THE EFFECT OF MEDICAL INSURANCE ON UTILIZATION OF HEALTH SERVICES. A CASE STUDY OF AFRICA AIR RESCUE (AAR)

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C/50/P/9171/04

A PROJECT SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF A MASTER'S DEGREE OF ARTS IN MEDICAL SOCIOLOGY

NOVEMBER 2011

DECLARATION

I declare that this project is the result of my own work and that it has not been submitted either wholly or in part to this or any other University for the award of a degree.

Sign..... Date 16/11/2011

Kinionye, Julia Naitore

This paper has been submitted for examination with our approval as University Supervisors

Sign..... Date....16/11/2011.....

Allan Korongo
(Supervisor)

DEDICATION

I would like to dedicate my work to God for giving me grace and the opportunity to complete my degree. To my lovely children Brandon Munene and Zara Apple Makena who have been the source of my inspiration throughout this journey. May God bless them to one day pursue their Masters degrees just like their mother, and to even go further.

ACKNOWLEDGEMENTS

I would like to acknowledge the almighty God who gave me wisdom and grace to see me through my studies. To my supervisor, Mr. Allan Korongo for his patience, guidance and commitment to helping me attain this degree. I cannot take his valuable input for granted. God bless him.

I acknowledge my parents Mr & Mrs. Mugambi for their financial, moral and spiritual support through prayers and encouragement. To my brothers, relatives and friends, thank you for being there when I needed you most. Further acknowledgements go to my best friend, the late Mwai Mugambi who encouraged me to complete my degree even when the going was tough. I will forever be indebted.

My colleagues from the MA class, especially, Ms. Mary Muturi and Ms. Safia Abdi who gave me abundant help and advice when I was starting out this project. To Mr. Kithinji Marete who acknowledged when I needed a rest and gave me a push when it was time to get up and work. I would not have made it without all your support.

Finally, special acknowledgement goes to my lovely son Brandon Munene for enduring the absence of a mother at a tender age of 1 year during my postgraduate study period.

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ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
AI ICO	American Life Insurance Company
CBHC	Community Based Health Care
CDR	Crude Death Rate
DHMBs	District Health Management Boards
FBOs	Faith based organizations
GOK	Government of Kenya
HDI	Human Development Index
HFA	Health For All
HIV	Human Immunodeficiency Virus
HMO	Health Management Organisation
ICCPR	International Covenant on Civil and Political Rights
IMR	Infant Mortality Rate
KDHS	Kenya Demographic Health Survey
KHPF	Kenya Health Policy Framework
MCH/FP	Maternal and Child Health Services / Family Planning
MDG	Millennium Development Goal
MIP	Medical Insurance Providers
MOH	Ministry of Health
NGO	Non Governmental Organization
NHIF	National Health Insurance Fund
NHSSP	National Health Sector Strategic Plan
PHC	Preventive Health Care
SAPs	Structural Adjustment Programmes
SMR	Standard Minimum Rules
SPSS	Statistical Package for Social Scientists
UNDP	United Nations Development Program
WHA	World Health Assembly
WHO	World Health Organization

ABSTRACT

In recent times health insurance in Kenya has experienced tremendous changes with an increase in most employers offering health insurance to their employees. Indeed, health care provisions offered by employers determine whether an employee's preference for certain jobs. In an attempt to provide employees with medical insurance, employers have ended up offering the services under corporate coverage. This in effects determines health seeking behaviour of employees.

However, employees also develop coping mechanisms in order to access adequate and appropriate health care. This study examined the influence of medical insurance on health seeking behaviour of the insured; it is a case of AAR whose clients are mostly corporate. The study was conducted in Nairobi City. Specifically, the study sought to identify products and services that are preferred by the insured; establish challenges faced by the insured in regard to seeking health services and establish coping mechanisms employed by the insured to overcome health insurance challenges.

The study used both qualitative and quantitative methods to collect data. The survey mainly utilized the survey research that adopted the cross-sectional design and a semi-structured questionnaire was used to interview 124 respondents. The study also used field research in which key informants were interviewed by used of interview guide. The key informants included four doctors and two employers and two AAR administrators. The quantitative data were analyzed using SPSS (Statistical Package for Social Scientists).

It was established that the insured are better off compared to the uninsured in so far as access to health care is concerned. Health insurance offers a promising way to improve access to health care, mitigate the risks of disease and ill health. Significant benefits for the insured are across multiple dimensions of improved access, more timely care, increased availability of preventive care and health education, and reduced risk of catastrophic financial influence. However it was also established that the insured have few choices when it comes to health seeking as they are insured with AAR and have

limited choices. The insured seldom have time to present their views and the premiums are already packaged making it hard for them to seek for extra services once covered under specific premium by their employer.

The study also identified significant challenges faced by the insured seeking health care and noted that this has resulted in development of coping mechanism with the aim of accessing adequate health care.

Given the findings, there is need for medical insurance providers, employers and the insured to increase efforts with the aim of enhancing service delivery to the insured. There are a number of areas in which MIPs and employers can improve including expanding member benefits, developing payment options, improving efficiency to achieve larger scale, and forging collaboration between public and private sectors. Thus, there is need to emphasize awareness, enforcement of policies and collective responsibility of all stakeholders in enhancing health care services to the insured. There is also need for more research to improve the overall understanding of health care services in Kenya.

CHAPTER ONE: BACKGROUND AND PROBLEM STATEMENT

1.1 Background

Insurance involves transfer of financial consequences of a risk to some other more competent party to handle it. Risk in this context will mean ill health. Insurance is also a means of spreading an individual's risk across a number of people so as to make it more bearable for the individuals exposed to the risk. The person to whom the risk is transferred is called the insurer while the person transferring the risk is the insured. Insurance however, does not prevent losses from occurring.

For most people living in developing countries, health insurance is an unknown concept. It is generally assumed that, with the exception of the upper classes, people cannot afford such type of social protection. However, even the poor people also require protection against the financial costs of illness. For these people, illness still represents a permanent threat to their income earning capacities. Besides, the direct costs for the missing labor force of the ill and the occupying person have to be shouldered by the household.

However, health insurance schemes are an increasingly recognized factor as a tool to finance health care provision in low-income countries, given the high latent demand from people for health care services of a good quality and the extreme under utilization of health care services. Health insurance is an institutional and financial mechanism that helps households and private individuals to set aside financial resources to meet costs of medical care in event of illness. It is based on the principle of pooling funds and entrusting management of such funds to a third party that pays for healthcare costs of members who contribute to the pool. The third party can be government, employer, insurance company or a provider (Kraushaar, 1994). In health insurance, every member of the insurance scheme pays the premiums irrespective of whether he or she gets sick. As such, insurance schemes have a higher potential for cost recovery (Tenambergen 1994, Shaw 1988). Cholleteta (1997) observes that by pooling the risk of large healthcare expenditures of many people, health insurance can make necessary healthcare affordable to all.

1.1.2 Health Care Policy, Reforms and Insurance

The history of modern health care services in Kenya can be traced to the well-documented history of this county. By the time Kenya attained its independence, Kenya's national health care system was made up of the public, private and mission health care systems, which were referred to as the modern health care system and the traditional African health care system (Mburu, 1992). The emphasis of colonial health services was hospital-based and mainly targeted the white settlers, expatriate population, military personnel and employees of large private industries. The racial policies saw the majority of the African population involved in menial work with low pay miss adequate health care. The low income ensured that accessibility of health care facilities was out of reach of the average African.

To address these social inequalities, in 1965 the government abolished user fees for outpatient health facilities with a view to making accessibility of health care available to the whole population. However, a nominal fee of Kshs. 20/ for inpatient treatment in government hospitals was retained (Mwabu, 2004). The problems of social inequalities persisted as majority of the hospitals were concentrated in urban areas thus marginalizing the rural population.

In the 1970's a long term planning process started in Africa culminating in the declaration of Health For All (HFA) by the World Health Assembly in 1977. Later many countries endorsed the declaration at Alma-Ata in 1978. The primary health care approach was seen as the strategy by which the ultimate objective of Health For All (HFA) would be attained. Subsequently in 1985, the World Health Assembly adopted the Three-Phase African Health Development scenario under which the district became the focus of health development. In 1998, the World Health Assembly (WHA), requested that Health For All (HFA) in the 21st century should serve as a framework for the development of future policy through the implementation of regional and national policies (WHO, 2000)

However, despite gains that had been made, the late 80's and early 90's saw a lack of economic growth, rising unemployment, diminishing health related sectors (education, water supply and sanitation), emergence of new diseases such as HIV/AIDS, re-emergence of old diseases such as tuberculosis and natural disasters in most developing counties.

Since the 1980's, the number of all health facilities (hospitals, health centers, sub-centres, and dispensaries) in most African countries has increased by one third. Although there are regional differentials due to the fact that most well-equipped health care facilities and medical personnel are concentrated in urban areas, the rural areas are reasonably served well by either the private, public, non governmental or mission health- systems. This is because nearly all of the growth of health facilities has occurred in the rural areas. The district hospitals and innumerable small-scale public health facilities are crucial as they form the first contact for a large majority of the population in seeking health care services. They provide curative and preventive health services, Maternal and Child Health Services and Family Planning (MCH/FP).

In the past, government reforms included decentralization of health service delivery. Provision of health services in most urban areas in Kenya is thus shared between the central and local governments. In Nairobi, for example, the Nairobi City Council dispensaries provide the first contact in the formal health care system as a decentralization measure. The health care system in Kenya is pyramidal in nature with the referral hospitals meant for complicated cases. The assumption is that this decentralization translates into increased efficiency in health facilities (Mushi et al, 2004).

The responsibility of the management of the well-being of the population is the very essence of the government (WHO, 2001). The government therefore has an obligation to provide and guarantee rights to people under its control and to formulate public health policies that ensure that everyone is healthy. Indeed all human interdependent rights recognized in the Universal Declaration of Human Rights (UDHR) and signed by the United Nations member states on 10th December 1948.

These unalienable rights are acknowledged by internationally recognized instruments such as International Covenant on Civil and Political Rights (ICCPR), Standard Minimum Rules on Economic, Social and Cultural Rights (SMR) and CEDAW (IMLU, 2002). The upshot of the signing of the international instruments and domestication of the laws means that a sick person, irrespective of whether free or in confinement, should be treated as such and be able to access health care so as to get well. Unfortunately, the most of the poor Kenyans are often forgotten in this equation. (Reyes, 2001)

The National Hospital Insurance Fund (NHIF) covers inpatient care in both public and private facilities, and serves about 6 million people. Like other insurance schemes, it has promoted increased consumer demand and health-care choices by lowering the cost of care at the time of illness. This has probably increased the use of private health facilities. However, lowering health costs may be lead to over-consumption of services and increase costs of insurance in Kenya. The public system is financed by graduated contributions from workers' monthly incomes. After government introduced cost sharing, all kinds of government and private facilities have sought to increase their revenues from the insurance schemes.

A second type of insurance is private insurance taken out by individuals or employers for their employees. There is no estimate of the number of persons covered, but most clients are in urban areas and employed in the formal sector whose pay is better.

1.1.3 Health Seeking Behaviour in Context

Health or care seeking behaviour has been defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy. This is based on an explanatory model that represents a coherent picture of specific cultural features that affect people's health behaviour. The explanatory model of a particular illness consists of signs and symptoms by which the illness is recognised; presumed cause of the illness and prognosis established. These are in turn interpreted by individuals and or significant others and on

labeling the problem, proceed to address it appropriately through recommended therapies.

Health seeking behaviour is preceded by a decision making process that is further governed by individual and/or household behaviour, community norms and expectations as well as provider related characteristics and behaviour. For this reason the nature of care seeking is not homogenous depending on cognitive and non-cognitive factors that call for a contextual analysis of care seeking behaviour. Context may be a factor of cognition or awareness, socio-cultural as well as economic factors.

1.2 Problem Statement

Overall majority of public health expenditures are expended on salaries in place of key patient related inputs such as drugs and other medical supplies (*Kenya, 2001*). Insurance companies play a pivotal role in helping the insured access medical attention. In 2006 there were 43 insurance companies in Kenya, 21 offering General insurance, 7 offering Life insurance and 15 composite insurance companies (both General and Life). (2006 Association of Kenya Insurers report) Yet with all these insurance companies operational in Kenya, proper health care services are a preserve of a few. This has not even spared the insured, who at times face lot of difficulties in accessing proper health care for themselves or families.

There is sufficient evidence that doctors and hospitals are responsible for the increase in health care costs. Medical insurance providers, it has been noted are also partly responsible for this. By denying health care financing to some clients through restrictions, doctors and hospitals provide false information often resulting in false claims.

Where as those who are employed enjoy employer-funded health plans, comprehensive medical cover is not available to majority of Kenyans (self employed or otherwise) due to prohibitive cost of insurance premiums. This exploratory study focuses on the influence of medical insurance on the insured, in terms of seeking health service. Of particular concern is that the insured are not usually well sensitized on their terms of coverage. Hence, the likelihood of redress is diminished.

Medical insurance providers focus mainly on corporate as opposed to individual clients; this has resulted in huge amounts of losses and fraud to the providers. Consequently health insurance coverage prices must either go up or the cover becomes more restrictive with more exclusions. This negatively affects the insured. On the same note, the insured finds it difficult to sort out the coverage available under their health plans and quite frustrating to reconcile the explanations of benefits and the multiple bills they receive from different providers for the same episode of care.

Indeed, data on health risks to determine insurance premiums with accuracy is inadequate. Consequently, health care costs charged to insured by the medical insurance providers are totally unpredictable in Kenya coupled by lack of historical data on health risks, which is largely to blame for the inaccuracy of premium predictions that most of the insured face while dealing with their medical insurance providers. Most of those insured under corporate schemes do not know, for example, if they will receive health benefits in retirement and if so, how much they have to pay and what the plans cover.

The insured have become price-sensitive when it comes to buying insurance. Not because they ignore health problems, but because they do not want to tie up scarce funds by paying insurance premiums. Consequently, this makes the ability to save an important way to "self-insure".

In recognition that medical insurance coverage barely exists for majority of poor Kenyans while in cases where these products are available they are usually unaffordable, public social insurance services is insufficient and mostly exclude those working outside the mainstream economy. The result is that nine out of 10 people in Sub-Saharan Africa do not have access to medical or accident insurance. In addition they must pay high costs for medical treatment and healthcare out of pocket.

Those living below the poverty line, which includes more than 40 percent in Sub-Saharan Africa, are hit particularly hard, (Mutie and Gakuru, 2008). They may have to take out loans, use up their savings or sell essential household goods or other resources to pay for medical attention, resulting in them falling into even deeper poverty. This shows the

extent to which health insurance is interlinked with the well being of people in Kenya and the important role that medical insurance plays in determining the health seeking behaviour of the insured.

An answer to their dilemma lies in the form of medical insurance, which can help overcome the vicious circle of poverty and illness. This would mean consideration to insurance, which would deliver medical insurance services to the poor in Kenya. In some cases, where the insured is not aware of the terms and conditions, cases arise where the medical insurance providers cannot pay for some services. Medical insurance providers should be able to offer basic insurance services for low premiums, which are affordable to most people. Key to economic prosperity of this country is a kind of health insurance that improves access and quality of health services and avoids exorbitant prices that consequently lock a lot of people out of medical insurance.

1.3 Research Questions

This research sought to answer the following questions;

1) What is the effect of medical insurance services on the insured in terms of accessibility to health services
2) What challenges are faced by those insured in seeking health insurance products?
3) How does the partnership between the employer and health insurance companies affect the insured's medical attention
4) How are the insured coping with the challenges that they have been facing and
5) What recommendations can be made to improve health insurance services

1.4 Study Objectives

1.4.1 Broad Objective

The broad objective of this study is to establish the effect of medical insurance on utilization of health services.

1.4.2 Specific Objectives

Specifically, this study sought;

1. To identify products and services that are preferred by those insured by medical insurance providers
2. To find out how health insurance companies / employer partnerships affect the insured persons health seeking behaviour.
3. To establish challenges faced by the insured in regard to seeking health services
4. To establish coping mechanisms employed by the insured to overcome health insurance challenges.

1.5 Rationale/ Justification of the Study

First, past studies have shown that majority of the Kenyan population is unable to access quality health care due to factors like; financial constraints or the long distances people have to cover to access health care facilities. Health insurance services in Kenya are nonetheless also not much utilized by many Kenyans whilst in the case of the insured the issue of accessibility to quality health care facilities at times gets a lot of challenges ranging from cost to all sorts of administrative bureaucracies. Some of these factors have reduced access to health care even by the insured. This research will therefore seek to understand the influence of medical insurance on the health seeking behaviour of the insured.

Secondly, the policies of the government seldom focus on affordable medical insurance protection covers neither have the government policies addressed key issues to do with health care and mainstreaming this important health sector. Thus the study will seek to ascertain whether medical insurance providers are responsive to the expectations of the insured as regards to quality of health coverage. This study would in the long run help in shaping health policies developed which usually face many concerns about how well health insurance policies reach their target, encourage appropriate health care and improve health and economic outcomes.

Thirdly, by conducting this research, the results of this study will be useful to government policy makers and other health actors including medical insurance providers in identifying medical insurance needs of the public by understanding its influence on the health seeking behaviour of the insured whose needs have been neglected by several medical insurance providers and instead up- bottom policy making structures reign supreme in the medical insurance sector mostly driven by the urge for huge profits.

Fourthly, most studies have not considered the policies and terms of medical insurance providers on the health seeking behaviour of the insured. This study will bring out the links between these factors that determine why the insured seek medical care and what drives them to various health care providers. This study will be a fundamental contribution to the already existing knowledge and bridge the much needed information gap since it will provide basic data for medical insurance sector and other health care providers.

1.6 Scope of the study

The focus and objectives of this research limited its scope to the effect of medical insurance on the utilization of health services at AAR clinics

Medical insurance provision is a wide concept measured with a variety of health care indicators and accessibility to these services. Medical insurance providers are concerned with provision of health cover to the insured. This study concentrated on understanding the effect of medical insurance on utilization of health services.

The problem being investigated has implications for men, women and children who are insured. A survey was conducted within the Nairobi city administrative area to understand the influence of medical insurance on the insured. Due to the fact that it would require a lot of resources in terms of finances and time to cover all the medical insurance providers and all the aspects of the insured, this study limited its scope to the influence of AAR medical insurance on the health seeking behaviour of the insured. The

study further involved a case study of African Air Rescue (AAR) clients who are covered by their employers.

1.7 Limitations of the Study

The number of respondents recruited for the study is limited to AAR as this was a case study of an insurance provider that offers corporate cover when there is evidence that some medical insurance providers (MIPs) do offer covers for retail business i.e. individuals.

The target respondents are direct and indirect beneficiaries of medical insurance covers provided by employers. These include the employees and their next of kin. It was assumed that by undertaking the study the respondents would be willing to participate and provide the correct information by agreeing to respond to the study.

The sample design might not give us the right representation of the study population but the limited resources and time factors have occasioned this situation.

It is also presumed that some of them will not be willing to discuss their encounters under the MIPs care, as it would also be undermining their employment contracts. This is anticipated as a limitation to the study since withholding of relevant information is going to affect the outcome of the study.

1.8 Operations Definitions of Key Concepts and Variables

Definition of Key terms

Key terms used in this paper are defined here.

Health: WHO definition, states that health as "a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Insured: The person who obtains or is otherwise covered by insurance on his or her health. The insured in a policy is not limited to the insured named in the policy but applies to anyone who is insured under the policy.

Medical insurance: Insurance against expenses incurred through illness of the insured.

Health Seeking Behaviour: According to the Nursing Outcomes Classification (NOC), health seeking behaviour is defined as personal actions to promote optimal wellness, recovery and rehabilitation. Health-seeking behaviour is what people do in order to maintain health and/or return to health, ranging from individual behaviour to collective behaviour. It concerns specific steps taken (sometimes called hierarchy of resort) and what is done and why.

Health care decision-making: A process of deciding on a course of action in relation to maintaining or restoring health, including factors and/or people who influence the decision and reasons (explicit and implicit) for the decision.

CHAPTER TWO: LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.0 Overview

The objective of this chapter is to capture relevant literature reviewed with regard to the influence of health seeking behaviour of the insured. In this chapter, the researcher reviews literature under the following sub-sections:

2.1 Literature Review

Existing research suggests that insurance may be a powerful instrument to protect the poor from diverting limited income or eroding their household balance sheet (asset depletion and borrowing) when coping with large shocks. The coping mechanisms best suited to deal with large and small shocks are often different, as are the consequences of failing to adequately provide for a large versus small shock. There is some evidence that there are benefits to clients in having insurance for covering infrequent but large and/or covariant shocks; largely because other mechanisms such as friends and family are less suited to cover these large shocks (Clarke & Dercon, 2009; Gertler & Gruber, 2002).

We look at the added value of insurance in the context of these alternative tools and consider which, if any, insurance may replace. Relatively little work has done on this approach; Portfolios of the Poor (Collins, Morduch, Rutherford, and Ruthven, 2009) is a notable exception, recording the various coping mechanisms households use and analyzing the interplay between them. A number of studies have found that having health insurance leads to a reduction in out-of-pocket expenditures in the event of a large health shock (Chankova, Sulzbach, et. al., 2006, 2008; Devadasan et al., 2007; Giné, Townsend, et. al., 2007), but these often do not clearly explain the full cost of the insurance product or fully explore the trade-offs between insurance and subsidized coping mechanisms such as government transfers, public health systems and intra-family transfers such as remittances. A few studies find that microinsurance may help households avoid borrowing, especially at disadvantageous terms. This is a critical issue for the poor, whose individual savings rarely cover the cost of large shocks. Kruk, Goldman, and Galea (2009) highlight that the risk of borrowing or selling assets to pay

for healthcare in 40 low- and middle-income countries was higher among the poorest households and in countries with less health insurance. Aggarwal (2010) finds, encouragingly, that total borrowings in the event of surgery are 30-36% less for the insured than for the uninsured.

According to Techlink International Report (1999), few firms provide healthcare insurance in the strict sense of insurance in private healthcare insurance in Kenya. The general insurance firms offering healthcare insurance as one of their portfolio of products include CFC Life, Apollo Insurance, GMD Kenya, Kenya Alliance Insurance Company Ltd, and UAP Provincial Insurance. Other firms run medical schemes and they are in two categories: the first category provides healthcare through own clinics and hospitals (these include AAR Health Services, Avenue Healthcare Ltd, Comprehensive Medical Services, Health Plan Services), while the other category provides healthcare through third party facilities (examples are Bupa International, Health Management Services and Health First International). These medical schemes are also known as Health Management Organisations (HMOs).Stiff competition in the medical sector has forced service providers to ease access conditions widening the range of choice and improving pricing for consumers, industry insiders say. (James Makau, Daily Nation - 6th Sept 2008)

The existing literature points to two related financial benefits that insurance, primarily health insurance, offers to poor clients when financial shocks are small. It can reduce the cost of the shock by cutting outof-pocket spending and it can smooth cash flows by collecting small regular payments to cover irregular needs. It is important to note, however, that many studies of health insurance look at products that cover both small and large shocks and fail to disaggregate the effects.

Evidence from existing research on the effect of microinsurance on out-of-pocket spending for small shocks is mixed. While some studies find that insurance decreases spending on small shocks or outpatient care (Ekman, 2004), many are inconclusive (Chankova et al., 2008; Wagstaff, 2007). Some studies even find that insurance can increase out-of-pocket expenditures because the insured are less likely to forgo care

(Wagstaff and Lindelow, 2008). If coverage is not complete, patients who receive care must then pay additional costs of some of treatment, drugs, copays or others to continue their treatment.

The "negative" outcome of this additional spending must be viewed in light of the positive effect on health seeking behaviors and health outcomes. There is limited but positive evidence that insurance helps to smooth cash flows and stabilize income for small shocks. Hamid, Roberts, et al. (2010) illustrate that prepaid health microinsurance cards covering routine care in Bangladesh have a positive effect on stability of household income via food sufficiency. Aggarwal (2010) notes that borrowing and/or asset sales associated with primary healthcare are as much as 61% lower for the insured versus the uninsured. Increased access has, however, come with a rise in demand for better value, forcing service providers to change their approach.

It has been noted that most large insurance players had abandoned individual cover products terming it cost laden, with thin margins. It has however been shown according to Techlink International Report (1999), that many risks are not covered, and indeed the markets for the service of risk coverage are poorly developed or non-existent. Arrow (1963) argues that to achieve Pareto optimality, insurance policy against all risks should exist. Therefore, absence of insurance policy would be a necessary and sufficient condition for market failure. Therefore, the government should undertake insurance in those cases where an efficient market has failed to emerge. To approximate an optimal state, it would be necessary to have collective intervention in the form of subsidy, tax or compulsion.

Players in this industry say focus on corporate as opposed to retail clients have led to high amounts of losses and fraud. With insurance, the price must either go up or the cover becomes more restrictive with more exclusions says insurance firms have been slow to innovate, leaving their products pricier than those of health management organizations (HMOs).

HMOs such as AAR, Resolution Health and Health First are credited for changing the medical services environment in the country by introducing managed health care through affordable and flexible products. The problem with providing health insurance is that both moral hazard and adverse selection are rife because risks can be sizeable and require an established partner to provide reinsurance. Secondly, data on health risks is inadequate to determine insurance premiums with accuracy. Health care costs are totally unpredictable.

Lack of historical data on health risks is largely to blame for the inaccuracy of premium predictions (D. Michuki et al, 2007). Most employees do not know, for example, if they will receive health benefits in retirement and if so, how much they have to pay and what the plans cover. On the same note he asserts that health insurance consumers find it difficult to sort out the coverage available under their health plans and get quite frustrated when trying to reconcile the explanations of benefits and the multiple bills they receive from different providers for the same episode of care.

But in Kenya especially, health insurance may not be enough. Coupling insurance with health education and an emergency fund to cover temporary non-health crises can make insurance more effective for clients and providers alike (V. Guan et al, 2005)

Customers in Kenya may be price-sensitive when it comes to buying insurance. This should not be portrayed to mean that they ignore health problems, but because they do not want to tie up scarce funds by paying insurance premiums. This makes the ability to save an important way to "self-insure".

But even then, the medical insurance services in Kenya and generally in Africa is still characterized by low penetration, escalating costs and an over emphasis on curative medicine rather than a preventive led approach (Njau J. 2003) If a household then faces a health crisis, they are doubly hit since they must contend both with the original (uninsurable) loss plus the fact that their health problems are no longer covered.

2.1.1 Health Policy in Kenya

Since 1980, a wave of de-nationalisation has made a shift from state capitalism to a more pure market regulated capitalism (Gakuru, 2002). It is also a multi-dimensional concept incorporating economic, culture and political dimensions. As a result of globalisation, the economic recession experienced by most countries in the 1980's saw the Bretton Woods Institutions sponsor a series of Structural Adjustment Programmes (SAPs) (Shauri, 2001). These were implemented in Kenya as pre-conditions for more economic aid. The SAPs resulted in the increasing privatisation of services and introduction of cost-sharing in the health sector (Shauri, 2001; World Bank, 1987, Collins et al., Mbatia, 1996).

Previously in Kenya, health care was free and the Kenya government was reluctant to introduce user fees in hospital (Geest, 1992). People felt that this was a service that had to be provided free by the governments (Korte et al, 1992). The new cost-sharing policy under the SAPs required that users of public services paid user fees. The purpose of the user fees was to increase the government's financial capacity to provide good quality health care in the face of the increased cost of health care (Republic of Kenya, Kenya National Development Plan, 1989). The assumption here was that cost- sharing fees would ensure resources were available and that health facilities were run efficiently.

Due to social and political reasons, governments tend to charges lower user fees in rural areas (Korte et al, 1992). In Kenya, outpatient fees were temporary suspended on 1st September 1990 (Shauri, 2001) as it had been observed that people stayed at home with their illnesses (Mbatia, 1996). Between 1992-1993, the District Health Management Boards (DHMBs) formed in May 1992 (Kenya Gazette, 1992) recommended low outpatient fees. This was designated as the acceptability phase (Shauri, 2001). Health insurance attempts to reduce the financial and non-financial risks associated with chronic illness or injury, since individuals are uncertain about health status and expenditures in future. The risks include loss of life and deterioration of health. Deterioration of health reduces the ability of an individual to work, or reduces the productivity while working such that the individual faces the risk of lost (market and non-market) wages. Another risk may arise, as an individual may be unable to enjoy other forms of consumption, like

participation in sports because of their health status, or they may suffer emotional and psychological trauma associated with physical deterioration. These events and consequences are uncertain, both in size and in occurrence. Individuals are therefore always willing to pay to reduce this risk (Jack, 1999). Due to this risk aversion behaviour, many individuals will seek insurance and they will effectively pool their risks through an insurer.

The withdrawals of state subsidies through the SAPs have had a great influence on national social structures such as poverty, population and urbanization (Gakuru, 2002). It is evident that foreign debt has curtailed the growth of third world countries (Bradshaw et al, 1993). It is unlikely that these developing countries will ever achieve the high human development indices experienced by developed countries.

Health development and trends in health system in Africa are therefore beset by uncertainties of having capacity to overcome poverty and to provide universal access to essential health care (WHO, 2000b). This has influenced negatively on the health of the people because it is the people in the lower classes who will feel financial constraints when illnesses strike (WHO 2001). Indeed, health constitutes a strong entry point for poverty reduction and economic growth (WHO, 2003). Thus towards achieving the set goals and objectives in its vision 2030, the government must invest more in the people health.

In an attempt to ensure good health for all, WHO has formulated three goals for health systems to guide policies that ensure good health, responsiveness to the expectations of the population and fair financial contribution (WHO, 2000). This means that the government's responsibility to ensure good health of its people is continuous and permanent. It is a national priority (WHO, 2001) because the healthy status of a nation is an indicator of the quality of life in a society. It is well recognized that a government that protects its people against financial costs of illnesses ensures growth of the socio-economic status of its people. The pursuit of improved standards of health has therefore become a primary health concern for most governments.

Health care reforms have therefore been recognized as being a fundamental step in strengthening a country's health care system. These reforms may involve a number of strategies, policies and interventions designed to strengthen the health care system (Dmytraczenko et al, 2003). Thus the WHO reforms have shifted the focus of health systems away from curative to preventive and promotional pattern of health interventions (WHO, 2003).

On its part, the 1989-1993 Kenya Development Plan emphasized the government's commitment to developments in the health sector that were geared towards the attainment of "HFA by the Year 2000" (Republic of Kenya, Kenya National Development Plan, 1989). The government integrated an approach to the health system that involved such essential components such as health education, provision of proper nutrition, basic sanitary facilities, maternal and child health including family planning and immunization against major infectious diseases amongst other measures.

Meeting health goals requires awareness not only of the biological transmission of diseases between men and women but also the social and cultural factors that promote good health. Pertinent issues are the different health risks suffered by men and women, implications of these differences for health service delivery, the effect of differences in the availability of and access to health services and the women's ability to independently decide on the use of these services. These are important when designing strategies aimed at meeting the health goals. Indeed policymakers have a number of policy instruments to promote gender effectiveness. However, effective action requires that policymakers take account of local realities when designing and implementing policies and programmes (King et, al, 2001).

WHO has therefore targeted vulnerable groups such as women, children and the handicapped in its policies (WHO, 2003). This has come from the realization that sick women are more likely to avoid or postpone seeking medical care because of gender-based constraints such as domestic responsibilities, cost of travel and treatment. (King et al, 2001). More often than not, these women are given low priority due to their low social

status. It is worthy of note that gender inequalities impose large costs on the health and well- being of the whole population. They lower prospects of reducing poverty and ensuring economic progress (King et al, 2001).

2.1.2 Health care Access

The majority of Kenyans do not have access to affordable healthcare. Furthermore nearly half (46%) of the population live below the poverty line. According to the Household Health Expenditure Report of 2003, 44% of Kenyans who fall sick do not seek health services due to lack of finances. This implies that low income remains a major hindrance to accessing health care services in the country (First Medium Term Plan, 2008-2012, GoK, Nairobi, 2008)

As has been seen noted earlier, the protection of the public health is one of the most pressing issues in developing countries (Correa, 2000). This can only be achieved if resources are spent to promote access to health care to sustain a healthy population. Towards this end, the WHO Abuja Declaration of 25th April 2000 requires that member countries spend at least 15% of the GDP on health. Currently, Kenya only spends about 9% of its GDP on health (Njeru et, al, 2004). Notably, Kenya has been ranked 143 in the Human Development Index (HDI) with sustainable accessibility to affordable drugs put at 0.49% (WHO, 2004).

The demand for health services has increased despite the inadequacy of resources (Collins et al., 1994). Many people in the urban areas lack access to health care (UNDP, 1999). Thus, there is no doubt that scarcity of resources for provision of health care is one of the primary causes of poor health in Kenya and particularly Nairobi. However, even where there has been infusion of resources in developing countries, this has not translated to better health status of the people. This has been the case due to poor institutional framework and lack of political good will.

Like other developing countries, Kenya also invests heavily in highly trained medical personnel. In 1988, there were 13.75 doctors per 100,000 population and 18.00 per

100,000 population in 1994 (Republic of Kenya, 1994a; Mbatia, 1999). This did not however, translate to higher health statuses across the general population. The Infant Mortality Rate (per 1000 live births) (IMR), Crude Death Rate (per 1000 population) (CDR) and Life Expectancy at birth varied by province. In the period 1979-1989, IMR was highest in Western and Nyanza Provinces at 101.0 and 111.0 respectively and lowest in Nairobi and Central Provinces at 49.0 and 30.0 respectively (CBS, 1996).

It is correct to state that the differentials in health status in most African countries are due to the fact that access to personal health care tends to be highly unequal across administrative districts and between rural and urban areas. In Nigeria, three-fourths of the country's public and private health facilities are located in urban areas, which contain only 30% of the total population. In Kenya, there was one doctor on average for 500 people compared with one per 160,000 people in rural Turkana District. In addition, major urban health facilities are served with the largest proportions of highly trained health personnel. In patient spending in major hospitals is applied to hospital-based treatment as opposed to curative or Preventive Health Care (PHC) (World Bank, 1994).

Consequently, various studies have been conducted with a view to finding a lasting solution to the inequitable distribution of health care in Africa and other countries. In Kenya, a study conducted by Mwabu et al, suggested that strong efficiency and equity reasons supported the spread of medical insurance (Mwabu et al, 2002). The researchers, however, pointed out that in institutionalizing insurance in communities, it was important to ensure that vulnerable groups in the community were not excluded from medical schemes that they invested in.

In another study conducted in Nigeria, the researchers recommended that better access would mainly involve the establishment of new public health care facilities (Mbanefoh et al, 2004). The same study also found that there were high transportation costs and the time spent in accessing health care facilities in the rural areas. It has been suggested in other studies that that when distances between facilities and providers is short, the use of facilities is highest (Gesami et al, 2004). Previous studies in Kenya have confirmed that

state that the high costs and long distances limit health care services for many Kenyans One such study showed that 40% of the poor did not seek medical care when they fell sick due to financial constraints while 2.5% did not do so due to the long distance of the health facilities from where they stayed (Njeru et al, 2004).

This is debatable as other studies have shown that even when facilities are near, the demand for health care has decreased. This has been attributed to other policy interventions. Like in most other countries in the developing world, the introduction of cost-sharing in 1989 in government facilities in Kenya showed a decline in utilization. The negative publicity and lack of acceptability for the strategy by the poor persisted (Shauri, 2001). Many people suffered because of mismanagement of funds. The resultant effect was that millions of the Kenyan people could no longer access health care as the health system had collapsed.

There were complaints that the introduction of the user fees had not resulted in improvements of quality of care. This is because despite paying the user fees, there were no essential medicines in the public facilities forcing people to purchase medicine from chemists (Daily Nation 11th January 1990). Mbatia (1996) observed that Kenyatta National Hospital remained virtually empty as people suffered at homes with their illnesses. Notably, there is less reduction in the non-governmental health facilities, as people perceive them as being able to offer higher quality of the health services. (Gesami et al.2004).

2.1.3 Funding Health Care

However, despite efforts to tackle affordability and access to health care services, the health situation has been deteriorating since independence (Njeru et al, 2004). Factors that led to the deterioration of health care situation included corruption, misuse of funds, lack of medical personnel, rapid population growth, rising costs in health care and poverty. Many Kenyans are unable to access institutional health care due to their limiting economic capabilities and therefore find their life and security threatened due to high mortality rates.

This socio-economic differentiation is considered both unethical and socially undesirable. Thus the idea behind equity and socio-economic agenda built in the economic recovery programme by the Kenya government for the period 2003-2007 was aimed at reducing these gaps in inequality or narrowing gaps of inequality in all sectors by creating wealth and employment (Kenya, 2003). For instance, the health reform measures in the said strategy include enacting legislation to convert the current National Hospital Insurance Fund into a National Social Health Insurance Fund, rehabilitation of existing health facilities, creation of an endowment fund to cater for the vulnerable groups and overhauling the whole drug procurement procedures (Njeru et al, 2004).

The health reforms have therefore shifted the focus of health systems from curative to preventive or promotional pattern of health interventions. It is expected that these health interventions will create opportunities for the poor to enter the labour market with increased capacities and result in higher productivity thus alleviating poverty. This is because health constitutes a strong entry point for poverty reduction and economic growth. Wang'ombe et al (1994) identify two categories of private health insurance in Kenya: direct private health insurance and, employment-based insurance. Direct private health insurance is very expensive and only the middle and high-income groups afford it (Nderitu, 2002). In the employment-based plans, the employer provides care directly through employer-owned on site health facility, or through employer contracts with health facilities or healthcare organisations. These are both voluntary health schemes and are not legislated by the government.

In recognition that health must work with synergy with other sectors to foster equity, United Nations Development Programme (UNDP) was instrumental in the identification of 8 Millennium Development Goals (MDGs) at the Millennium Summit in 2000. The Kenya government is a signatory of the Millennium Declaration. Goal 6 of the MDGs aims to combat HIV/AIDS, malaria and other diseases. The seventh target of these goals gears to begin to reverse the spread of HIV/AIDS by 2015 while target eight is to reverse the incidence of malaria and other major diseases by 2015 (UNDP, 2005).

Thus client based factors, provider-based factors caretaker perceptions; social and demographic factors, cost, social networks and biological signs and symptoms work synergistically to produce a pattern of health seeking behaviour. What is then observed is a sequential behaviour pattern often drawing from redefinition of illness and a multiplicity of treatment sources.

In addition to explanatory models, there are noncognitive factors such as availability and cost of health services that are drawn into the decision making process. The determinant models of health seeking behaviour include demographic aspects such as the level of education; occupation and income of the head of household, which are critical, particularly in developing countries where these have been explored.

To this extent, cost and physical accessibility of services clearly play a role in influencing the observed health-seeking behaviour.

In their early studies Foster and Anderson noted that underutilization of modern health services is rarely due to the influence of local beliefs or an aversion of western medicine but rather depends on the cost and availability of those services. Whereas availability and physical access is important, it has become apparent that client perspectives on the quality of care as experienced through the client-provider encounter is recognised as playing a major role in health seeking behaviour. An essential factor in determining whether a person seeking health care complies with treatment and maintains a relationship with the health facility and/or provider is client satisfaction. Client satisfaction may be described as the subjective assessment of quality of services received by the client. The assessment of client satisfaction is based on the verbal and non-verbal interaction that occurs between the health provider and individuals seeking information or services. Depending on the nature of the interaction, the physical environment and the provider attitude, this experience may influence the client's perspective of the quality of services and ultimately influence the subsequent health seeking behaviour.

2.1.4 Kenya Vision 2030

The Kenyan insurance policy position is therefore clear on the need to address equity and sustainability of quality health care delivery and collaboration with non-state actors. Health insurance can play a key role in societal development only if the poor in the society are seriously considered. (First medium term plan -2008 -2012) part of the vision Kenya Vision 2030 goal is to provide equitable and affordable quality health services to all Kenyans. This is in recognition of the fact that good health and nutrition boost the human capacity to be productive. Social health care provision is emphasized in the vision 2030 as key to development of key sectors of the Kenyan economy. (GoK, Vision 2030, 2008)

However, quality health care services are low particularly in government run facilities because of lack of supplies / stocks. With a total of 6,194 health facilities, while the remaining 49% are faith based organizations (FBOs) and private facilities. However only 51% are within 5 kilometers to the health facilities (GoK, First Medium Plan - 2008-2012, Kenya Vision 2030, 2008)

2.2 Theoretical Framework

This study used two different frameworks; Structural Functionalist Theory and Rational Choice Theory were discussed in relation to the study. Their relevance in addressing the issues raised from the study was vital.

2.2.1 Structural Functionalist Theory

Structural functionalism is also known as social theory and refers to social functions various elements of the society perform in regard to the entire system. Functionalism addresses society as a whole in terms of the function of its constituents elements namely norms, customs, traditions and institutions.

The various parts of the society are assumed to work unconsciously towards maintenance of the overall social equilibrium, Layton; 1997: 38. Durkheim urges that societies tend to be segmentary being composed of equivalent parts that are held together by shared values and common symbols. Talcott Parsons describes the society as being in a state of equilibrium of balance and as change occurs in one part, there must be adjustments in the other parts.

In this study there is AAR which is viewed as the social structure that is being used by its members to deliver medical services. AAR administrators play a key role by ensuring that its members are well catered for at their clinics by delivering quality services.. The employers, also another social structure, should endeavour to get the best medical cover for their employees at good terms and conditions. The employers should also be able to discuss with the employees on their medical needs and benefits before buying some of the medical packages from AAR.

When the employers and AAR administrators decide on what to give the employees as medical benefits without consultation, the balance of equilibrium is shaken and members opt to pay for medical services as out-of-pocket expenses. The need to establish why AAR members were using out-of-pocket expenses was critical as it would help in knowing which component of the structure was not fully functioning. It is important to note that if one of the actors failed to perform their responsibilities, it would affect the operations of the entire structure.

2.2.2 Rational Choice Theory

Theories of rational choice are guided by the assumption that people are rational and base their actions on what they perceive to be the most effective means of achieving their goals. In a world full of scarce resources, individuals have to constantly evaluate and weigh alternative means against alternative ends and choosing between them, hence the term rational choice. This approach can be used to understand how people chose to access different types of health insurance services, provided by medical insurance providers in Nairobi today. Here individuals are seen to be motivated by wants and goals

that express their preferences. They act within specific given constraints and on the basis on the information that they have about the conditions under which they are acting. The relationship between preferences and constraints can be seen as relationships of a means to an end. They have to make choices to attain these goals and anticipate the outcomes of alternative courses of action and calculate that which is best for them. Rational individuals choose the alternative that is likely to give them the greatest satisfaction. Heath, 1976:3; Carling 1992:27 Coleman, 1973

In sociology, the best-known examples of rational choice are those associated with Social Exchange theory. Exchange theorists conceptualise social interaction as a choice that people make to participate in an exchange after they have examined the costs and the rewards of alternative courses of action and then choosing the best alternative. One of the propositions adopted by the rational theorists is that goods or services will generally be more expensive if they are provided by a monopolist than if they are provided by a number of firms in competition with each other. In the case of the few MIPs, which could be a monopoly providing health services to the insured, accessibility will be more out of reach.

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

Research involves the planning, execution and interpretation of scientific observation (Singleton et al, 1988). Thus the key elements and considerations in the overall plan is what is referred to as research design. This chapter presents the methodological design of the study. Given the nature and the scope of this research, qualitative and quantitative research methods were used to make generalizations of the phenomenon under study.

3.2 Site selection and description

The survey was conducted within the administrative boundaries of Nairobi City, Nairobi County of Kenya. The study focused on AAR clientele which is more organized MIP and serves a huge corporate clientele. The overriding consideration for the purposive selection of the study site was the knowledge of the study area by the researcher and the extensive awareness of AAR clientele base and policies. AAR Health Centres have fully equipped outpatient facilities, centrally located to serve the members. In Kenya, AAR operates six centres in Nairobi, and one each in Nakuru, Kisumu, Mombasa and Kabarak. The centers operated in Nairobi: AAR offers a hospital network services to its clientele and inpatient services, where is partners with more than 30 facilities in Nairobi. Due to cost implications, the study was restricted to four study sites in Nairobi. AAR Health Services provides healthcare through own clinics and hospitals.

Table 3.1: AAR Clinics and location within Nairobi

AAR Williamson House Health Centre (24 hrs)	Williamson House, 2nd Floor, 4th Ngong Avenue
AAR City Centre	ICEA Building, 6th Floor, Kenyatta Avenue
AAR Sarit Health Centre	Sarit Centre, 4th Floor, Nairobi
AAR Karen (at the Karen Hospital)	Karen Hospital – Langata Rd. Ground Floor
AAR Thika Road Health Centre	Near PAC University off Zimmerman road
AAR Parklands Centre	MediPlaza 1st Floor Opp Aga-Khan Hospital Casualty

3.3 Research Design

Research design in the plan of procedures for data collection and analysis that are undertaken to evaluate a particular theoretical perspective. The research design involves the entire process of planning and carrying out a research study (Miller, 1975). It is used by the researcher to come up with solutions to problems and guides him in the various stages of the research. It allows the researcher to draw casual relations among the variables under investigation and where the results obtained can be generalized to larger populations or different situations.

In this study survey research was adopted because it was considered a conventional research method which allowed the use of questionnaire to obtain information from interviewees.

3.3.1 Unit of analysis

The entities under study are referred to as units of analysis (Singleton et al, 1988). It refers to some attributes that must be the subject of the study. The unit is simply what or who is to be described or analyzed. This study sought to explore the effect of AAR insurance cover on the utilization of health services by the insured is the researchers unit of analysis.

3.3.2 Unit of observation

Observation unit or unit of data collection is an element or aggregation of elements from which information is collected (Singleton et al, 1988). The unit of observation in this study was adults under the AAR medical scheme.

3.3.3 Target population

This study targeted AAR corporate clients in four AAR facilities namely; AAR Williamson House Health Centre, AAR City Centre, AAR Sarit Health Centre and AAR Thika Road Health Centre, in Nairobi to ensure that only the target population participated in the study. These four sites were targeted because of the high number of

patients who visit the sites due to their centrality. The client's survey questionnaires were administered to clients on entry. 124 respondents participated in the survey.

3.3.4 Sample Procedures

Sampling is the process of selecting a subset of cases so as to draw conclusions about the entire set (Singleton et al 1988: 163). The procedure for selecting a sample is called a sampling design. Limited fund and time required that this research use a sample of the study population.

The study used the technique of convenience sampling depending on the availability and willingness of the respondents. The population was too large and was therefore impossible to include very individual that visited the four clinics. A convenience sample is either a collection of subjects that are accessible or a self selection of individuals willing to participate.

A sample respondent was initially to be drawn from six AAR centers that were purposively chosen after discussions with the AAR management staff but this was changed to four centers because of centrality and clientele base, as two of the centers were viewed as not busy enough. At the AAR facilities, respondents were selected to give all of them an equal chance of participation. Once the patients entered the clinics they were given the questionnaires after registering as they waited to see the doctors. Those who were called by the doctor before completing the questionnaire were requested to continue afterwards as they awaited their medicines/lab tests.

3.3.5 Sample size

A sample of 124 respondents participated in this study. This was considered appropriate from the four AAR sites that were purposively sampled in Nairobi. Respondents were drawn randomly to give them an equal chance of participation. The researcher ensured that an informed consent was obtained before any commencement of the interview session. A balance was struck between adult males and female respondents to ensure equal gender representation. The sample size is an adequate representation for study since it allows for statistical analysis of findings

Table 3.2: Sample size

Facility	Frequency
AAR City Centre	36
AAR Sarit Health Centre	33
AAR Thika Road Health Centre	31
AAR Williamson House Health Centre	24
Total	124

3.4 Types and sources of data

Primary and secondary data were collected during this study. Primary data was collected from the four AAR clinics in Nairobi, from key informants in the same institution and from employers within the corporate sector. Secondary data was obtained from government records, local and international published and unpublished works and the Internet / web.

3.5 Data collection methods

Emphasis was laid on obtaining both qualitative and quantitative data:

3.5.1 Library research method

The study utilized both published and unpublished material to obtain the secondary data required. These included books, journals, national development plans, official statistics and reports of previous surveys among others. In addition, the study made use of some gray literature from the Internet. The major purpose of using this method was to explore the nature of the problem and to supplement and/or cross check the information obtained from the primary data.

3.5.2 Survey interview

This constituted one of the two main sources of primary data guided by the objectives of the study. A pre-coded and open ended questionnaire was used to record responses from sampled insured health seekers within AAR facilities.

To administer the questionnaires two research assistants were recruited and trained in data collection techniques and research ethics.

3.5.3 Key informant interviews

Interviews were conducted with persons strategically placed to possess vital perspectives on the issues of medical health provision / insurance including; responsible personnel who work in AAR and other policy makers conversant with health insurance in Kenya. Their views and opinions were sought on the influence of medical insurance provision on the health seeking behaviour of the insured.

3.6 Data analysis

3.6.1 Quantitative data

This basically involves methods and ideas of organizing and describing data using graphs, numerical summaries and more elaborate mathematical descriptions. With the aid of a computer, quantitative data received from the interviews was analyzed to assist presentation and collation of research findings using SPSS. The researcher used tables, charts and figures to capture the required information. Throughout the research, efforts were made to provide answers to the research questions.

According to Baker (1988:388) descriptive statistics refers to "simple statistical methods, which do not support or falsify a relationship but help in description of the data." Thus the descriptive data enables the researcher to organize data in effective and meaningful way; the data was reduced to way that is meaningful. Qualitative data derived from secondary data, key informant interviews with doctors and employers was analyzed by noting themes that emerged from their opinions. Babbie (1995:296) points out that in field research, "you look for similarities and dissimilarities; one looks for these patterns of interaction and events that are generally common to what you are studying. Field notes were evaluated and analyzed to determine the adequacy of information and the credibility, usefulness, consistency and validation of the hypotheses.

3.6.1 Qualitative data

Data collected from key informant interviews conducted with persons with in-depth information on the objectives and this study were reviewed for consistency for triangulation purposes with our findings from the quantitative and primary data sources.

3.7 Challenges Encountered

As anticipated in any research, the researcher encountered several challenges. First the sample size was not easily met due to several clients not who are dependents not being aware about the insurance scheme under which they are covered. Secondly, some patients said, they were too sick to participate in the study, and hence declined participating in the interview; in addition the questionnaire was somewhat long for some respondents which made them to complain and as such the researcher had to constantly affirm to the respondents the importance of their participation in the study. Furthermore, in some cases it was difficult to interview patients who were just about to see the doctors or in cases where a doctor had called in a patient to attend while the interview was halfway; this means that the researcher had to increase number of days of data collection at sampled clinics

The sample was well balanced in terms of gender representation with slightly more than half (53.2%) being female while 46.8% were male.

4.1.3 Age of Respondents

Table 4.2: Age of Respondents

Age of respondents	Frequency (n=124)	Percent
18-25 years	14	11.3
26-30 years	35	28.2
31-40 years	36	29.0
41-50 years	31	25.0
(>50 years	8	6.5

Age is an important research aspect that presents to the researcher population dynamics. In this study majority (84.2%) of the respondents fall in the within 26 - 50 years, 11.3% fall in the age range of 18-25 years while 6.5% were aged more than 50 years as illustrated in figure above. This means that majority of those who attend AAR facilities are in their productive age. They suffer all forms of ailments and thus health care and insurance costs are matters of concern to these groups.

4.1.4 Marital Status

Table 4.3: Marital Status

Marital status	Frequency (n=124)	Percent
Single never got married	30	24.2
Married	86	69.4
Single, divorced	4	3.2
Separated	4	3.2

On marital status, 69.4% were married, 24.2% were single and had never been married, while 3.2% had separated and 3.2% divorced. This representation is typical Kenyan situation and can also be explained by the age distribution.

4.1.5 Educational Background

This study also attempted to capture the level of education of the respondents. Generally, education plays an important role in empowering individuals with the awareness and knowledge to make informed decisions about themselves and the world around them. Education would particularly be useful in influencing choice of insurance policy and increased an individual's knowledge of premiums or products offered in the insurance industry. In order to capture the levels of education, the respondents were required to give their highest level of education. The data on this variable are presented in the table below.

Table 4.4: Level of education

Level of education attained	Frequency (n=124)	Percent
Primary education	4	3.2
Secondary education	50	40.3
College or polytechnic	26	21.0
University	36	29.0
Post graduate	8	6.5
Total	124	100

The table 6 above shows that all respondents had attained some level of education. It is also evident that the majority 40.3% had secondary education, 21.0% had attained college of polytechnic education while those who had attained university or post-university education constituted 35.5%. From findings here it can be argued deduced that generally in Kenya and particularly in Nairobi today, an increasing number of the population are pursuing and prioritizing education beyond the secondary level. The growing number of middle level colleges offering certificate and diploma courses especially in Nairobi and its environs may partly explain this trend.

4.1.6 Occupation of Respondents

Table 4.5: Occupation of Respondents

Occupation of respondents	Percent
Driver	14.3
Teacher	7.1
Security guards	7.1
Secretary	7.1
Businessman	21.4
Hotelier	7.1
Housewife	28.6
Student/ Johnseker	7.1

Because of the high level of awareness of these groups, they seek medical insurance cover individually or get better employment that caters for their medical needs. The entry of several universities and campuses has also increased enrollment and attainment of university education. For instance, the government of Kenya, through various University Councils and the Commission for Higher Education (CHE), has set out to promote the expansion of university education and training in tandem with population growth and high demand for university education (News letter of Ministry of Education, 2007). It is also worth noting that the competitive job market has also forced Kenyans to seek for highest educational levels.

4.1.7 Monthly Incomes

Table 4.6: Monthly Incomes

Monthly Income	Frequency (n=124)	Percent
Kshs10, 000-20,000	34	27.4
Kshs 20,001-40,000	32	25.8
Kshs 40,001-100,000	28	22.6
Unemployed	26	21.0
Total	120	96.8
Missing System	4	3.2
Total	124	100.0

The respondents' monthly incomes were also considered in this study, as one of the socio-economic indicators. The respondents were required to report their monthly incomes. Drawing from the findings presented in figure 1 above, 22.6% had an average income ranging between Kshs. 40,001-100,000, 25.8% (Kshs. 20,001-40,000) while 27.4% had monthly salaries in the range of Kshs. 10,000-20,000. Notably 21.0% said they were unemployed, thus were benefiting from corporate insurance cover. Overall majority of respondents are in the middle income group and are more likely to be covered under corporate health care system, they are thus likely to be faced with challenges under this scheme and in the long run must develop coping mechanisms. This also implies that the corporate insurance scheme is a noble measure whose weaknesses need to be identified and promoted to cover more Kenyans. This will ensure adequate and effective healthcare services are accessible to many Kenyans.

The study sought to establish whether the respondents were covered under AAR in line with the key objectives of the study. Notably, the findings revealed that more than half of the respondents (51.7%) have been covered under AAR scheme for between 1-4 years while only 21.7% had been covered under AAR medical scheme for less than a year. This shows that the findings are informative as those sampled had been with AAR medical scheme for some quite a long period of time.

4.2 Preferred Medical Insurance Products/ Services

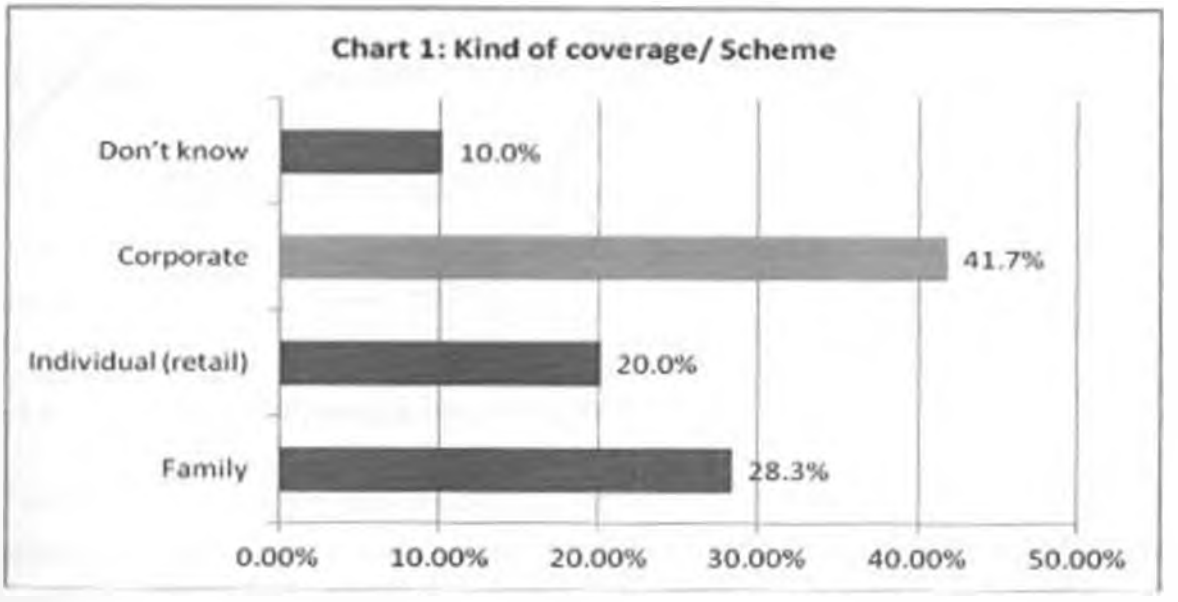
Providing employees medical insurance is the most valuable benefit that an employer can offer. The peace of mind that it will give them cannot be quantified. This study also sought to establish preferred medical insurance products offered by health insurance companies. Health insurance providers offer one stop shop for all medical needs ranging from inpatient, outpatient, maternity, dental, optical and scheme administration. Optional services that the insured identified include: outpatient cover, dental cover, optical cover, maternity cover, last/ funeral cover and excess loss cover. Majority (81%) of the respondents said they prefer the inpatient cover. This, they said caters for most of their medical needs as accessing optional services. Discussion with key informants in the medical facilities and employers concurred that it is cheaper to offer inpatient group

cover to employees as this reduces medical costs and enhances their productivity at the work place.

4.3 Type of Coverage

The study also explored types of coverage for most corporate clients. Findings revealed that 41.7% were covered as corporate clients where the institutions or companies where they are employed pay for their medical care, 28.3% said they are covered as under the family scheme while 20.0% said they are covered under individual scheme. However 10.0% of the respondents were not aware about their medical cover (some of these respondents were not aware of the kind of coverage because they are covered under corporate coverage and are not aware about the details of the coverage. Further, when asked to describe their medical insurance schemes, many, either described their medical coverage as in terms of the company making deductions from their pay or group care (corporate cover).

Chart 1: Kind of coverage/scheme



Many said that the scheme is efficient and cost effective. From the bio-data it can be deduced that majority of the clients of AAR are from lower-middle and middle income

groups. Discussions with key employers reveal that health care benefits are an important factor in either taking a new job or staying with a current job.

Table 4.7: Period respondents have been covered by AAR

Period covered by the AAR	Frequency (n=124)	Percent
less than 1year	26	21.7
1-4 years	62	51.7
4-10 years	32	26.4
Missing	4	0.3
Total	124	100.0

Even among the poor, the private sector is an important source of health care. For example, 47 percent of the poorest quintile of Kenyans use a private facility when a child is sick (Marek et al.2005). In recognition of this important role, the Government of Kenya has developed strategies to develop the private health sector in its Vision 2030 plan as well as in the strategic plans for 2008 2012 of the Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS).

When asked to state what period they have been covered under AAR, 21.7% said they had been covered for less than one year while 78.1% had been covered for between 1-10 years. The longer periods of health insurance under AAR by majority of respondents confirms the preference of products offered by the AAR and health care solutions gained by the respondents.

4.4 Deductions/ Premium payable to AAR

One of the agenda for health reforms in Kenya as outlined in the Health policy framework paper of 1994, is generation of increased levels of financial resources, for the provision of cost-effective services through widely accepted Cost sharing and alternative health financing initiatives. The alternative financing initiatives alluded to include health insurance.

Asked how much is deducted or paid as premium for medical cover, half of the respondents said they pay between Kshs 500-2000 or the amount is deducted from their salary as medical cover by their employers while almost one third of the respondents pay between Kshs 2001-5000 while almost a quarter of the respondents were not aware about the deductions paid for their medical cover. These are respondents who are either beneficiaries of family or corporate cover. Majority of the respondents were in the bracket of lower middle class or middle class.

Further, the researcher sought to know if there are some family members who are not covered under the AAR health scheme and the finding reveal that more than half (55.4%) of the respondents have some their family members not covered compared to 41.1% who said that all of their family members are covered under their insurance scheme. Discussions with AAR management staff revealed that this happens in because of the terms of coverage including:

- Non-allowance of members over 65 years
- Annual renewal medical examinations for members over 65 years
- Non-coverage of families suffering from some particular diseases considered expensive to care for.

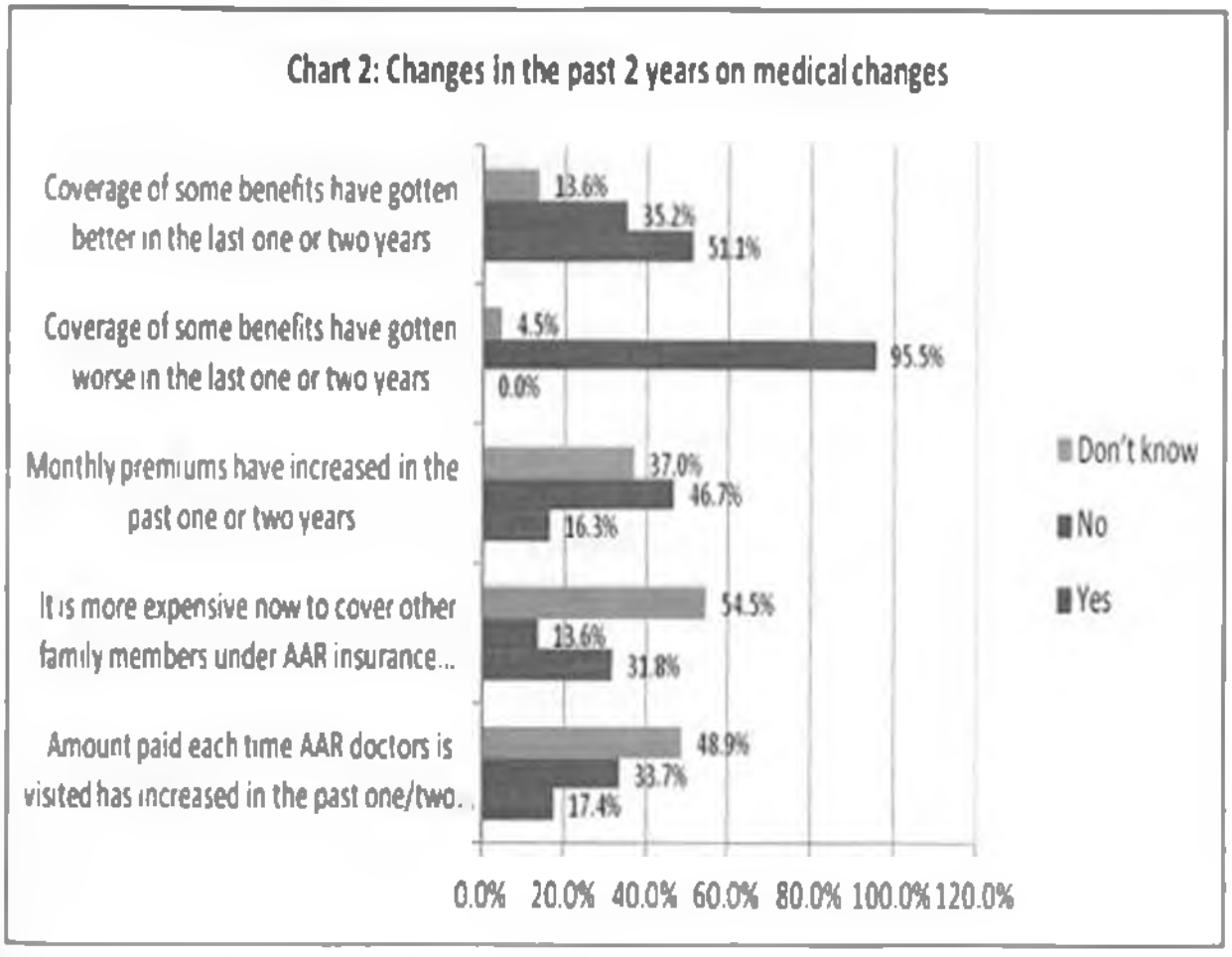
This clearly indicates that there are some challenges still being faced by the insured in ensuring that all family members despite of other factors are well covered. These challenges in accessing health care for all members of the family implies that the insured have to produce more cash to provide for the health needs for some of their family members.

4.5 Changes in Medical Insurance

The findings aforementioned show that accessing adequate healthcare under the corporate scheme presents some challenges which are normally not clear when one is joining the scheme, the researcher thus sought to know if the health insurance has changed over the past year or two in the amount paid each time a service is used, like visiting a doctor at AAR for consultancy. Findings reveal that 48.9% were not aware about changes that have resulted into increase in amount of money paid, 33.7% said that there had not been

any changes in premiums paid when one visits the doctor while 17.4% affirmed that the amount paid each time for a service like visiting a doctor at AAR had increased in the past year or two. These respondents asserted that they now pay more in terms of deductions compared to two or one year ago. According to one respondent, "changes in premiums seem to be happening in complete disregard of the clients, who are never consulted by either the employers or the insurance companies"

Chart 2: changes in the past 2 years on medical changes



Drawing from finding presented in chart 2 above, 51.1% of the respondents were in agreement that coverage of some benefits have gotten better in the last two years, 16.3% responded that monthly premiums or deductions had increased in the past one or two years. 31.8% concurred that it is now more expensive to cover other family members

under AAR insurance scheme while 17.4% said the amount paid every time AAR doctor is visited has increased in the past one or two years.

Drawing from these findings on changes on the last two or so years, it can be concluded that health insurance companies have been effecting changes in their schemes which have ended up discouraging their clients from accessing adequate health care workers need adequate information, education and communication on the benefits that accrue by enrolling with such covers through their employers to make informed decisions. During key informant interviews, the issue of inadequate information was identified as one minimizing access to healthcare by the insured.

The study sought to know if the insured would be willing to pay, say Kshs 200 a month more to AAR to improve health coverage in to keep their existing benefits if employers would otherwise cut back and the finding reveal that, an overwhelming 87.5% are willing to do so while 3.4% said they aren't willing to add any money to what is already deducted or paid are premium. This is an indication that medical insurance is perceived positively by majority of the insured inspite of the economic challenges as it lightens the burden of health care costs to corporate clients in Kenya. Actuaries say insurers structure premiums based on the number of times a targeted group makes hospital visits.

Table 4.8: Whether respondents are willing to pay more for premiums

Willing to pay more	Percent
Yes	87.5
No	3.4
Missing	9.1
Total	100.0

Table 4.10: Whether health insurance dictates health services accessed

Health insurance dictates health services accessed	Percent
Yes	45.6
No	27.9
Missing	26.5
Total	100.0

For those who had said that the insurance scheme dictates access to health services, most noted that this had limited their access to health care services. Asked to state the extent to which they are satisfied with the services offered under their schemes 35.0% said they are very satisfied while only 65.0% said they are slightly satisfied.

However when asked to state how they compared to the insured how they would rate themselves in regard to accessing healthcare as a client of AAR, 68.3% of the respondents they are better off, 11.7% said they are same and 6.7% said they are worse off. 13.3% of the respondents could not say whether they are better off or worse off in terms of accessibility to health care services when compared to the uninsured. For those who said they are worse off, some of the reasons given include; out of pocket expenses and management of chronic illnesses which present huge challenge to them.

Table 4.11: How the insured compare to the un-insured

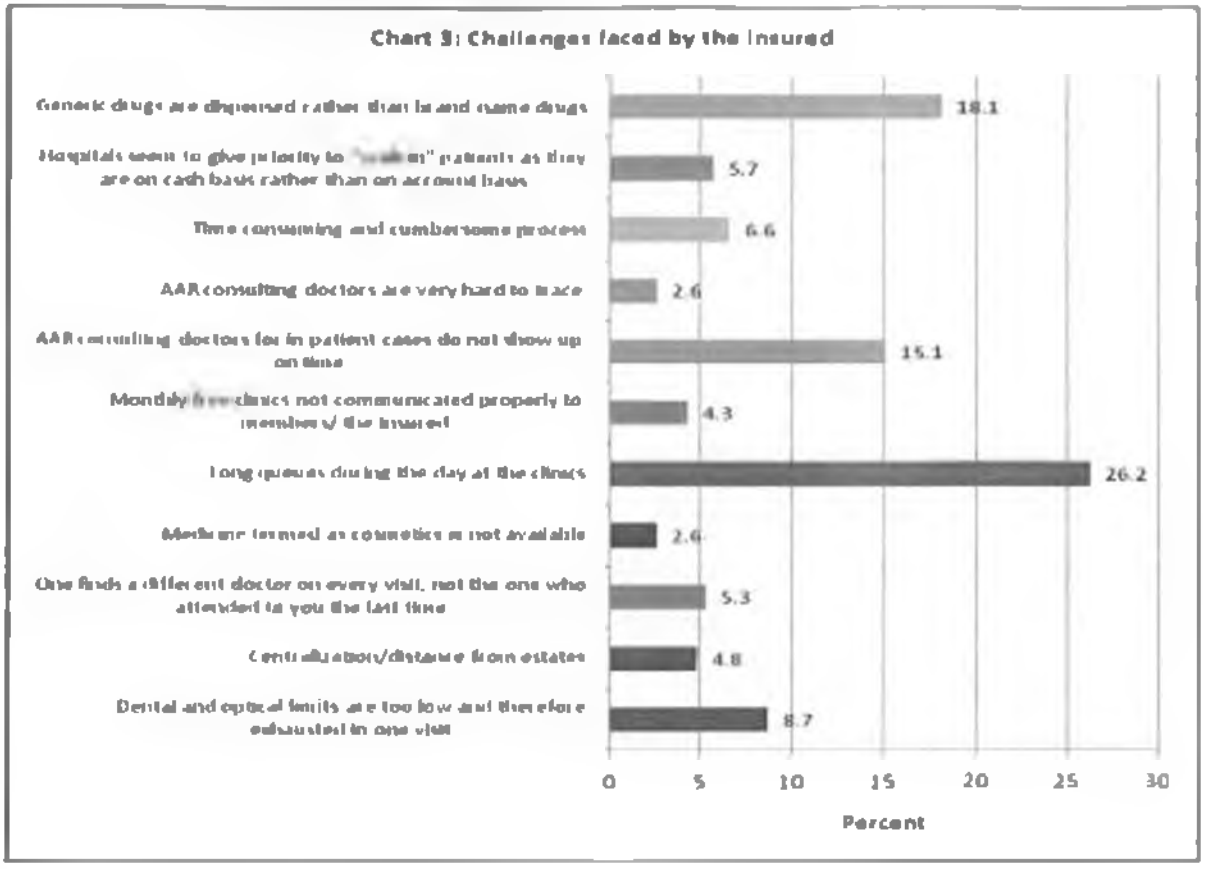
Comparison between the insured and the un-insured	Percent
Same	11.7
better off	68.3
worse off	6.7
Missing	13.3
Total	100.0

4.7 Challenges faced by the insured

Health care is a problem to many the world over. For those who do not access health insurance and those under-insured, several problems are faced. It is also not surprising that the insured on the other hand also face several problems. The study sought to

understand challenges that have been faced by the insured and the findings reveal that several challenges are faced; 48.2% of the insured said they face challenges under their health insurance schemes while slightly more than half (51.8%) said they do not face any challenges. For those who said they face challenges, we sought to know what challenges have been facing them. The table below summarizes the challenges that the insured face.

Chart 3: challenges faced by the insured



According to Chart three above, it is clear that the biggest challenge facing many of the insured is the issue of long queues due to the big number of clients that visit the facilities within the city. This was cited by 26.2% of the respondents, other challenges also faced are the issuance of generic drugs rather than brand-name drugs (18.1%), consulting doctors for in-patients not showing up on time (15.1%) and the challenge of dental and optical limits being too low that at in many cases they are exhausted in one visit (8.7%). other challenge cited by the respondents include:

- Hospitals giving priority to walk in patients who pay cash at the expense of those based on account basis or corporate clients;
- Some of the respondents also say that medical attention in the AAR clinics is time consuming and cumbersome;
- Finding different doctors for consultation on every visit curtails proper diagnosis, care and attention and;
- Centralization of the facilities, some of the insured clients argues that the AAR hospitals centers are located far from their dwellings

One key challenge identified by the key informants was in regard to Insurance Regulatory Authority (IRA) and other relevant arms of government which still have punitive and discriminatory premiums for persons with pre-existing conditions in securing health insurance. This has affected these peoples' health seeking behaviors negatively.

One response by MIPs is to try to improve the information they have about the insured, by undertaking "utilization reviews"—essentially checking that doctors are not providing "too much" care. In order to motivate doctors, MIPs may indeed give them stakes in the insurance company, converting it to a managed care organization. Such an organizational design is efficient, as long as the information asymmetry is removed. In practice, the physician is the primary source of this information such that he or she confers an information advantage on the patient vis-à-vis the insurer when acting as the patient's agent.

However, when acting for the insurer, the physician may put the patient at a disadvantage, and warranted treatments could be withheld. The usual competitive forces that induce firms to maintain high quality healthcare may not work well in this situation, and quality of care could suffer. Therefore, the government is bound to come in for the protection of consumers.

4.8 Coping Mechanisms

The study established that as a result of facing health care challenges enumerated above, the insured have developed some coping mechanisms in order to fill the gaps in health care. For each specific challenge the insured have developed coping mechanisms are outlined in the table below:

Table 4.12: Challenges faced by the insured and coping mechanisms

	Challenges	Coping Mechanism
1.	Dental and optical limits are too low and therefore exhausted in one visit	Seeking alternative low cost dentists elsewhere
2.	Centralization/distance from estates	Seeking alternative treatment especially for minor ailments.
3.	One finds a different doctor on every visit, not the one who saw you the last time	Explaining history of sickness on every visit, it is tiring and exhausting especially for a sick person.
4.	Medicine termed as cosmetics not available	If prescribed, one has to buy from outside chemists
5.	Long queues during the day at the clinics	Visit the clinics very early or very late in the evening if not an emergency
6.	AAR consulting doctors for in-patient cases do not show up on time and are also very hard to trace leading to a lot of frustration and time wasting. checking out after discharge can also be pretty slow.	• Calling AAR staff to find out where their doctors are. • Lodging complaints or posting letter to the suggestion box
7.	The hospitals seem to give priority to "walk-in" patients as they are on a cash basis rather than "on-account" patients as these are credit based.	Stamping ones authority at the hospital if there is still some energy
8.	Generic drugs are dispensed rather than brand-name drugs.	• Specifically ask for the brand-name drugs as they have them on the shelves • Buy the brand names form pharmacies elsewhere

Some coping mechanisms have been noted to result in use of more money from the insured especially where money have to be spent on health care. On the other hand, it was established that there are some health challenges that have been hard to cope-up with in addition to some coping mechanisms developed being quite unproductive to the insured.

Specifically some respondents identified non-involvement in decision making on issue so of health care issues by their bosses or the corporate managers as one challenge that is hard to cope with. It was noted that some of the coping mechanisms are internal and dictated by the socio-economic characteristics of the insured. The upper middle class can access the services elsewhere while those that are not well to do in most cases have no alternative. The coping mechanisms by the insured may also be approached through a mixture of mechanisms as indicated in the table above.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Findings

Equity and universal coverage currently dominate policy debates worldwide. Health financing approaches are central to universal coverage. The employers pool resources used to purchase or provide health care services which should be carefully considered to ensure that the insured needs are addressed under appropriately. This study was set out to establish the effect of medical insurance on the utilization of health services by the insured. It specifically, identified products and services preferred by those insured by medical insurance providers; found out how health insurance companies / employer partnerships affect the insured's health seeking behaviour; established challenges faced by the insured in regard to seeking health services; establish coping mechanisms employed by the insured to overcome health insurance challenges.

The study established that the insured have few choices when it comes to health seeking as they are insured with AAR and have limited choices. The insured seldom have time to present their views and their premiums are already packaged making it hard for them to seek for extra services once covered under specific premium by their employer. Thus they have to embark of accessing various other products not offered under their schemes by forking resources 'out-of pocket'.

Demand literature has pointed to the need to offer "tangible" frequently-used products to create value for clients, but this premise remains largely untested. The study established that the insured are better off compared to the uninsured in regard to access to health care. Health insurance offers a promising way to improve access to health care, mitigate the risks of disease and ill health. Significant benefits for the insured are across multiple dimensions of improved access, more timely care, increased availability of preventive care and health education, and reduced risk of catastrophic financial influence. However it was also established that the insured have few choices when it comes to health seeking as they are insured with AAR and have limited choices. The insured seldom have time to

present their views and the premiums are already packaged making it hard for them to seek for extra services once covered under specific premium by their employer.

The study also identified significant challenges faced by the insured seeking health care whence it becomes a case of having health insurance but still struggling to pay their healthcare bills. Many of them are faced with rising deductibles, and copayments, as well as limits on coverage for various services or other limits and excluded services that can increase out-of-pocket expenses. Thus, even when they go without preventive care and necessary prescriptions, some of the corporate client would be considered as underinsured as they are still unable to cover all their medical expenses.

As part of the objectives of the study, researcher found that the insured developed coping mechanisms to cater for their health care needs. Thus they have to embark of accessing various other products not offered under their schemes by forking resources 'out-of pocket'.

5.2 Conclusion

In conclusion it is evident that health insurance schemes provided by employers are preferred by the employees as it has made it cheaper for them to access healthcare. However they insured want to be provided with more health products like dental, which was noted to be inadequate, they also want their families to be covered more by their health insurance.

It is also evident that health insurance companies / employer partnership has ensured that employees access better health care services compared others Kenyans who are not insured. This in essences covers even their families and thus increases their productivity in the work place. However because of non-involvement of the insured in their health insurance schemes and decision making processes, it has limited their access to adequate health care. Thus, at times they end up forking more from their pocket to meet other health care needs. Consultations with the insured play a key role in ensuring satisfaction with health care services offered by the medical provides like AAR.

It is clear that although employers have made it their policy to provide health care insurance to their employees, still there are challenges faced by the insured. The serious challenge being long queues as most patients attend the facilities to access health care services and the issues of generic drugs being dispensed rather than brand name drugs. The challenges faced have resulted in some of the insured looking for coping strategies like seeking alternative dental and optical services elsewhere, visiting clinics very early or very late amongst other strategies.

5.3 Recommendation for Policy

On the basis of the above findings, the following recommendations can be made

5.3.1 Policy Recommendations

1. The government should streamline operations of health insurance providers to ensure that they adhere to guidelines set
2. Employers and health insurance providers should hold consultations with the employees constantly to make necessary changes to their insurance schemes where necessary
3. The government of Kenya should make policy follow-ups on the conditions of health insurance in Kenya
4. Setting prices, monitoring health provider performance, risk management and quality assurance are all vital to optimising the efficiency of insurance operations, and, just as importantly, the performance of the health system in providing safe and effective care to individuals.

5.3.2 Recommendations for AAR

1. Due to the high cost of visiting dentists and opticians, AAR should increase the limits of the two services for their clients.
2. More clinics should be put up especially in the residential areas for easy access, especially because for non-emergency cases a member should only visit the AAR

clinics. Also, long queues will be a thing of the past.

3. Doctors to be given easy to follow schedules of work whereby it will be easy for patients to know when that particular doctor is available.
4. Members should be educated on the differences between generic and "original" medicines. Cosmetic medicines should also be explained to the patients as they are still prescribed in the clinics.
5. AAR should acquire their own full hospital to be a first stop and only stop for all medical procedures including x-rays, laboratories and in-patient services. This also ensures that patients are attended to immediately they are admitted to the hospitals as the doctors are readily available.

5.3.3 Areas for Further Research

A number of areas merit further exploration: other health financing approaches (e.g. contracting out, vouchers, and donation of subsidized products and other inputs); building capacity in the health workforce (e.g., project workforce needs); exploring private sector provision of medical health education; and prioritization of health care markets followed by more in-depth analysis.

Also to better understand the value of health insurance, more rigorous studies of a broader range of products are needed. Studies should include a broader contextual and nuanced discussion that takes into account the added value of corporate insurance and the trade-offs people face when purchasing insurance or paying premiums through salary deductions.

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APPENDIX 1: QUESTIONNAIRE

Part A: Demographic information

1) Respondent's sex

1=Male 2=Female

2) How old are you?

01= (18-25 years) 02= (26-30 years) 03= (31-40 years)
04= (41-50 years) 05= (>50 years)

3) What is your occupation?.....

4) What is your Income per month?

1= < 10,000
2= Kshs10, 000-20,000
3= Kshs 20,001-40,000
4= Kshs 40,001-100,000
5= Kshs 100,001-500,000
6= >Kshs. 500,001
7= Unemployed
8= Refused / Missing

5) Level of education attained

01= None/ illiterate
02= Primary education
03= Secondary education
04= College or polytechnic
05= University
06= Post graduate

6) Marital status

1= Single never got married
2= Married
3= Single, divorced
4= Widow/ Widower
5= Separated

Part B: Preferred Medical Insurance Products/ Services

7) For how long have you been covered by the AAR?

1= less than 1year
2= 1-4 years
3= 4-10 years
4= More than 10years

8) Under which kind of coverage/ scheme are you?

1=Family,
2=Individual (retail),
3=Corporate
4=I don't know
5=Other .....*specify*

9) How much do you pay / is deducted for your insurance coverage each month?

1= < than Kshs 500
2= Kshs 500-2000
3= Kshs 2001-5000
4= >Kshs 5000
5= Nothing etc

10) **Do you have some of your family members who are NOT covered under your AAR health insurance?**

1= Yes
2= No
3= DK
4= Refused

11 **Kindly describe to me your health insurance scheme? And why you prefer it.**

_____
_____
_____
_____

12) **Has your health insurance changed over the past year or two in any of the following ways...Has the amount you pay each time you use a service, like visiting a doctor at AAR, increased?**

1= Yes
2= No
3= DK
4= Refused

13) **If YES [in question 12 above], why?**

_____
_____

14) **Has your health insurance changed over the past year or two in any of the following ways...Is it more expensive now to cover other family members under your AAR insurance cover?**

1= Yes
2= No
3= DK
4= Refused

15) **Has your health insurance changed over the past year or two in any of the following ways...*Has your share of the monthly premium* [*amount or instalment (to be) regularly paid for an insurance policy*] increased?**

1= Yes
2= No

3= DK
4= Refused

16) **Has your health insurance changed over the past year or two in any of the following ways...*Has coverage of some benefits gotten worse*?**
1= Yes
2= No
3= DK
4= Refused

17) Has your health insurance changed over the past year or two in any of the following ways...*Has coverage of some benefits gotten better*?
1= Yes
2= No
3= DK
4= Refused

18) **Would you be willing to pay, say Kshs 200 a month more to AAR to improve your health coverage in any of the following ways...*To keep your existing benefits, if you employer said your benefits would otherwise cut back*?**
1= Yes
2= No
3= DK
4= Refused

19) **Are there some conditions or practices, under your insurance scheme that you dislike? Which ones?**

_____
_____
_____
_____

20) **Overall, how would you rate the quality of health care you receive from AAR? Would you say it is -- excellent, good, fair, or poor?**
1= Excellent
2= Good
3= Fair
4= Poor
5= DK
6= Refused

Part C: Influence of Insurance Companies-Employer Partnership

21) Do you think that employers should be required to provide health benefits at no charge to all their employees?

1= Yes
2= No
3= DK
4= Refused

22) What health insurance services are you able to access through your scheme at AAR?

_____
_____
_____

23) Does your health insurance scheme dictate what health services you can access?

1= Yes
2= No
3= DK
4= Refused

24) How has this influenced your accessibility to health care?

_____
_____

25) Why do you say so?

_____
_____

26) To what extent are you satisfied with these services offered under your scheme?

1= Very Satisfied
2= Slightly satisfied
3= Slightly dissatisfied
4= Not satisfied

27) Compared to the uninsured, how would you rate your accessibility to health services as a client of AAR?

1= same
2= better off
3= worse off
4= can't say / don't know

Part D: Challenges faced by the Insured

28) Are there some challenges that you have faced as a result of being insured under AAR?

1= Yes

2= No

3= DK

4= Refused

23) If yes, which challenges have you faced? [*Probe*]

24) How do you cope with these challenges in order to access health care services? [*Probe*]

25) Are there some challenges that you have been unable cope up with? Which ones?

26) How does your employer involve you in decisions making regarding your choice and kind of insurance coverage? At what level?

27) In your opinion what should the following players do to ensure that medical health insurance services are improved? *(Probe)*
A) The Government or insurance regulator

B) What should health insurance providers like AAR do to improve its services to the insured?

C) You, the insured

Thank you

APPENDIX II: KEY INFORMANT INTERVIEW SCHEDULE

Position held by the key informant.....

Years spent at the institution as an employee.....

1) What health services are offered by AAR are mostly used / accessed by the insured?

_____

_____

_____

2) In your opinion, what are the challenges facing the insured in accessing health care services provided by AAR?

_____

_____

_____

3) In order to address the above-mentioned challenges what measures has AAR put in place as a medical insurance provider?

_____

_____

_____

4) What are some unique requests by employers while getting medical insurance for their employees?

_____

5) What services are preferred by the insured? Please explain why this is so.

_____

6) In your opinion what challenges face the insured in seeking medical care form AAR?

_____

7) In your opinion, what should MIPs, health centers, the government and other stakeholders within the insurance sector do to improve accessibility and affordability of health services to the insured?

a) MIPs	b) Health centers	c) Government, policy makers & Insurance Regulatory Authority (IRA)
1.	1.	1.
2.	2.	2.
3.	3.	3.

Thank you

APPENDIX III: EMPLOYER'S INTERVIEW SCHEDULE

Name of company / firm .....

Position of interviewee .....

1) For how many years has your company been a client of AAR.....

2) Which insurance benefits do you offer to your employees?

_____
_____
_____
_____

3) What services do your employees use most at AAR?

_____
_____
_____

4) Are you the person who decides what health insurance plans get offered to employees of your Organisation? If NO, how is this decided? Do you involve your employees?

_____
_____
_____

5) What conditions must an employee meet in order to be eligible for health insurance coverage by the AAR?

_____
_____
_____

6) Is health insurance provided to all your employees? If NO, who are covered and which cadre of employees are not covered?

7) Do your employees have to contribute more towards health insurance coverage? If YES, for what purposes / coverage?

_____
_____
_____

8) If an employee chooses not to take health insurance coverage, does that employee receive compensation for not taking health insurance from your organization? If yes, what kind of compensation do such employees receive?

9) Compared to three years ago, has the percentage of employees who choose not to take health insurance increased, decreased, or remained about the same? Why has that been so?

10) What challenges if any has your company faced / been facing in providing medical insurance coverage to your employees

11) What has been done to solve the challenges faced?

12) What can be done to improve health insurance provision and services by AAR to the insured?

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Thank you

APPENDIX IV: INTRODUCTION LETTER

Julia Kimonye
Masters of Arts
University of Nairobi
Department of Sociology

Dear Sir/Madam,

Ref: Introduction Letter

My name is Julia Kimonye, and I am conducting a research on "the effect of medical insurance on the utilization of health services - A case of AAR". This is my thesis project and it's also important as it will make important contributions to informing policy on improving services provided by the Medical Insurance Providers. The information that you will give me, will be treated with utmost confidentiality. This questionnaire is being administered to outbound insured respondents and you have been chosen randomly to participate in the study.

It is my hope that you will be kind enough to spare some time and respond to a few questions.

Yours faithfully,

Julia Kimonye