service counters at each branch (see Appendix 2). Each questionnaire was accompanied by a letter of introduction that explained the objectives and benefits of the study and highlighted the right of respondents to opt out of the study if they so wished (Appendix 1). Moreover, the researcher got permission from CIMAS management, her

employer, before data collection began. Thus, the research procedure complied with ethical protocol.

Ethics are of paramount importance in both the primary and secondary research due to ethical issues that relate to fair and unbiased selection of sources and analysis (Farrimond, 2013). Walliman (2004) postulates that ethics is about moral principles and rules of conduct. Hammersly and Traianou (2012) suggest five commonly recognised principles as minimising harm, respecting autonomy, reciprocity, protecting privacy and treating people equitably. The researcher was guided by these principles throughout her research. Prospective respondents could opt out of the study once they were informed about it. And for those who proceeded to complete the questionnaire, they were informed not to write their names or membership number anywhere on the questionnaire.

3.5.6 Data inputting and cleaning and analysis

The returned questionnaire was initially scrutinised for missing data (unfilled questions) and those with at least five unfilled questions in Section 2 of the questionnaire, the conceptual framework, were put aside. Data from the rest of the questionnaire was captured in Microsoft Excel. The data were then exported into Statistical Package for the Social Sciences (SPSS) Version 22 and cleaned.

3.6 Data analysis: Descriptive statistics, validity and reliability

3.6.1 Descriptive statistics

The data from Section 1 of the questionnaire were analysed with SPSS using descriptive statistics, namely, frequencies, percentages and mean scores. Once the validity and reliability of the factors were ascertained (next two sections), the factors and their constituent variables were also analysed with SPSS and the findings were reported in mean scores and standard deviations.

3.6.2 Validity: Exploratory factor analysis (EFA), confirmatory factor analysis (CFA) and structural equation modelling (SEM)

The data from Section 2 of the questionnaire were initially analysed with EFA through the principal components analysis (PCA) technique to identity the key determinants of service quality from the dataset. Factor analysis is used to validate instruments (Truong and McColl,

2011; Hair et al., 2010). Validity is the degree to which the data collection tools can measure the intended variables in the study (Cooper and Schindler, 2003). While the questionnaire was preliminarily validated through literature review, expert consultations, and pilot survey before the survey, it was also validated with EFA was the data were gathered. Meaningful factors with variable factor loadings are greater than or equal to .500 are valid (Truong & McColl, 2011; Hair et al., 2010). The same cut-off point was used in the measurement model (CFA) structural or path model (SEM).

3.6.3 Reliability: Cronbach's alpha

Reliability is the extent to which a research instrument can able to produce consistent results (Saunders et al., 2009). In this study, the researcher used the Cronbach's alpha technique, which is commonly used to examine reliability. A Cronbach's alpha is number between 0 and 1 and an acceptable reliability is expressed by a Cronbach's Alpha of at least .700. Thus, interpretable and valid determinants of service quality were retained provided they had the minimum acceptable level of reliability as specified above.

3.7 Study limitations

Limitations are those conditions beyond the control of the researcher that may place restrictions on conclusions of the study and applications to other situations (Best and Khan 1993). There were several factors that affected the success of this study. The researcher had limited time, people and material resources to invest in the research project.

3.8 Conclusion

This chapter has explained the research methodology applied to attain the objectives of this study. The chapter has described the research philosophy, approach to theory development, sampling procedure, the population, sample size, methodological choice, research strategy, time horizon, data collection method and data analysis procedures adopted and used in the study in accordance with the research onion model proposed by Saunders et al. (2016).

Chapter Four

Data Analysis, Presentation and Interpretation

4.1 Introduction

This chapter presents and discusses the study's findings. The main objective of the study was to identify the determinants of service quality in CIMAS and ascertain their impact on member satisfaction and loyalty. The secondary research objectives were to: (i) identify the determinants of service quality in CIMAS, (ii) confirm the identified determinants of service quality in CIMAS, (iii) measure the impact of the identified determinants of service quality on customer satisfaction in CIMAS, and (iv) assess the impact of customer satisfaction on customer loyalty in CIMAS. The study's findings and discussions are presented under relevant secondary research objectives. Nonetheless, the chapter opens by reporting the response rate and characterising the demographics of the respondents.

4.2 Response Rate

A total of 310 questionnaires were distributed in the two-week period set aside for data gathering in February 2020 and 218 usable ones were returned yielding a response rate of 70.32% (see Table 4.1). A response rate of 70% is considered reasonable in research methodology literature (Baruch & Holton, 2008; Perneger, Chamot and Bovier, 2005).

Table 4.1: Response rate

	Frequency	Valid Percentage
Completed (usable)	218	70.32
Incomplete (not returned)	92	29.68
Total	310	100

4.3 Demographic Analysis

4.3.1 Distribution of respondents by gender

Most of the respondents were females totalling 56.4% and the remaining 43.6% were males as shown in Table 4.2 below. This indicates that the sample was well distributed hence the responses received expressed views of both sexes.

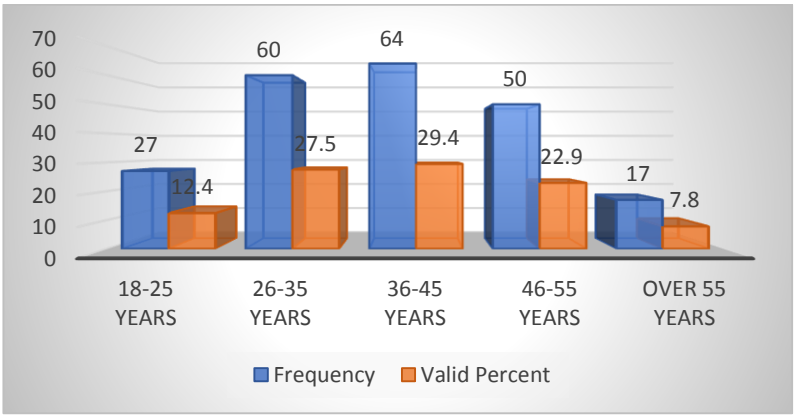
Table 4.2: Distribution of respondents by gender

	Frequency	Valid Percent
Male	95	43.6
Female	123	56.4
Total	**218**	**100**

4.3.2 Distribution of respondents by age

The researcher inquired the age distribution of the respondents. The results were that the majority (29.4%) of the respondents were in the age group 36-45 years and the least (12.4%) were in the cluster 18-25 years (Figure 4.1). As evident in the figure, the results show that the researcher gathered views from diverse age brackets.

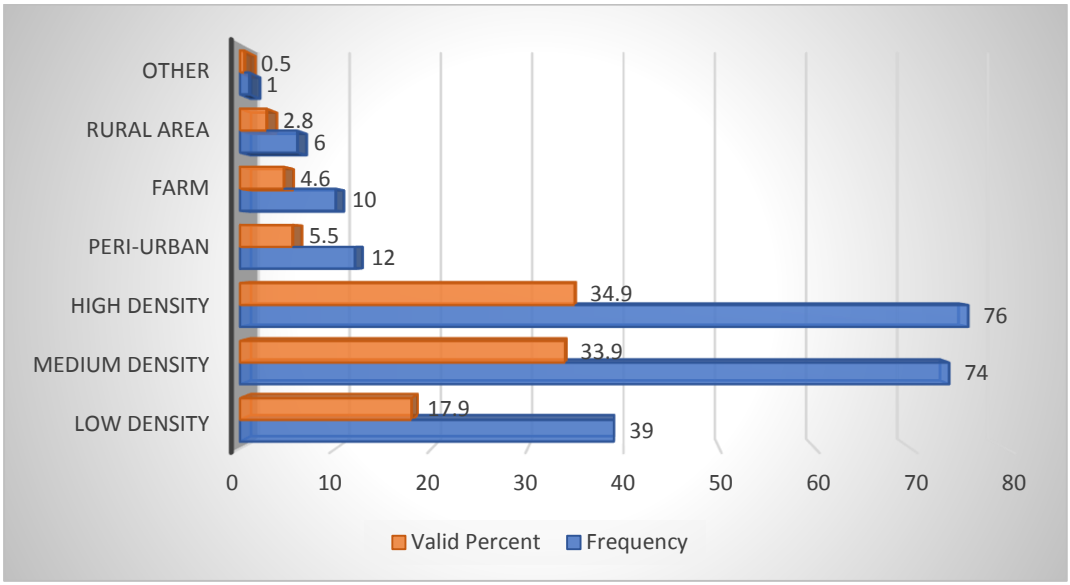
Figure 4.1: Respondents age



4.3.3 Distribution of respondents by area of residence

Figure 4.2 shows that most of the respondents were from the high-density areas of Harare constituting 34.9%. This was followed by those residing in the medium density suburbs of Harare with 33.9%. Those from the low density arears were 17.9%. The least respondents were from the rural areas (2.8%) and, finally, 0.5% did not disclose the type of settlement from which they came.

Figure 4.2: Distribution of respondents by type of residence



4.3.4 Distribution of respondents by highest level of education

The extent of level of education of the respondents may affect the way they interpret the questions. The study observed that 30.7% of the respondents had attained a first degree and those with diplomas accounted for 28.09%, while those with advanced level constituted on 12.8% of the respondents as shown in Table 4.3 below.

Table 4.3: Distribution of respondents by level of education

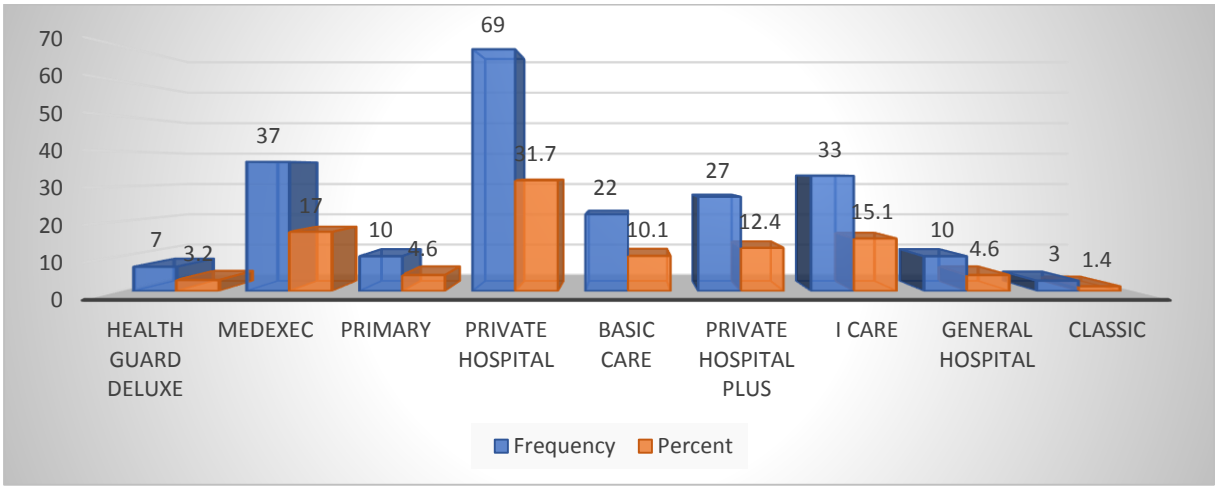
	Frequency	Valid Percent
Primary School	1	0.5
Ordinary Level	17	7.8
Advanced Level	28	12.8
Certificate	19	8.7
Diploma	63	28.9
First Degree	67	30.7
Master's Degree	20	9.2
Doctoral Degree	2	0.9
Other	1	0.5
Total	**218**	**100**

4.3.5 Distribution of respondents by package

Figure 4.3 depicts that most CIMAS members were registered under the Private Hospital package which constituted 31.7%. This was followed by MedExec with a contribution of 17%,

followed by ICare contributing 15.1%. The package with the least respondents in the sample was Classic with 1.4%.

Figure 4.3: Distribution of respondents by CIMAS packages



4.3.6 Distribution of respondents by type of account

Table 4.4 below shows that most members were registered under company accounts (64.2%) as opposed to individual accounts (35.8%). This implies that CIMAS Medical Aid Society had to have customised marketing strategies for each customer segment.

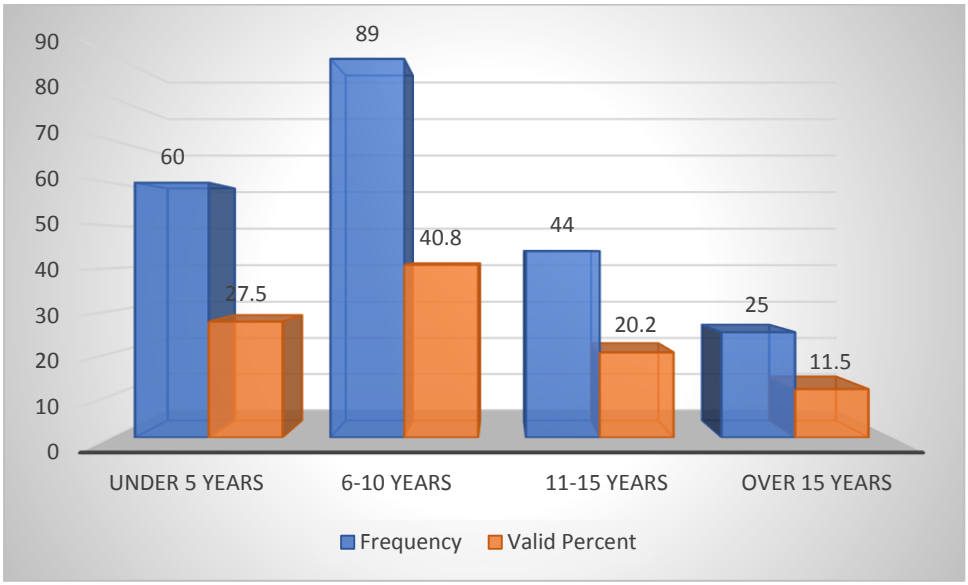
Table 4.4: Distribution of respondents by type of account

Type of Account	Frequency	Valid percent
Company	140	64.2
Individual	78	35.8
Total	**218**	**100**

4.3.7 Distribution of respondents by length of membership

Most members (40.8%) had been with medical aid society for 6-10 years and the least members (11.5%) had been with CIMAS for over 15 years. These findings somewhat suggest that the medical aid society had challenges in retaining customers for more than 10 years. This was not a good sign for member loyalty.

Figure 4.4: Distribution of respondents by length of membership



4.3.8 Distribution of respondents by type of membership

Table 4.5 below shows that principal members (62.4%) dominated the sample and non-principal members accounted for the remaining 37.6% of dependents. While the views of non-principal members were import as they might be in the decision-making unit, the fact that principal members dominated the sample might be welcome as these respondents were the ones paying medical insurance subscriptions to CIMAS.

Table 4.5: Distribution of respondents by type of membership

Primary Member	Frequency	Valid Percent
Yes	136	62.4
No	82	37.6
Total	**218**	**100**

4.3.9 Distribution of respondents by claim record

As shown in Table 4.6, an overwhelming majority of respondents (86.2%) had claimed or used their medical aid insurance before while only 13.8% had not. The researcher assumed that respondents who had used their medical aid insurance before could give a more informed assessment of the quality of services delivered by CIMAS than those who had not.

Table 4.6: Distribution of respondents by claim record

Claimed	Frequency	Percent
Yes	188	86.2
No	30	13.8
Total	**218**	**100**

4.3.10 Distribution of respondents insured with other medical aid societies

Most of the respondents (85.8%) had medical insurance with CIMAS only but the remaining 14.2% of respondents were concurrently insured with another medical aid society. This was so because of employer policies that provided employees to be insured with only one medical insurer since the subscription was often partly paid employers. Thus, the dominance of the sample by respondents who were insured with CIMAS only is not a measure of loyalty in the medical aid firms.

Table 4.7: Distribution of respondents insured with other medical aid societies

	Frequency	Valid percent
Yes	31	14.2
No	187	85.8
Total	**218**	**100**

4.4 Exploratory and Confirmatory Factor Analysis

The first secondary objective of the study was "to identify the determinants of service quality in CIMAS". This objective was attained through exploratory factors analysis (EFA).

4.4.1 Suitability of factor analysis to data reduction: Kaiser-Meyer-Olkin's measure of sampling adequacy, Bartlett's test of sphericity and correlation analysis

A dataset can be analysed with factor analysis if its Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy is greater than .500 (Costello & Osborne, 2011; Field, 2013) or .600 (Pallant, 2013). The strength of the relationship between variables in an identity can be measured by the Bartlett test of sphericity. It is a measure of a multivariate normality of set of distribution. This test also checks the null hypothesis that the original correlation matrix is an identify matrix (Pallant, 2013; Field 2009). Nevertheless, the Bartlett's test of sphericity is notorious for its sensitivity to, and dependence on sample size thus can still corroborate the

null hypothesis in large samples even if correlations are low (Field, 2013; Tabachnick and Fidell, 2007). Consequently, correlation analysis was also used to confirm the appropriateness of factor to analyse the study's data. Data can be factorised if variables have correlations (r) greater than .300 (Malhotra and Dash, 2011; Tabanichnick and Fidell, 2007).

Given the KMO measure sampling of adequacy of 0.839 shown in Table 4.8, the study had an adequate sample to justify the use of factor analysis as a data reduction and validation tool. The suitability of factor analysis as a technique of analysing data in this study was also confirmed by the Bartlett's test of sphericity because the hypothesis that the correlation matrix is an identity matrix was refuted (χ^2=3353.808; df = 325; *p*=.000). Furthermore, most of the factor correlations in the Pearson's correlations matrix (Table 4.9) are greater than or equal to .300 hence factor analysis can be used to analyse the data (Field, 2013; Tabanichnick and Fidell, 2007; Malhotra and Dash, 2011).

Table 4.8: KMO measure of sampling adequacy and Bartlett's test of sphericity

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.839
Bartlett's Test of Sphericity	Approx. Chi-Square	3353.808
	Df	325
	Sig.	.000

Table 4.9: Pearson correlation matrix

	Satisfaction	Loyalty	Tangibles	Reliability	Responsiveness	Product	Assurance	Empathy
Loyalty	.763							
Tangibles	.234	.311						
Reliability	.247	.179	.459					
Responsiveness	.380	.345	.384	.547				
Product	.368	.388	.552	.386	.554			
Assurance	.400	.421	.407	.322	.442	.509		
Empathy	.388	.372	.276	.253	.482	.358	.393	
Price	.585	.514	.193	.228	.440	.413	.370	.432

4.4.2 Determinants of service quality in CIMAS: Validity and reliability

To evaluate the validity and reliability of conceptual factor model, researchers need variables which are consistently moving together. Thus, to identify such variables EFA was conducted on the dataset using the principal components analysis (PCA) technique. EFA is a statistical procedure used to reduce many observed variables to small factors or variables. In EFA the consistent movements of observed variables are identified, considering cultural differences and research settings (Pallant, 2013). Using EFA with PCA the researcher extracted seven factors in line with the conceptual framework and the only difference being a slight shift in the variables under each component (Table 4.10). The conceptual model had 33 items categorized into the very seven constructs, but the empirical model has 26 items. This means that seven items were deleted from the factor structure because their factor loadings were below the cut-off point of .500 (Truong & McColl, 2011; Hair et al., 2010) and probably had a negative impact on the reliability of the model.

Table 4.10: Rotated Component Matrix: Determinants of service quality in CIMAS

	Component						
	1	2	3	4	5	6	7
PRC3 I am happy with what I pay to CIMAS for my medical aid cover	**.862**	.165	.041	.049	.096	.165	.065
PRC4 I am happy with the amount CIMAS refunds me for health services I pay for in advance of consumption	**.856**	.136	.082	.063	.000	.103	.093
PRC5 I incur reasonable shortfalls on the CIMAS package I subscribe	**.799**	.126	.064	-.005	.025	.001	.062
PRC2 CIMAS premiums are worth the service customers get	**.788**	.162	-.037	.212	.051	.200	.015
PRC1 CIMAS offers affordable premiums to customers	**.757**	-.007	.029	.273	.166	.171	.179
ASU3 CIMAS employees are consistently courteous and professional	.208	**.837**	.080	.041	.077	.106	.115
ASU4 I feel safe in my interactions with CIMAS	.258	**.785**	.072	.122	.140	.108	.022
ASU2 CIMAS employees have knowledge to answer members' questions	.076	**.776**	.074	.269	.088	.107	.140
ASU1 CIMAS employees behave in a manner that always instils confidence in members	.062	**.742**	.178	.217	.056	.137	.134
TAN3 CIMAS physical facilities are in quiet places	.134	.054	**.781**	-.048	.029	.085	.255
TAN2 CIMAS physical facilities are visually appealing	-.036	-.009	**.778**	.384	.206	.020	.018
TAN1 CIMAS has modern-looking equipment	.016	.120	**.723**	.364	.270	.011	.063
TAN4 CIMAS has necessary materials for providing services	.055	.293	**.679**	.066	.079	.166	.084

PRO2 CIMAS always updates its medical aid packages to suit modern trends	.266	.201	.251	**.784**	.088	.017	.079
PRO1 CIMAS offers a range of medical aid packages that meet members' needs	.210	.203	.164	**.762**	.118	.142	.250
PRO4 CIMAS operating hours are convenient to members	.078	.366	.154	**.688**	.156	.142	.103
REL2 CIMAS always meets its promised time frames for responses	.107	.001	.145	.144	**.821**	-.032	.146
REL1 CIMAS always performs services right the first time	.089	.065	.020	.181	**.738**	.020	.203
REL3 CIMAS employees always have sincere interest in solving members' problems	.010	.262	.268	.083	**.656**	.218	-.188
REL4 CIMAS keeps error-free records	.056	.127	.120	-.086	**.618**	.090	.345
EMP1 CIMAS employees give members individual attention	.106	.087	.088	.155	.085	**.860**	.142
EMP2 CIMAS employees have members' best interests at heart	.171	.174	.026	.046	.129	**.857**	.172
EMP3 CIMAS employees always seek to understand a member's specific needs	.385	.208	.181	.036	-.039	**.718**	.070
RES7 CIMAS always takes reasonable time to process members refunds	.175	.043	.123	.089	.185	.087	**.774**
RES6 CIMAS always pays members' healthcare service providers within reasonable time	.041	.143	.116	.100	.240	.113	**.770**
RES8 CIMAS takes reasonable time to preauthorize treatment	.131	.246	.143	.257	.018	.232	**.603**
Actual Eigen values	**8.274**	**2.933**	**1.934**	**1.699**	**1.534**	**1.273**	**1.119**
Eigen value- Percentage Variance	**31.82**	**11.28**	**7.44**	**6.54**	**5.90**	**4.90**	**4.30**
Cronbach's alpha	**.817**	**.749**	**.839**	**.849**	**.869**	**.858**	**.904**

Extraction Method: Principal Component Analysis.

Rotation Method: Varimax within Kaiser Normalization.

a. Rotation converged in 6 iterations.
b. Total variance explained- 72.18
c. Factors – 1 = Price; 2 = Assurance; 3 = Tangibles; 4= Product; 5= Reliability; 6= Empathy; 7= Responsiveness

It can be hard to name the components after extraction based on their factor loadings because PCA criteria is that the first factor or component accounts for the maximum part of the variance (Pallant, 2013). Therefore, as shown in Table 4.10, to interpret them, the rotation of factors assists in this process, for this reason the factors were rotated with the Varimax within Kaiser Normalization technique. Accordingly, factor rotation changes the pattern of the unrotated factors (as shown in component matrix above) and increases the understanding of each factor, by presenting the pattern of loadings in a manner that is easier to interpret and understand (Pallant, 2013: 184).

However, in the case of this study, the constructs had been predetermined in the conceptual model and the predicted variables loaded neatly and significantly into those components as predicted. Theory may be tested in preliminary form with factor analysis by comparing the obtained empirical factor solution to the expected model (Tabachnick & Fidell, 2007:611). So, if the researcher had had the hypotheses that 'there were seven determinants of service quality', it would have been confirmed with EFA. The factors are Price (Factor 1), Assurance (Factor 2), Tangibles (Factor 3), Product (Factor 4), Reliability (Factor 5), Empathy (Factor 6) and Responsiveness (Factor 7). As evident in Table 4.10, the factor loadings of all variables in the constructs are greater than .500, which means that the model is valid (Truong & McColl, 2011; Hair et al., 2010). Validity is the degree to which an instrument measures what it is intended to measure (Pilot & Hungler, 2013). Construct validity refers to the extent to which an instrument represents the factors understudy. In order to achieve the content validity, questionnaires included a variety of questions on the knowledge of CIMAS members about the service quality levels.

The Cronbach's alpha values for the factors are all equal to or greater than .749, which means the factors are a reliable measure of service quality (Griethuijsen et al., 2014; Shemwell, Chase, &Schwartz,2015; Rui Sarmento and Costa, 2017). Reliability in this study was measured with Cronbach's alpha, which is a measure of internal consistency, that is, how closely related a set of items are as a group. Cronbach's alpha reliability coefficient normally ranges between 0 and 1. The closer Cronbach's alpha coefficient is to 1.0 the greater the internal consistency of the items in the scale. George and Mallery (2010: 231) provide the following rules of thumb: ≥0.9 (Excellent), ≥0.8 (Good), ≥0.7 (Acceptable), ≥0.6 (Questionable), ≥0.5 (Poor), and ≤0.5 (Unacceptable). While increasing the value of alpha is partially dependent upon the number of items in the scale, it should be noted that this has diminishing returns.

A reliability analysis was carried out on the perceived service quality and customer satisfaction scale. Cronbach's alpha in Table 4.10 above showed the questionnaire to reach acceptable reliability, α=0.81. All the items appeared to be worthy of retention. The result of the reliability measure was good, α= 0.817 in the study and it was concluded and that all items in the model were internally consistent and reliable to assess the perception of the members.

Factor 1(Price) consists of 5 items of which variable PRC1 CIMAS offers affordable premiums to customers has the lowest factor loading of .757 and variable PRC3 I am happy with what I pay to CIMAS for my medical aid cover has the highest factor loading of .862. This is the most

important factor as it has an eigenvalue of 8.274 and percentage variance of 31.82, the highest in the factor model. It has a Cronbach alpha of .817 which means that the factor has a very good reliability (Zikmund et al, 2013).

As evident in the table above, the rest of the remaining determinants are valid and reliable because their factor loading, and Cronbach's alpha were above the comfortably above the minimum standards. The determinants are Assurance (Factor 2); Tangibles (Factor 3), Product (Factor 4), Reliability (Factor 5), Empathy (Factor 6), and Responsiveness (Factor 7).

4.4.3 Confirmation of identified determinants of service quality in CIMAS: Further validation through standardized regression weights and goodness of fit indices

4.4.3.1 Model validation through confirmatory factor analysis (CFA)- Standardized regression weights

The second secondary research objective of this study was 'to confirm the identified determinants of service quality in CIMAS'. This objective was fulfilled through confirmatory factor analysis (CFA), a statistical technique used to verify the factor structure of a set of observed variables (Sekeran & Bougie, 2013). CFA allows a researcher to test the hypothesis that the relationship between observed variables and their underlying latent constructs exists (Brown, 2015; Finch, 2011), which is measuring validity. The model extracted by EFA with PCA was subjected to confirmation with CFA and the findings are as given in Figure 4.5 and Table 4.11. The standardized regression weights (SRWs) or standardized factor loadings are all equal to or greater than .500. Based on the SRWs in the figure and table the factor model is valid. Most of the determinant correlations in the figure are above .300, which means that the factors are significantly correlated to warrant use of factor analysis to analyse dataset (Brown, 2015; Finch, 2011). Nonetheless, the correlations are below .900, which means that the factors are not significantly correlated to have multicollinearity (Furr and Bacharach, 2013).

Figure 4.5: Determinants of service quality measurement model- CFA output

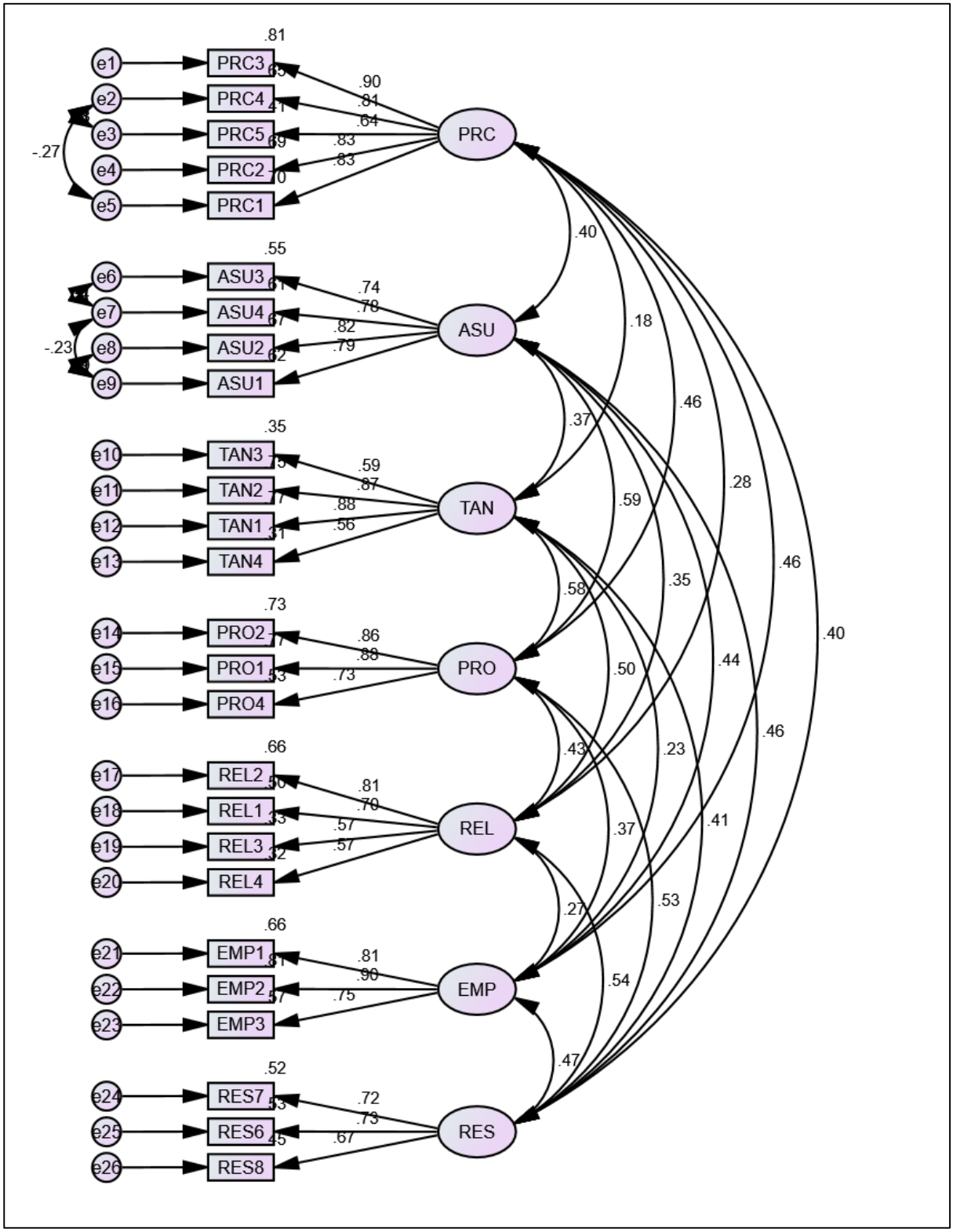


Table 4.11: Measurement model CFA and descriptive statistics

Determinants and variables	SRWs	Cronbach Alpha
Price		**.904**
PRC3 I am happy with what I pay to CIMAS for my medical aid cover	.901	
PRC4 I am happy with the amount CIMAS refunds me for health services I pay for in advance of consumption	.806	
PRC5 I incur reasonable shortfalls on the CIMAS package I subscribe	.636	
PRC2 CIMAS premiums are worth the service customers get	.832	
PRC1 CIMAS offers affordable premiums to customers	.834	
Assurance		**.869**
ASU3 CIMAS employees are consistently courteous and professional	.743	
ASU4 I feel safe in my interactions with CIMAS	.779	
ASU2 CIMAS employees have knowledge to answer members' questions	.819	
ASU1 CIMAS employees behave in a manner that always instils confidence in members	.786	
Tangibility		**.817**
TAN3 CIMAS physical facilities are in quiet places	.588	
TAN2 CIMAS physical facilities are visually appealing	.865	
TAN1 CIMAS has modern-looking equipment	.875	
TAN4 CIMAS has necessary materials for providing services	.556	
Product		**.849**
PRO2 CIMAS always updates its medical aid packages to suit modern trends	.856	
PRO1 CIMAS offers a range of medical aid packages that meet members' needs	.876	
PRO4 CIMAS operating hours are convenient to members	.731	
Reliability		**.749**
REL2 CIMAS always meets its promised time frames for responses	.812	
REL1 CIMAS always performs services right the first time	.705	
REL3 CIMAS employees always have sincere interest in solving members' problems	.573	
REL4 CIMAS keeps error-free records	.565	
Empathy		**.858**
EMP1 CIMAS employees give members individual attention	.813	
EMP2 CIMAS employees have members' best interests at heart	.899	
EMP3 CIMAS employees always seek to understand a member's specific needs	.753	
Responsiveness		**.839**
RES7 CIMAS always takes reasonable time to process members refunds	.720	
RES6 CIMAS always pays members' healthcare service providers within reasonable time	.730	
RES8 CIMAS takes reasonable time to preauthorize treatment	.667	

4.4.3.2 Validating determinants of service quality in CIMAS using goodness of fit indices (GFIs)

The GFIs test is used to test if sample data fits a distribution from a certain population. Chi-Square goodness of fit test is a non-parametric test that is used to find out how the observed

value of a given phenomenon is significantly different from the expected value. In Chi-Square goodness of fit test, the term goodness of fit is used to compare the observed sample distribution with the expected probability distribution. Chi-Square goodness of fit test determines how well theoretical distribution (such as normal, binomial or Poison) fits the empirical distribution. In Chi-Square good ness of fit test, sample data divided into intervals, the number of points that fall into the interval are compared, with the expected numbers of points in each interval (https://www.statisticssolution.comAccessed 26.02.2020).

Root Mean Square Error of Approximation (RMSEA) is a measure that attempts to correct the tendency of Chi-square statistics to reject models with large samples. RMSEA is considered very good if it is ≤ .05, good between .05 and .08 and acceptable if higher than .10 (Portela, 2012). Comparative fit index (CFI) analyses the model fit by examining the discrepancy between the data and the proposed model while adjusting for the issues of sample size intrinsic in the Chi-squared test and the normed fit indexed. It is considered very good if it is ≥0.95 (Portela, 2012).The findings from the study showed that the structural model fitted the data quite well as depicted by Table 4:12. The RAMSEA, CFI and the Chi-Square values all fitted well.

Table 4.12: Goodness of fit indices

GFI	STANDARD(S)	FINDINGS
Chi-Square	<2 (Suhr,2006; Fabozzi et al,2014)	2.316
CFI	≥0.90 (Portela, 2012), 0.80 (Fabozzi et al ,2014)	0.915
RMSEA	≤0.05 (Portela, 2012) 0.05 (Msydeu-Olivares	0.058

4.4.4 Impact of determinants on satisfaction with service quality in CIMAS and association between satisfaction and loyalty

The third and fourth, last, secondary research objectives of this study were 'to measure the impact of the identified determinants of service quality on customer satisfaction in CIMAS' and 'to assess the impact of customer satisfaction on customer loyalty in CIMAS'. The last secondary objective of this study was to test the relationship between determinants of service quality and satisfaction (the mediating variable) and loyalty (the dependent variable). These two objectives were simultaneously met through structural equation modelling (SEM) whose output is the structural model presented in Figure 4.13 and Table 4.12 below. The SRWs of

variables (attributes) of all seven independent variables, are greater than .500 which is above the cut-off point. The impact of the determinants of service quality (independent variables on satisfaction (the mediating variable) and the impact of satisfaction on loyalty (the dependent variable) are as shown in the aforementioned figure and table below.

Table 4.13: SEM and descriptive statistics

Determinants and variables	SEM Statistics			Descriptive statistics	
	SRWs	p-values p≤.05	Hypotheses testing	Mean score	Std Dev
Price	**.460**	.000	Accept	**3.14**	**.680**
PRC3 I am happy with what I pay to CIMAS for my medical aid cover	.901			3.07	.782
PRC4 I am happy with the amount CIMAS refunds me for health services I pay for in advance of consumption	.806			3.12	.828
PRC5 I incur reasonable shortfalls on the CIMAS package I subscribe	.636			3.12	.794
PRC2 CIMAS premiums are worth the service customers get	.832			3.20	.833
PRC1 CIMAS offers affordable premiums to customers	.834			3.17	.760
Assurance	**.180**	.003	Accept	**3.71**	**.614**
ASU3 CIMAS employees are consistently courteous and professional	.743			3.71	.734
ASU4 I feel safe in my interactions with CIMAS	.779			3.78	.690
ASU2 CIMAS employees have knowledge to answer members' questions	.819			3.67	.727
ASU1 CIMAS employees behave in a manner that always instils confidence in members	.786			3.67	.743
Tangibility	**.010**	.875	Reject	**3.90**	**.633**
TAN3 CIMAS physical facilities are in quiet places	.588			3.72	.920
TAN2 CIMAS physical facilities are visually appealing	.865			4.00	.800
TAN1 CIMAS has modern-looking equipment	.875			3.95	.863
TAN4 CIMAS has necessary materials for providing services	.556			3.73	.800
Product	**.170**	.004	Accept	**3.78**	**.692**
PRO2 CIMAS always updates its medical aid packages to suit modern trends	.856			3.88	.839
PRO1 CIMAS offers a range of medical aid packages that meet members' needs	.876			3.94	.759
PRO4 CIMAS operating hours are convenient to members	.731			3.88	.825
Reliability	**.110**	.071	Reject	**3.54**	**.595**
REL2 CIMAS always meets its promised time frames for responses	.812			3.44	.749
REL1 CIMAS always performs services right the first time	.705			3.61	.798
REL3 CIMAS employees always have sincere interest in solving members' problems	.573			3.63	.759
REL4 CIMAS keeps error-free records	.565			3.50	.844
Empathy	**.160**	.008	Accept	**3.46**	**.687**
EMP1 CIMAS employees give members individual attention	.813			3.45	.774
EMP2 CIMAS employees have members' best interests at heart	.899			3.45	.792
EMP3 CIMAS employees always seek to understand a member's specific needs	.753			3.50	.770
Responsiveness	**-.240**	.000	Accept	**3.45**	**.522**

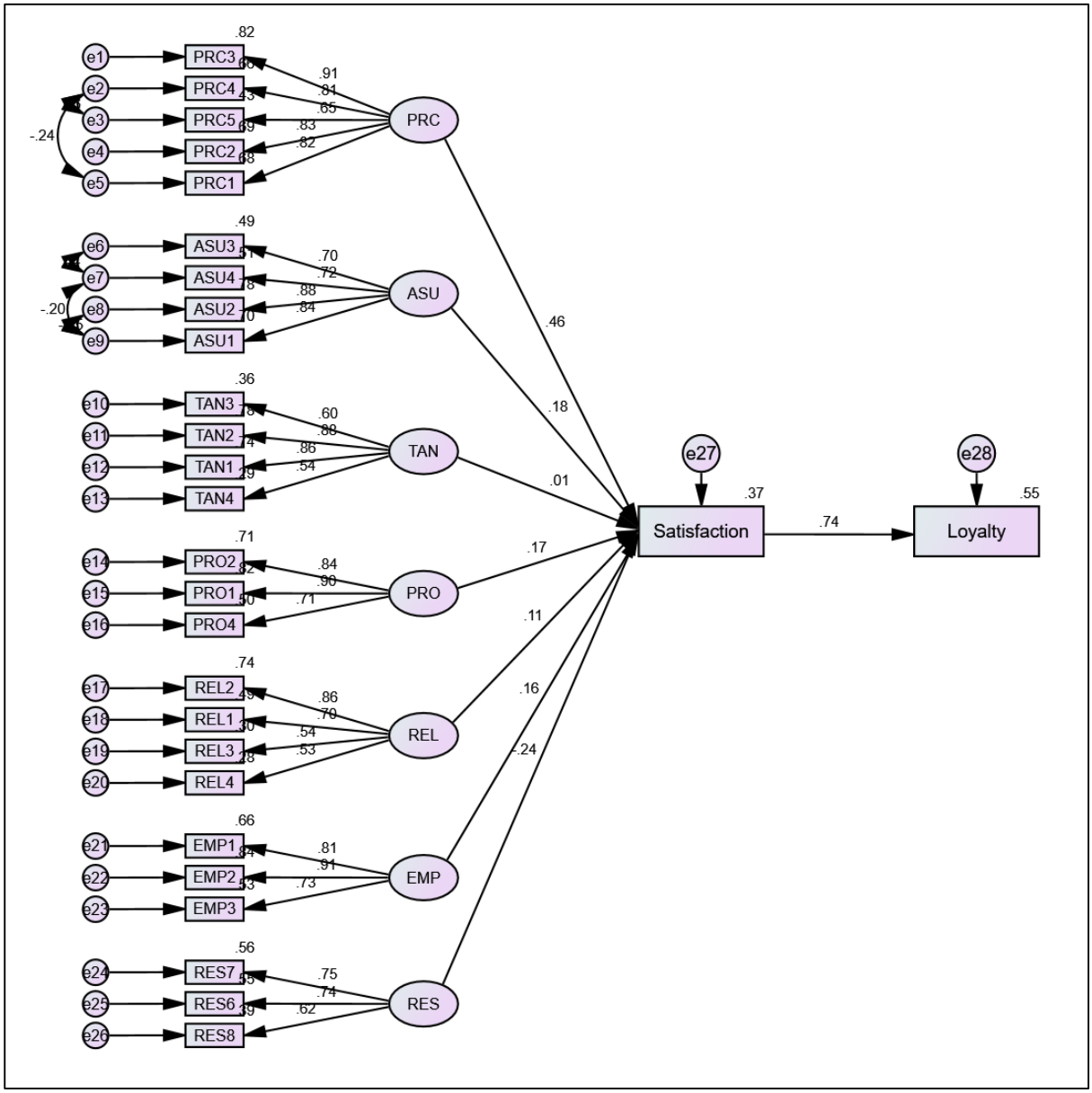
RES CIMAS always takes reasonable time to process members refunds	.720			3.40	.757
RES6 CIMAS always pays members' healthcare service providers within reasonable time	.730			3.37	.776
RES8 CIMAS takes reasonable time to preauthorize treatment	.667			3.46	.673
LOYALTY<---SATISFACTION	**.740**	.000	Accept		

Among the seven determinants of service quality in the structural model, price is the most important one (SWR=.46) and is positively related with satisfaction (p=.000). Therefore, Hypothesis 7 (H_7) has been confirmed (***H_7:*** *Price has a positive and significant correlation with customer satisfaction*). Price has a mean score of 3.14 measured on a 5-point Likert scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree. Given that 3 represented Neither Disagree nor Agree, any mean scores below 3.1 would be meaning CIMAS members would be disagreeing that the determinant or variable concerned is critical to their satisfaction with the society. Therefore, the mean score attained on the price determinant suggest that customers agreed that price is a measure of their satisfaction with CIMAS.

The assurance determinant was found to be positively and significantly correlated with customer satisfaction (β=.180; p=.003; μ=3.71; SD=.614). Thus Hypothesis 5 (***H_5:*** *Assurance has a positive and significant correlation with customer satisfaction*) was confirmed. Assurance is an important component of service quality and customer satisfaction.

Although tangibility had the highest mean score it was found not to be an important predictor of customer satisfaction in CIMAS (β=.010; p=.875; μ=3.90; SD=.633). Therefore, the Hypothesis 1 (***H_1:*** *Tangibility has a positive and significant correlation with customer satisfaction*) of the study was rejected.

Figure 4.6: Structural model of determinants of service quality and their impact on satisfaction and loyalty



One of the two constructs that was added to the SERVQUAL model to predict the impact of service quality on customer satisfaction is product. The construct had a significant and positive association with customer satisfaction in CIMAS (β=.170; p=.004; μ=3.78; SD=.692) hence Hypothesis 6 (***H₆:*** *Product has a positive and significant correlation with customer satisfaction*) was accepted.

Reliability was not found to be an important factor of customer satisfaction in CIMAS (β=.110; p=.071; μ=3.54; SD=.595). As a result, Hypothesis 2 (***H₂:*** *Reliability has a positive and*

significant correlation with customer satisfaction) was rejected due to lack of supporting evidence.

Empathy emerged to be an important service quality determinant of customer satisfaction in the medical aid society (β=.160; p=.008; μ=3.45; SD=.687). So, Hypothesis 4 (***H_4: Empathy has a positive and significant correlation with customer satisfaction***) was confirmed.

Responsiveness was found to be positively and significantly correlated with customer satisfaction in CIMAS (β=-240; p=.000; μ=3.46; SD=.522). Consequently, Hypothesis 3 (**H_3:** Responsiveness has a positive and significant correlation with customer satisfaction) was supported. This means that CIMAS must always take into account the determinant when it designs its service delivery and customer satisfaction strategies.

Lastly, the study found that there was a positive and important association between the mediating variable (satisfaction) and dependent variable (loyalty) (β=.740; p=.000). Therefore, customer satisfaction was an important determinant of customer loyalty.

4.5 Discussion

Shahin and Samea (2010) postulated that organizations must provide quality services that are customer focused. Service quality is perceived differently among customers depending on how well the delivered service meets their needs. This study sought to identify the determinants of service quality in CIMAS and ascertain their impact on member satisfaction and loyalty.

4.5.1 Determinants of service quality in CIMAS

The research investigated service quality levels in CIMAS by examining whether the offices were modern, are in quite places, and visually appealing, if services are performed right the first time and responses meet promised time frames. The study also sought find out if customer calls are responded within a reasonable time if claims refunds are processed within reasonable time and if the premiums are affordable. These responses were answering the questions from the five determinants of service quality as tangibility, empathy, reliability, responsiveness and assurance. The findings are consistent with the literature that confirms that quality customer service must meet standards like tangibility, empathy, reliability, responsiveness and assurance (Parasuraman and Zeithamal, 1985). From the results members are very much sensitive to the premiums charged by CIMAS which they feel is not giving expected value.

4.5.2. Confirm the identified determinants of service quality in CIMAS

From the results, it came out that CIMAS have more awareness on costs, infrastructure, business processes and products on offer and a concentrate more on revenue than it does on service delivery and customer satisfaction. As stated in the literature that the distinguished features or characteristics of services are important in the design of an appropriate marketing mix (Gilmore, 2003). As such CIMAS must design its premiums and products on offer in such a way that its members will get value for their money. CFA and SEM were used to confirm the factors extracted from the data with EFA.

4.5.3. Impact of identified determinants on satisfaction with service quality in CIMAS.

The study investigated the impact of each determinant on customer satisfaction by examining if the received services were excellent, problems were resolved on time, the employees were knowledgeable to answer member questions, if the employees were courteous and professional. Customers in any business look forward to helpful employees (Parasuraman et al., 1985) and the collected results indicated that more need to be done to meet this. In relation to the collected results, the employees are not well informed in terms of products and services and, they lack that personalized customer service. CIMAS need to engage in customer service training programmes and this will enhance the potential of turning around the fortunes of the society.

4.5.4. Association between member satisfaction and loyalty in CIMAS

The study investigated the customer satisfaction levels as well as the loyalty levels of members in CIMAS. Gera (2011) established that quality of service greatly impacts customer satisfaction and value perceptions in a positive manner, and this leads to loyalty. The members were asked if the employees behave in a manner that instils confidence in them and if they feel safe in interacting with CIMAS. Customer satisfaction and loyalty were e positively correlated. As such CIMAS should recognize that an increase in customer satisfaction will strongly lead to customer loyalty.

4.6 Chapter Summary

From the results, the SERVQUAL scale has been confirmed to be a competent rating that can be utilized by CIMAS and other medical aid companies to measure their performance in as far as meeting customer expectation, customer satisfaction and customer loyalty is concerned.

Chapter Five

Summary, Findings, Conclusions and Recommendations

5.1 Introduction

The chapter presents the summary of findings, conclusions and recommendations in line with the data analysed in Chapter Four above. The conclusions of the study discuss whether the findings are in support of the hypothesis, answer the research questions and meet the objectives of the study. The conclusion catered for each research objective that was stated in Chapter One above. Some limitations were identified, and recommendations were drawn for CIMAS to gain insights into retaining its members through constant improvements in the areas that matter to its members. The contributions of the study are presented based on theoretical and methodological approaches. Finally, recommendations are outlined in this chapter for further research and reference.

5.2 Conclusions

The conclusions for the study are classified according to the research objectives and to identify these objectives, the SERVQUAL model was utilised to determine the perception and expectation of CIMAS members. The research objectives are addressed as follows:

5.2.1 Identify the determinants of service quality in CIMAS.

The five determinants of service quality were identified through a survey, namely tangibles, empathy, reliability, responsiveness and assurance to determine the extent to which perceptions and expectations were or were not met (Parasuraman et al., 1985). Price and product were the added determinants from the findings and the reliability and validity was achieved by the conducting the exploratory factor analysis (EFA) through principal component analysis (PCA). From the context of these findings, the study first secondary objective was attained,

5.2.2 Confirmation of identified determinants of service quality in CIMAS and their impact on customer satisfaction

From the results it was clear that CIMAS should focus on the seven confirmed determinants of customer satisfaction. Five of the determinants are in accordance with SERVQUAL model but two were added by the author. The determinants extracted from the data by EFA through PCA were then confirmed with CFA. The fact that the factors from PCA significantly loaded into the predicted factors in CFA and structural equation modelling (SEM) is a measure of the

validity of the model. The factors are price, assurance, tangibles, product, reliability, empathy, and responsiveness.

5.2.4 Association between member satisfaction and loyalty in CIMAS

Customer satisfaction plays an important role and increases the likelihood of customer loyalty. Based on the findings from this study, service quality, through customer satisfaction, plays an inevitable role in customer loyalty. Service quality can lead to customer loyalty by itself, however there is an increased probability of customer loyalty when it is merged with satisfaction. The high levels of loyalty were as a result of high satisfaction which confirms a positive relationship between the two variables. CIMAS should know how to keep its customers, although they may appear satisfied. This is because they must recognise that to survive and grow, they must find and maintain profitable customers (Ganiyu, Uche& Adeoti, 2012). From the findings, customer satisfaction and loyalty are positively correlated.

5.2.5 Modified model of service quality customer satisfaction and loyalty

The SERVQUAL has five determinants of service quality which are also used to measure customer satisfaction—empathy, reliability, responsiveness, tangibles and assurance. The researcher modified the SERVQUAL model by adding to two other determinants, namely, product and price. The conceptual framework with these seven determinants had 33 variables but only 26 have been retained after validation while at the same the seven components were retained two. Nonetheless, what has only changed is that the empirical model has 27 variables only for measuring the relationship between service quality, customer satisfaction and customer loyalty. In addition, it has emerged that price is the most important factor of customer satisfaction. Therefore, CIMAS can consider adopting this model as a starting to designing strategies to improve its service quality, customer satisfaction and loyalty.

5.3 Recommendations

Measurement of the quality of service remains a challenge since it services are an intangible factor that cannot be physically inspected for defects. However, using research findings recommendations can be drawn to augment service quality, customer satisfaction and customer loyalty in the medical insurance industry. CIMAS management and other medical insurance companies need to adopt the GAP model and ensure that all the gaps are closed.

5.3.1 Adoption of the gap model

Management of CIMAS must do surveys and research and understand what customers expect from them in terms of service quality (Shariff,2012). Failure to address customer needs will lead to a negative effect on customer satisfaction and loyalty. Management must create good relationships with members such that they feel that there are well taken care of. They must also improve on the bottom-up communication, by enhancing a face to face approach with those frontline customer service officers. It is of great essence that employees have the information necessary to perform their duties adequately (Zeithamal et al., 1997; Abukhalifeh &Som,2013). Coaching, trainings, and workshops should be conducted to ensure customer service officers are knowledgeable on what CIMAS offers. The researcher believes customer service training shapes and develop a good customer service representative. CIMAS must ensure effective communication, that is both internal and external. This can be done using big data, internet and all other online communication tools and processes.

5.3.2 Maintain loyal customers

In addition, CIMAS need to tailor make its packages so that it caters for all groups of people. There is need to exercise personalised service to those long-standing individual members and corporates to retain them. This can be done through offering premium discounts, offer branded gifts like T-shirts, pens, caps and calendars. Continuous customer engagements on new developments will make them feel sense of belonging and this will enhance loyalty. Once these members are satisfied, they will spread their satisfaction either through word of mouth or any other means which is an advantage to the society.

5.3.3 Improve on turnaround times

CIMAS need to improve its contact centre to ensure that service is provided without members necessarily coming in for things like quotation authorisations and submission of proof of payments. This will reduce number of walks in clients thus reducing queries as well. Phone calls should be answered within the stipulated time of three rings. New technology and innovations should be introduced to improve on processes like member registrations, amendments, terminations, processing and payments of claims refunds.

5.4 Limitation of the study

The study solely focused on the on the validation of service quality determinants in one area which is Harare and in this case the researcher does not claim that the findings can be generalized to other areas. If the research was done on the same topic in other towns of Zimbabwe, it could have yielded different results.

The researcher also faced a challenge where some respondents were hesitant to air their views out about the service quality, satisfaction and loyalty. The researcher then educated them that the research was only for academic purposes hence there was no need for them to provide personal details will remain anonymous.

5.5 Areas for further studies

The study mainly hammered on the three variables being service quality, customer satisfaction and customer loyalty. The researcher did not seek to clarify on the roles of internal customers in establishing external customer satisfaction and customer loyalty. The research only validated the service quality determinants on customer satisfaction and customer loyalty. However, there is still needed to measure the modified or empirical model of service quality.

The researcher recommends further research on the role of internal service quality, customer satisfaction and internal loyalty. Also, the measure of service quality, customer satisfaction and customer loyalty using the empirical model. The two studies will form a basis for further research.

5.6 Chapter Summary

The findings of the present study are extensively discussed in this chapter. Furthermore, this chapter summarizes the tasks completed in this study by reporting the hypotheses testing, answering the research questions and the achievement of the research objectives. In addition, this chapter also outlines some limitations and recommendations for CIMAS and other players in the medical aid insurance industry. The study ends with the contributions of the study and some suggestions for future research.

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APPENDIX 1: LETTER ACCOMPANYING QUESTIONAIRE

LETTER ACCOMPANYING QUESTIONNAIRE

Stand 2478

Aspindale Park

Harare

15 January 2020

Dear Sir/Madam

RE: MBA RESEARCH QUESTIONNAIRE

The researcher is a final year student studying for a Master's in Business Administration degree with the University of Zimbabwe Graduate School of Management. The researcher is conducting a research on the ***IMPACT OF SERVICE QUALITY DETERMINANTS IN MEDICAL INSURANCE AND ASCERTAIN THEIR IMPACT ON MEMBER SATISFACTION AND LOYALTY.***

This researcher is an issue of great importance within Zimbabwe and yet little is known about how service quality has impacted upon the operations of medical aid insurance industry with CIMAS being the case study.

The researcher would greatly appreciate if you could assist by completing and return the attached questionnaire by 04 February 2020. All information provided will be confidential and will not be disclosed to third parties without your permission. Your name and personal details will not appear on the questionnaire and there is identification code or number. This for academic purposes only and all the information received will be treated in the strictest of confidence.

Thank you in advance for your corporation in this matter.

Yours faithfully,

Ellen Sande.

APPENDIX 2: RESEARCH QUESTIONAIRE

Section 1: Demographics

1.1 What is your gender? *(Please put a tick "√" or put an "X" on the right answer.)*

Male ( ) Female ( )

1.2 What is your age group? *(Please put a tick "√" or put an "X" on the right answer.)*

18-25 years ( ) 26-35 years ( ) 36-45 years ( )
46-55 years ( ) Over 55 years ( )

1.3 Where do you live? *(Please put a tick "√" or put an "X" on the right answer.)*

Low density suburb ( ) Medium density suburb ( )
High density suburb ( ) Peri-urban area ( )
Farm ( ) Rural area ( )
Other (specify) ……..

1.4 What is your highest level of education? *(Please put a tick "√" or put an "X" on the right answer.)*

Primary school ( ) Ordinary level ( ) Advanced level ( )
Certificate ( ) Diploma ( ) First degree ( )
Master's degree ( ) Doctoral degree ( ) Other (specify)……

1.5 Kindly indicate the CIMAS package you are currently registered under. *(Please put a tick "√" or put an "X" on the right answer)*

Health Guard Deluxe ( ) MedExec ( ) Primary ( )
Private Hospital ( ) Basic Care ( ) Private Hospital Plus ( )
I Care ( ) General Hospital ( ) Classic ( )

1.6 Are you registered under a company or individual account? (*Please put a tick "√" or put an "X" on the right answer)*

Company Account ( ) Individual ( )

1.7 For how long have you been a CIMAS member? *(Please put a tick "√" or put an "X" on the right answer)*

Under 5 years ( ) 6-10 years ( )
11-15 years ( ) Over 15 years ( )

1.8 Are you the primary member i.e. registered with CIMAS and paying the subscription? *(Please put a tick "√" or put an "X" on the right answer)*

Yes ( ) No ( )

1.9 Have you ever made a claim to CIMAS? *(Please put a tick "√" or put an "X" on the right answer)*

Yes ( ) No ( )

1.10 Are you currently a member of any other medical aid society besides CIMAS?
(Please put a tick "√" or put an "X" on the right answer)
Yes ( ) No ( )

1.11 If you are a member of any other medical aid society, could you please name it?

……

SECTION 2: DETERMINANTS OF SERVICE QUALITY

On a scale ranging from 1 (Strongly Disagree), 2 (Disagree), 3 (Neither Disagree Nor Agree), 4 (Agree) to 5 (Strongly Agree), indicate the extent to which you would agree or disagree that each of the following statements determines your satisfaction with service quality at CIMAS. (*Please just assess CIMAS, the medical aid society, not its health facilities like laboratories, clinics, etc.*)

Determinants and Variables	**Scale**				
TAN: Tangibility					
TAN1 CIMAS has modern-looking equipment	1	2	3	4	5
TAN2 CIMAS physical facilities are visually appealing	1	2	3	4	5
TAN3 CIMAS physical facilities are in quiet places	1	2	3	4	5
TAN4 CIMAS has necessary materials for providing services (pamphlets, forms, etc.)	1	2	3	4	5
TAN5 CIMAS employees appear neat always	1	2	3	4	5
REL: Reliability					
REL1 CIMAS always performs services right the first time	1	2	3	4	5
REL2 CIMAS always meets its promised time frames for responses	1	2	3	4	5
REL3 CIMAS employees always have sincere interest in solving members' problems	1	2	3	4	5
REL4 CIMAS keeps error-free records	1	2	3	4	5
RES: Responsiveness					
RES1 CIMAS employees always inform customers when services will be performed	1	2	3	4	5
RES2 CIMAS employees always give services on time	1	2	3	4	5
RES3 CIMAS employees are ever willing to help and solve members' problems	1	2	3	4	5
RES4 CIMAS employees always answer the phone within reasonable time	1	2	3	4	5
RES5 CIMAS employees are always available to respond to members' requests	1	2	3	4	5
RES6 CIMAS always pays members' healthcare service providers within reasonable time	1	2	3	4	5

RES7 CIMAS always takes reasonable time to process members refunds	1	2	3	4	5
RES8 CIMAS takes reasonable time to preauthorise treatment	1	2	3	4	5
PRO: Product					
PRO1 CIMAS offers a range of medical aid packages that meet members' needs	1	2	3	4	5
PRO2 CIMAS always updates its medical aid packages to suit modern trends	1	2	3	4	5
PRO3 Health service providers always accept the CIMAS medical aid card	1	2	3	4	5
PRO4 CIMAS operating hours are convenient to members	1	2	3	4	5
ASU: Assurance					
ASU1 CIMAS employees behave in a manner that always instils confidence in members	1	2	3	4	5
ASU2 CIMAS employees have knowledge to answer members' questions	1	2	3	4	5
ASU3 CIMAS employees are consistently courteous and professional	1	2	3	4	5
ASU4 I feel safe in my interactions with CIMAS	1	2	3	4	5
EMP: Empathy					
EMP1 CIMAS employees give members individual attention	1	2	3	4	5
EMP2 CIMAS employees have members' best interests at heart	1	2	3	4	5
EMP3 CIMAS employees always seek to understand a member's specific needs	1	2	3	4	5
PRC: Price					
PRC1 CIMAS offers affordable premiums to customers	1	2	3	4	5
PRC2 CIMAS premiums are worth the service customers get	1	2	3	4	5
PRC3 I am happy with what I pay to CIMAS for my medical aid cover	1	2	3	4	5
PRC4 I am happy with the amount CIMAS refunds me for health services I pay for in advance of consumption	1	2	3	4	5
PRC5 I incur reasonable shortfalls on the CIMAS package I subscribe	1	2	3	4	5

3. Any other comments you have on quality of service at CIMAS……

……

SECTION 3: SATISFACTION AND LOYALTY

3. Given how you have rated the quality of service at CIMAS above, at what minimum point should CIMAS be performing for you to be **satisfied** with its performance? *(Please put a tick "√" or put an "X" on the right answer)*

Scale		Tick
1	Lowest performance	
2		
3		
4		
5	Highest performance	

5. Given how you have rated CIMAS above on satisfaction (Question 4), at what minimum point should CIMAS be performing for you to be **loyal** to them? *(Please put a tick "√" or put an "X" on the right answer)*

Scale		Tick
1	Lowest performance	
2		
3		
4		
5	Highest performance	

Thank You