CHALLENGES IN THE UPTAKE AND PROVISION OF MEDICAL INSURANCE IN KENYA

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DECLARATION

This research project is my original work and has not been presented for a degree in any other university.

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DEDICATION

This project is dedicated to my beautiful wife Irene Njeri Kuria, daughter Lynne Waithera Kuria and mum Pauline Waithera Kuria for their love, support and encouragement. To my wife Irene Njeri, thank you for your invaluable support, you always inspire me to do more and I will always cherish your love and dedication. To my daughter Lynne Waithera, you have so much potential and I hope this will encourage you to aim higher. I pray for God's blessings throughout your life. To my mum Pauline Waithera, thank you for the gift of education and for always encouraging me to do more. To my dear brothers Billy Nganga Kuria and Philip Muriithi Kuria, I hope this will encourage you to do more.

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LIST OF ABBREVIATIONS/ACRONYMS

AKI	Association of Kenyan Insurers
GDP	Gross Domestic Product
HMO	Health Maintenance Organisations
IIK	Insurance Institute of Kenya
IRA	Insurance Regulatory Authority
MIP	Medical Insurance Providers
NHIF	National Hospital Insurance Fund
PCP	Primary Care Physician
POS	Point Of Service
PPO	Preferred Provider Organizations

ABSTRACT

The study investigated the challenges in the uptake and provision of medical insurance in Kenya. The objectives of the study were to determine the challenges in the uptake and provision of medical insurance in Kenya and measurers to be adopted in overcoming these challenges. A descriptive survey design was used; data was collected from respondents using semi-structured questionnaires and data was analysed using SPSS analysis software. Tables, bar graphs and charts were used in presentation of data. From the findings it is clear that cost of medical insurance, disposable income and marketing activities are the main challenges in the provision of medical insurance in Kenyan. Fraud, cost of health care and lack of knowledge on medical insurance are the major challenges in the provision of health insurance in Kenya. The study recommends that medical insurance providers should develop affordable products to avoid locking out many would be clients who cannot afford to pay costly premiums. By collaborating with health care providers, medical insurance providers could negotiate cheaper health care costs for their members. Medical insurance providers should carry out marketing campaigns and should also open more branches in rural towns so as create more awareness on medical insurance and its benefits. Insurers should also introduce discounts for clients with few claims to encourage prudent usage of medical covers which are often misused resulting to increased costs. The introduction of discounts may also avert moral hazard. The study recommends further research on medical insurance by narrowing down to specific challenges identified such as fraud or information technology.

CHAPTER ONE
INTRODUCTION

1.1 Background of the study

Risk may be defined as an uncertainty concerning a potential loss, a situation in which we are not sure whether there will be loss of a certain kind, or how much will be lost. Vaughan and Vaughan (2008) defines risk as a condition in which there is a possibility of an adverse deviation from a desired outcome that is expected or hoped for. The uncertainty concerning a potential loss and the undesirable element found with risk underlie the wish and need for insurance. It is commonly accepted that only financial, pure and particular risks are insurable. For a risk to be considered financial, it must have a financial measurement. For a risk to be considered pure, it must be real and not related to gambling. Risk that are not widespread in their effect are referred to as particular risk.

Insurance is a form of risk management strategy primarily used to hedge against the risk of a contingent, uncertain loss. It is a risk management tool that helps individuals deal with safety needs by transferring the risk. The safety needs include; personal security, financial/economic security, health and well-being and also safety net against accidents/illness and their adverse impacts (Maslow, 1943). The transfer of risk is achieved through the purchase of specific insurance covers that guard against the undesired outcome. In addition to eliminating risk at the level of the individual through transfer, the insurance mechanism reduces risk and the uncertainty related to risk for society as a whole.

According to Judy and Robert (2005), in any insurance transaction, the insurer is the company selling the insurance while the insured or policyholder, is the person or entity buying the insurance policy. The amount of money charged for a certain amount of insurance coverage is called the premium.

The transaction involves the insured making a relatively small payment to the insurer in exchange for the insurer's promise to compensate the insured in the case of a financial loss. The insured receives a contract, called the insurance policy, which details the conditions and circumstances under which the insured will be financially compensated.

Theories on which the study is based include Neo-classical welfare economic theory which assumes that individuals make rational choices based on cost-benefit calculations under varying conditions. It predicts that consumers will insure against catastrophic medical events and cover lower-cost services themselves. Another relevant theory is the economic utility theory which is used in economics to explain choice under uncertainty. Among the many classes of insurance that cater for specific insurance needs, medical insurance is the most important to an individual since accessing quality health care is an important objective for anyone who desires to remain healthy and productive.

Medical insurance is a critical cover for Kenyan families especially now that medical expenses have spiralled out of control. There are now many reported cases of lifestyle diseases and generally the need for a medical insurance cover is now greater than before. However, it is interesting to note that many people are still not insured. Medical insurance class reported the highest loss ratios in the insurance industry in the year 2012.

Health maintenance organisations have also stopped providing medical insurance exclusively and many have now started offering general insurance covers after acquiring new licences from the Insurance Regulatory Authority. The former HMO's are now general insurance companies. To develop and increase uptake of medical insurance, it is necessary to first understand the challenges in the uptake and provision of medical insurance in Kenya.

1.1.1 Risk and Insurance

Historically, economic risk was managed through informal agreements within a defined community (Judy & Robert, 2005). Members of the community would pitch in to assist one of their own who had suffered a loss. This cooperative pooling concept became formalized in the modern insurance industry. Under a modern formal insurance arrangement, each insurance policy purchaser also referred to as a policyholder still implicitly pools his risk with all other policyholders. However, it is no longer necessary for any individual policyholder to know or have any direct connection with any other policyholder. From an individual point of view, insurance can be defined as an economic device whereby the individual substitutes a small certain cost known as the premium for a large uncertain financial loss (the contingency insured against) that would exist if it were not for the insurance.

From the social point of view, insurance is an economic device for reducing and eliminating risk through the process of combining a sufficient number of homogeneous exposures into a group to make the losses predictable for the group as a whole.

Insurance therefore has two fundamental characteristics the first one being the transfer or shifting of risk from one individual to a group and the second being the sharing of losses, on some equitable basis, by all members of the group (Vaughan & Vaughan, 2008).

The primary function of insurance is the creation of the counterpart of risk, which is security. Insurance does not decrease the uncertainty for the individual as to whether the event will occur, nor does it alter the probability of occurrence, but it does reduce the probability of financial loss connected with the event. There are two main types of insurance, namely life insurance and general insurance.

Life insurance is an insurance coverage that pays out a certain amount of money to the insured or their specified beneficiaries upon a certain event such as death of the individual who is insured. Life insurance is long term in nature. The risks that are covered by life insurance are premature death, income during retirement and illness. Whole life, term, endowment and life annuity plan are the main products of life insurance.

General insurance is basically an insurance policy that protects against losses and damages other than those covered by life insurance. It is short term in nature and the coverage period for most general insurance policies and plans is usually one year. The main products of general insurance include auto insurance which protects the policyholder against financial loss in the event of an incident involving a vehicle they own, workers' compensation insurance which replaces all or part of a worker's wages lost and accompanying medical expenses incurred because of job- related injuries and property insurance which provides protection to property against risks such as fire, theft or weather damage (Vaughan & Vaughan, 2008).

Others include liability insurance which is a very broad superset that covers legal claims against the insured and medical insurance alternatively known as health insurance which covers the cost of medical treatments.

1.1.2 Medical Insurance Cover

A medical insurance cover/policy provides for the payment of the costs of medical care that result from sickness and injury and also provides preventive care through wellness programs. It helps meet the expenses of physicians, hospital, nursing, and related services, as well as medications and supplies (Green & Rowell, 2011). Benefits may be in the form of reimbursement of actual expenses (up to a limit), cash payments, or the direct provision of services. Coverage is sold both on an individual and group basis.

According to Vaughan and Vaughan (2008), the most common types of Medical insurance plans are Managed Care and Fee-for-Service plans. Most individuals who have medical insurance through their employer or those who are self- insured are enrolled in some type of a managed care plan. All managed care plans contract with doctors, hospitals, clinics, and other health care providers and these group of contracted providers becomes the health plan's network. In some types of managed care plans, a member may be required to receive all their health care services from a network of providers while in other managed care plans, a member may receive care from providers who are not part of the network, but he/she will pay a larger share of the cost to receive those services. This practice ensures that most health care needs of the members are sourced from contracted providers who have been vetted by the managed care plan provider.

Fee-for-Service plans are traditional kind of health care policies where insurance companies pay medical fees for each service provided to an insured patient. Fee-for-service plans offer a wide choice of doctors and hospitals. Fee-for-Service coverage falls into basic and major medical protection categories.

Basic protection deals with costs of a hospital room, hospital services, care and supplies, cost of surgery in or out of hospital, and doctor visits. Major medical protection covers costs of serious illnesses and injuries, which usually require long- term treatment and rehabilitation period. Basic and major medical insurance coverage can be combined to give a comprehensive health care plan.

A general medical insurance policy covers all medical related costs for an individual including physicians, surgeons, specialists and physiotherapist fees. Cost of prescribed drugs, X-rays, electrocardiograms and charges arising from the use of an ambulance are also covered (Green & Rowell, 2011). However, most covers exclude pre-existing & chronic conditions and intentional self-injury among others.

1.1.3 Insurance Industry in Kenya

The insurance industry in Kenya is governed by the Insurance Act and regulated by the Insurance Regulatory Authority. The Insurance Regulatory Authority has the role of regulating, supervising and developing the insurance industry. There is also self-regulation of the Insurance companies by the Association of Kenya Insurers (AKI). The professional body of the insurance industry is the Insurance Institute of Kenya (IIK) whose mission is to enhance insurance professionalism and sustainable high standards of service to the public through training, examinations, certification and research (IIK 2014 Public notice).

There are currently 49 licensed insurance companies in Kenya, 170 Insurance brokers, 3942 insurance agents and 22 medical insurance providers (brokers). Other licensed players included 123 investigators, 101 motor assessors, and 22 loss adjusters, 2 claims settling agents, 8 risk managers and 22 insurance surveyors (IRA 2014 Public notice). Twenty five of the forty nine licensed insurance companies write non-life insurance business only while ten write life insurance business only. Fourteen companies are composite meaning that they write both life and non-life business.

From AKI Report (2012), the gross written premium by the industry was Kshs. 108.54 billion compared to Kshs 91.6 billion in 2011, representing a growth of 18.49 %. The gross written premium for non-life insurance was Kshs 71.46 billion while that of life insurance business was Ksh 37.08 billion. Non-Life insurance premium grew by 17.78% while life insurance premium and contributions from deposit administration & investment/unit linked contracts grew by 19.88%.The industry incurred net claims totalling Kshs. 48.36 billion in 2012 compared to Kshs. 37.69 billion in 2011, representing an increase of 28.31%. The penetration of insurance computed as a ratio of gross premium to Gross Domestic Product (GDP) was 3.16% in 2012.

This comprised of 1.08% for life business and 2.08% for non-life business. According to Kubania (2011), the challenges facing the Insurance industry in Kenya include uncompetitive practices like poor underwriting and premium undercutting, negative industry perception, claims settlement, premium collection, staffing, insurance fraud, inadequate intermediate service, insecurity, terrorism and money laundering.

1.1.4 The Medical Insurance Sector in Kenya

The medical insurance sector in Kenya comprises of Public medical insurance also commonly referred to as National Hospital Insurance Fund (NHIF), and Private medical insurance.NHIF is a mandated hospital insurance program which has been in existence since 1966 and is currently governed by the NHIF Act No 9 of 1998. NHIF registers all eligible members from both the formal and informal sector.

For those in the formal sector, it is compulsory to be a member. For those in the informal sector and retirees, membership is open and voluntary. NHIF currently covers 3.3 million principal members with estimated total beneficiaries of 7.8 million (including dependents) which accounts for 20% of Kenya's population (NHIF 2014 Public notice).

Wang'ombe *et al* (1994) states that Private Medical insurance can be categorised into two groups; the first group is referred to as direct private medical insurance and comprises of insurance covers taken out by individuals. The second group is referred to as employment based insurance and it refers to medical insurance covers sourced by employers on behalf of their employees as part of the employee benefit package. The employer provides care directly through employer-owned on site health facility, or through employer contracts with health facilities or healthcare organisations.

Individuals who require a medical insurance cover can obtain it directly from an insurance company in what is referred to as Fee for service plan or they can buy medical insurance from any of the licenced medical insurance providers (MIPs) who are mainly insurance brokers who deal with medical insurance exclusively.

Employers have an option of purchasing medical insurance for their employees directly from an insurance company or from the medical insurance providers (brokers). Employers can also opt for self-funding whereby they set aside a fund for payment of medical expenses incurred by staff members and their dependants. These funds can be managed in house or they can be managed by a third party administrator at a fee. The advantage of the latter is the reduced cost of administration (Green & Rowell, 2011). There are currently fourteen general insurance companies underwriting medical insurance.

In the year 2012, medical insurance had a gross written premium of Ksh 13.1 billion. This accounted for 18.3% of the total gross written premium for that year (AKI Annual Report, 2012). Medical insurance had a loss ratio of 78.3% which was the highest among all the insurance classes underwritten in 2012.

Medical insurance in Kenya has always had a high loss ratio and this may be the reason that it is not underwritten exclusively. For instance AAR Health Services and Resolution Health East Africa came on board the Kenyan market as health maintenance organisation but have recently acquired licences to underwrite general insurance classes. The general cost of healthcare has been increasing steadily and those with a medical insurance cover always have access to quality healthcare services. Medical insurance therefore plays a critical role of facilitating access to quality healthcare services in Kenya.

1.2 Research Problem

The risk of health faces everyone and it is desirable that people have access to health facilities in order to deal with this risk. One of the ways of mitigating such a risk is through medical insurance. Medical insurance is important as it protects individuals from the high health care costs, especially those related to the need for hospitalization or chronic medical conditions (Wanderi, 2012). It protects savings and income. Many people get into financial problems because of health care cost associated with sudden illness or accidents or with prolonged illness which require frequent medical attention. Individuals also forgo health services because of the costs of health care. The importance of medical insurance therefore cannot be over emphasised.

With only 20% of the population benefiting from public medical insurance through NHIF which is way cheaper compared to private medical insurance, it is clear that a majority of the population is not insured yet medical insurance is a critical cover for Kenyan families. Kenyans are now more likely than before to be diagnosed with a lifestyle related disease which require frequent medical care. The general assumption would therefore be that every individual would buy a medical insurance cover so that they are better prepared.

However, this is not the case. The cost of health care has been increasing progressively and similarly, the levels of income of Kenyans have also increased however, there has not been a great improvement in the uptake of medical insurance especially among those who can afford it. Recently, two companies which were initially dealing with medical insurance exclusively have acquired licences to underwrite general insurance business so they may have had some challenges which led to this move. It is also not clear why medical insurance has been recording the highest loss ratios among all the classes of insurance in Kenya.

A number of studies have been done on the Medical insurance sector in Kenya. Kubania (2011) did a study on external environmental challenges affecting the performance of medical insurance sub sector in Kenya. Wanderi (2012) did a study on the factors influencing medical insurance practices among persons in Nairobi central business district while Kosgei (2009) did a study on factors influencing the choice of health care financing by informal sector employees. Mavalankar and Bhat (2000) did a study on opportunities, challenges and concerns facing health insurance in India, and according to the study, the challenge in India was to ensure that health insurance benefited the poor and the weak in terms of better coverage and health services at lower costs.

None of these studies highlighted above addressed the challenges in the uptake and provision of medical insurance in Kenya. It is against this background that this study sought to fill this gap by answering the question, what are the challenges in the uptake and provision of medical insurance in Kenya?

1.3 Research Objectives

The objectives of the study were to:

i. Determine the challenges in the uptake and provision of medical insurance in Kenya

ii. Determine the possible solutions to the challenges.

1.4 Value of the study

Medical insurance has three key players namely; policy holders, insurers or other medical insurance providers and health care providers.

For these players to work in harmony for the benefit of the policy holder, it is essential to have proper legal and regulatory framework. This study will provide the useful recommendations in formulation of legal and regulatory framework for further development of medical insurance in Kenya.

The study will provide more insight into medical insurance in Kenya and potential customers may use the information to make the best choices for their medical insurance needs. The identification of the challenges will also allow Insurance companies to improve existing medical insurance covers or come up with better medical insurance covers that will be attractive to the potential customers. The Insurance companies will also be able to device better marketing strategies that will result to an improvement in the uptake of medical insurance in Kenya.

The study will provide information to researchers, potential and current scholars on the challenges in the uptake and provision of medical insurance in Kenya. This would expand their knowledge on medical insurance in Kenya and also identify areas of further study.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the related literature on medical insurance in general, and specifically the challenges as presented by various researchers, scholars and authors. The materials are drawn from several sources which are related to the study objectives

2.2 Theoretical Foundations

The theories that inform the demand for health insurance include expected utility theory and neo-classical welfare economic theory.

2.2.1 Expected Utility Theory

Expected Utility Theory states that the decision maker chooses between risky or uncertain prospects by comparing their expected utility values, i.e., the weighted sums obtained by adding the outcomes multiplied by their respective probabilities (John, Hands, Maki & Elgar, 1997).This theory has proved useful in explaining some popular choices that seem to contradict the expected value criterion such as in the contexts of gambling and insurance. Expected utility theory is vastly used in utility values of economics to explain choice under uncertainty. If the consumer knew with certainty that she would never need medical treatment, she would presumably not be willing to pay for health insurance. It is the risk of becoming ill (at an uncertain time and with unpredictable severity and duration) that prompts a desire for access to medical care.

2.2.2 Neo-Classical Welfare Economic Theory

In neo-classical welfare economic theory presented by Kenneth Arrow, individuals make choices to maximize their preferences over time, and the goal of society is to maximize social welfare, or aggregate preferences. It assumes that individuals make rational choices based on cost-benefit calculations under varying conditions. Neo-classical theory predicts that consumers will insure against catastrophic medical events and cover lower-cost services themselves; in reality consumers typically choose policies with low deductibles and co-payments (Arrow, 1963). This approach asserts that the free market is the best way to allocate resources, as it values efficiency over equity.

Risk-averse individuals are predicted to choose insurance against large risks, leaving smaller risks uncovered, thereby improving their overall welfare. As stated above, however, in empirical studies, individuals find it difficult to make such choices. Health insurance markets are also not entirely free. Insurance companies have an information advantage, which they can use to pick out the kinds of consumers they insure and the kinds of coverage they offer them, in order to increase their profits. In consequence, more comprehensive coverage tends to be confined to wealthier individuals, reducing the pooling of risk across the population. Conversely, poorer individuals often fail to choose coverage that meets their health needs (Ruger, 2007).

2.3 Medical Insurance Underwriting

Medical insurance is insurance against the risk of incurring medical expenses among individuals. Medical insurance is important because of the unpredictable nature of spending on healthcare.

While individuals have some idea about their need for future medical services, the exact amount they spend on healthcare remains uncertain to them to a great extent. According to Vaughan and Vaughan (2008), in order to determine the premium to be charged for a medical insurance cover, the insurer actually estimates the overall risk of health care expenses among a targeted group, and then develops a routine finance structure, such as a monthly or annual premium to ensure that money is available to pay for the health care benefits specified in the insurance agreement. This is referred to as medical underwriting.

Medical underwriting can therefore be defined as the use of medical or health information in the evaluation of an applicant for coverage. It is usually done before cover commences. As part of the underwriting process, an individual's health information may be used in making two decisions: whether to offer or deny coverage; and what premium rate and conditions to set for the policy. Medical underwriting helps prevent adverse selection, which is a tendency for people to purchase health insurance coverage only when they are sick or need medical care. Proponents of underwriting believe that, if given the ability to purchase coverage without regard for pre-existing medical conditions which are reviewed during underwriting, people would wait to purchase health insurance until they got sick or needed medical care.

This then creates a pool of insureds with high utilization, which then increases the premiums that insurance companies must charge in order to pay for the claims incurred. In turn, high premiums further discourage healthy people from obtaining coverage particularly when they realize that they will be able to obtain coverage when they need medical care.

A medical insurance policy is a contract between an insurance provider and an individual or a group. The contract can be renewable either monthly or annually or it may be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a policy document for private insurance, or in a national health policy for public insurance (Vaughan & Vaughan, 2008).

Generally, individual health insurance policies are guaranteed renewable, meaning that once a policy has been issued, the policyholder can keep it forever regardless of medical conditions as long as the required premiums are paid. However in most instances insurers increase premiums or reduce benefits at renewal based on an individual's claim history or changes in their health status. Insurers have the right to cancel individually purchased insurance if the insurer finds that the applicant provided incomplete or inaccurate information on the application, thereby affecting the medical underwriting process. This practice, called rescission, protects insurers from intentional fraud. Most individuals obtain medical insurance either through a form of Medical insurance plan or through a Fee for service arrangement.

According to (Green & Rowell, 2011), the most common types of managed care plans are: Health Maintenance Organizations (HMOs) where members receive most or all of their health care from a network provider.Members have a provision to select a primary care physician (PCP) who is then responsible for managing and coordinating all of the member's health care needs. The PCP's serves as personal doctors to members and they include internal medicine physicians, family physicians, gynaecologists and paediatricians. Where necessary, PCP's also refers members to specialists.

Members who do not get referrals or those who choose a doctor outside the HMO's network are required to pay all or most of the cost of care received.

Preferred Provider Organizations (PPOs) where members receive a list from which they choose medical care providers. The list comprises of all medical care providers who have a contract with the PPO. A PCP is usually not required. Members of the PPO are allowed to receive care outside its network of providers but usually at a higher cost. Furthermore a member will need to pay the doctor directly and file a claim with the PPO to get reimbursed in such cases. PPO's have a deductible and a coinsurance feature.

Point-of-service (POS) plans which combines the features of the health maintenance organization (HMO) and the preferred provider organization (PPO). Members in a POS plan are required to choose a PCP from within the health care network and this PCP becomes their point of service. Whenever a member requires health care, they can decide to stay in the network and allow the PCP to manage the care or they can decide to go outside the network without a referral from the PCP. The member will however pay more if they go outside the network. Finally we have Self-funded health care plans where an employer provides health care to employees using its own funds. These are schemes where no form of cover is purchased, but rather the employer sets aside a fund for payment of medical expenses incurred by staff members and their dependants. Rules, scheme benefits and limitations are determined by the employer.

Medical insurance claims usually take a standard path from submission to adjudication to payment and finally notification. At each step of the path, there are variables; however, each health insurer follows the same basic procedures.

A normal medical insurance policy will generally cover the following benefits up to a stipulated limit per policy: Accident & illness hospitalization, surgeon's, physician's and anaesthetist's fees and the charge for use of an operating theatre, diagnostic consultations or specialist's, pathologist's and physiotherapist's fees. Registered private doctor's fees and the cost of prescribed drugs and dressings, x-rays, electrocardiograms, encephalograms, audio grams, radiotherapy or chemotherapy. Surgical appliances prescribed by a registered medical practitioner, charges arising from the use of an ambulance, cost of other transport or air fares for journeys incurred in cases of emergency in an attempt to save human life. Insured person's maintenance in any hospital or nursing home or sanatorium (Green & Rowell, 2011).

A normal medical policy has policy exclusions and limitations: the cover usually has a limitation on age for new entrants who are also required to wait for some time after signing up before they can start enjoying the benefits. Other exclusions and limitations include the following: Pre-existing & chronic conditions, congenital defects, war and kindred risks, cosmetic surgery unless caused by an accident, treatment other than a registered doctor of medicine, intentional self-injury, drunkenness, dissipation, psychoneurosis. HIV/AIDS related illnesses and dental and optical covers unless cover is purchased separately as a rider.

2.4 Challenges in Provision of Medical Insurance

Medical insurance, like other forms of insurance is not immune to problems. The problems are quite peculiar due to the complex nature of medical insurance and the involvement of multiple parties. Below are the challenges in provision of medical insurance.

Moral hazard occurs when a party insulated from risk may behave differently than it would behave if it were fully exposed to the risk. Moral hazard is a special case of information asymmetry in a situation in which one party in a transaction has more information than another. More broadly, moral hazard occurs when the party with more information about its actions or intentions has a tendency or incentive to behave inappropriately from the perspective of the party with less information.

The seminal works of Arrow (1963) and Pauly (1968) who proposed the moral hazard problem in medical care suggest that the policyholder does not consider the insurer's costs. Unregulated healthcare markets and private insurance encourage this behaviour since insurance lowers or avoids the cost of treatment at the point of treatment: consumers tend to demand more (consumer moral hazard). Providers have an incentive to render more or unnecessary care than might be medically appropriate (provider moral hazard).

To combat this problem, most insurance companies use mechanisms and conditionality's which in the end only create a burden on policyholders with the part of cost (Sonderstrom, 1997). Some of the mechanisms insurance companies have adopted are co- payments or co-insurance, deductibles or a reduced premium bonus for the future.

Another possibility of coping with moral hazard is to arrange special contracts (Jutting, 1999). The underlying principle of the special contracts or arrangements is to tackle the problem of information asymmetry and enforcement by establishing a long- term relationship and trust between the partners.

Sekhri and Savedoff (2004) states that the problem of moral hazard is compounded because it can also be practiced by doctors who may over-prescribe medications or order unnecessary services, knowing that the insurer and not the patient will be paying.

This provider-induced demand decreases the affordability of coverage and dampens insurance demand. Concerns with this problem include rising costs due to increased demand for medical care (for those with insurance) and consequently unnecessarily high claim rates. Insurance companies assess the health insurance portfolio as a low-profit-business line because of the moral hazard phenomenon (Mwaura, 2009).

Adverse selection can be defined as strategic behaviour by the more informed partner in a contract, against the interest of the less informed partner (Cutler & Zeckhauser, 1997). In the health insurance market it is relevant because each individual chooses among the set of contracts offered by the insurance companies according to his or her expected probability of using health services. In brief, those who foresee a medical problem in the near future for self and dependents will tend to choose more generous plan than those who do not. In the extreme, for each premium and degree of coverage, those who will decide to purchase that particular health insurance contract are those who expect to have health expenditure greater or equal to the premium paid. Then, whatever the premium, the insurance company may end up with a loss on each customer.

According to Cutler and Zeckhauser (1997), adverse selection has the potential to lead to three classes of inefficiencies; prices to participants will not reflect marginal costs, hence on a benefit- cost basis individuals will select the wrong health plans; desirable risk spreading is lost; and health plans will manipulate their offerings to deter the sick and attract the healthy. Adverse selection can lead any insurance plan to be unprofitable and eventually fail as a result of the insurer having a pool of more risky cases. This is because the insurer is unable to allow for this correlation in the price of insurance since the private information is known only to the individual or due to regulatory adverse selection whereby the regulations prevent the insurer from using certain categories of known information to set prices.

Adverse selection occurs because insurers have less information about an individual's health status than the individual. To protect themselves from this unknown risk, they will tend to set insurance premiums higher. In voluntary markets, this will result in healthier individuals not buying health coverage because their cost will be higher than the potential benefits. Sicker individuals will still choose to buy insurance resulting in a higher than expected average level of risk in the insurance pool. At the extreme, adverse selection can lead to the collapse of the insurance market (Cutler & Reber, 1998).

It also raises ethical and moral questions which has been an ever present fact in the insurance world, because only one party (insured) to an insurance transaction has the more relevant information than the other party who accepts the risk who is the insurance company (Dorfman, 2005).

Generally, there has been a growing concern about the rising cost of medical care and premium cost of health insurance not only because of increases in unit cost, but because of increased utilization of health services (Green & Rowell, 2011). Overutilization can takes two forms: increased frequency and duration of use and higher charges than otherwise would be imposed. Excessive cost may rise from unnecessary admission, and unnecessary use of diagnostic and treatment aids, unnecessary long period of stay, and unnecessary high charges for services rendered. Excessive charges may arise from the practice of caring for charity patients at less- than-average cost and adding the losses so incurred to the bills of paying patients, especially those with insurance. These abuses may arise from actions of patients, physician, and the hospital or insurers.

Health care fraud is committed when someone intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits payable. Fraud has three perpetrators. It can take place when an individual patient perpetuates a fraud scheme against his or her own health plan, also called beneficiary fraud, when the treatment providers and medical equipment vendors act on their own by using to their advantage a benefits plan, also known as provider fraud, and when there is collusion between the providers and patients, which essentially is a combination of provider and beneficiary fraud, but which opens the door to whole new sets of possible schemes to defraud the insurer. One of the greatest challenges for the insurer is to properly identify and prove whether or not the plan member is involved in the fraudulent or abusive scheme. All members usually plead that they were innocent victims (Busch, 2008).

2.5 Challenges in uptake of Medical Insurance

A common reason for the low demand for medical insurance in developing countries is the limited understanding of its benefits. Insurance is often perceived as a nonviable investment because premiums are collected every year but indemnities are paid much less frequently. Policy exclusions and coverage limitations are often a source of confusion. Thus, potential buyers, even educated ones, sometimes prefer to retain risk than trust a third party like an insurance company. Low-income household's reason that they do not require insurance. This is probably due to lack of confidence in insurers and poor understanding of the risk-pooling concept.

Many people do not understand the concept of insurance and how it works. In some cases, the views of poor people about insurance are negative. They see it as the reserve for the rich; something that is irrelevant, too expensive or even unfair (Cohen & Sebastad, 2005).

Medical insurance premiums are usually high because the risk exposures are considered to range between high exposure and very high exposure (IRA Report, 2013). This keeps off many who cannot afford the high premiums. Most medical insurance providers (brokers) also require payment of premiums annually and they usually do not extend credit due to the nature of the risk. The lack of flexibility in payment of premiums eventually keeps off many would be policy holders. Medical insurance covers are also characterised by many benefits which can be offered in many combinations and indeed most medical insurance providers (brokers) offer several unique medical insurance products. The availability of several homogenous products with many variations keeps off many people who get confused and opt to maintain the status quo.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter details how the proposed study was carried out. It covers the design adopted to cover the study, how data was collected and eventual analysis of the data in order to generate research findings for reporting.

3.2 Research Design

The study used a descriptive survey design in order to get an in depth understanding of the challenges in the uptake and provision of medical insurance in Kenya. The major purpose of descriptive research is to describe characteristics of objects, people, groups, organizations, or environments. It highlights a given situation by addressing who, what, when, where, and how questions (Zikmund, 2010).

3.3 Population and Sampling

There are a total of 49 licenced insurance companies in Kenya. However, for purposes of this study the target population was 17 insurance companies providing medical insurance covers and the 22 registered medical insurance providers (brokers). Sampling is concerned with the selection of a subset of individuals from within a statistical population to estimate characteristics of the whole population. If all the subjects are selected, then it is referred to as a census (Saunders & Lewis, 2009). This was a census since all the medical insurance providers totalling to 39 were selected.

One underwriting manager from each of the 39 providers was selected since they were in a position to answer questions on uptake and provision of medical insurance. The study sought the views of the insurance companies and medical insurance providers (brokers) mentioned above with a view to establishing the challenges in the uptake and provision of medical insurance in Kenya.

3.4 Data Collection

Both Primary and Secondary data were used. Primary data was collected by use of a questionnaire (See Appendix II) with both close and open-ended questions. A questionnaire is a research instrument consisting of a series of questions and other prompts for the purpose of gathering information from respondents (Mugenda & Mugenda, 1999). The questionnaires was administered to the respondents through mail survey.

This approach was considered appropriate for the study because it gave the respondents time to fill the questionnaire and also allowed the researcher an opportunity to review the questionnaires before picking them to ensure completeness of responses. Secondary data was derived from existing sources of data such as insurance industry reports and other publications on medical insurance.

3.5 Data Analysis

The filled questionnaires were checked for completeness and then coded and the data analysed using descriptive statistics. Descriptive statistics describe characteristics of a population or sample and this therefore enables one to present the data in a more meaningful way, which allows simpler interpretation of the data.

Means, medians, modes, variance, range, and standard deviation typify widely applied descriptive statistics (Zikmund, 2010).SPSS which is an analysis software was used in data analysis. The data was presented using tables and figures.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND DISCUSSIONS

4.1 Introduction

This chapter presents the findings of the study. The purpose of the study was to determine the challenges in the uptake and provision of medical insurance in Kenya.

4.2 Response Rate

A total of 39 questionnaires were administered to insurers and medical insurance providers (brokers). Thirty questionnaires were completely and adequately filled for inclusion in this study. This represents a 77% response rate which is considered a good response since the industry under study is very restrictive in giving out information.

4.3 Experience in medical insurance business

The study sought to find out the number of years that each of the medical insurance provider had been in operation. The information was captured from both Insurers and Medical insurance providers (brokers).

Table 4.1: Number of year's providers have been providing medical insurance.

	Frequency		Percent	
	Insurers	**MIP's (Brokers)**	**Insurers**	**MIP's (Brokers)**
2-5 Years		**2**	**0**	**13.3**
6-10 Years	**1**	**5**	**6.7**	**33.3**
11-20 Years	**5**	**3**	**33.3**	**20**
Greater than 20	**9**	**5**	**60**	**33.3**
Total	**15**	**15**	**100**	**100**

From Table 4.1, 60% of the respondents who are insurers have been providing medical insurance for more than 20 years while 33.3% have been providing medical insurance for between 11 and 20 years. Only 6.7% of the respondents have been providing medical insurance for less than 10 years. Information on Table 4.1 further indicates that 13.3% of the respondents who are medical insurance providers (brokers) have been providing medical insurance for less than 6 years while 33.3% have been doing it for between 6 and 10 years. The results further show that 20% have been providing medical insurance for between 11 and 20 years while 33.3% have done it for more than 20 years.

The results therefore show that majority of providers currently providing medical insurance covers have been doing it for quite a long time. The results further show that majority of the new entrants i.e. in operation for less than 5 years are the medical insurance providers (brokers) who incidentally do not carry any risk but benefit from commissions. This may mean that commissions from medical insurance business are very attractive.

4.4 Types of covers offered

Medical insurance covers provided by medical insurance providers generally have inpatient and outpatient benefits which are either offered to Corporates only or to both Corporates and Individuals. In addition to this, most medical insurance providers also provide fund management services to their corporate clients. This study sought to find out the types of covers and services offered by the medical insurance providers and also who the target clients were. The results are summarised in Table 4.2.

Table 4.2 : Types of Covers Offered

		Responses		
		N	Percent	Percent of Cases
Types of Covers offered by Insurers	Individual Inpatient Cover	12	20.0%	80.0%
	Individual Outpatient Cover	11	18.3%	73.3%
	Corporate Inpatient Cover	15	25.0%	100.0%
	Corporate Outpatient Cover	15	25.0%	100.0%
	Corporate Fund Management	7	11.7%	46.7%
Total		60	100.0%	400.0%
		Responses		
		N	Percent	Percent of Cases
Types of Covers offered by MIP	Individual Inpatient Cover	15	21.1%	100.0%
	Individual Outpatient Cover	15	21.1%	100.0%
	Corporate Inpatient Cover	15	21.1%	100.0%
	Corporate Outpatient Cover	15	21.1%	100.0%
	Corporate Fund Management	11	15.5%	73.3%
Total		71	100.0%	473.3%

Source: Author

From the table, it is evident that 80% of the respondents who are insurers offer individual inpatient covers while only 73.3% offer individual outpatient covers. All the respondents offer corporate inpatient and corporate outpatient covers while only 46.7% offer fund management services to corporates.

All respondents who are medical insurance providers offer inpatient and outpatient medical covers to both individuals and corporates. Only 73.3% of the respondents who are medical insurance providers offer fund management services. It is therefore clear from the findings that the insurance market has a wide range of medical insurance products for both individual and corporates

4.5 Business mix of the medical insurance covers portfolio

The respondents were requested to state the business mix of their medical insurance portfolio and the results are summarised in the below tables. Results on Table 4.3 show that 78.66% of all medical insurance business underwritten by insurers is from corporate clients while 21.33% is from individual clients.

Table 4.3: Insurers business mix for the year 2013

	N	Minimum	Maximum	Mean	Std. Deviation
Percentage of Corporate Business	15	70.00	90.00	78.6667	6.11400
Percentage of Individual Business	15	10.00	30.00	21.3333	6.11400
Valid N (list wise)	15				

From Table 4.4 it is clear that 86% of all medical insurance business underwritten by medical insurance providers (brokers) is from corporate clients while 14% is from individual clients.

Table 4.4: Medical Insurance Providers business mix for the year 2013

	N	Minimum	Maximum	Mean	Std. Deviation
Percentage of Corporate Business	15	80.00	90.00	86.0000	5.07093
Percentage of Individual Business	15	10.00	20.00	14.0000	5.07093
Valid N (list wise)	15				

Results on Table 4.4 show that medical insurance providers concentrate mainly on corporates and perhaps this may explain the low uptake as concentration is on corporates who are few compared to individuals.

4.6 Gross premiums on medical insurance business for the year 2013

The study sought to find out the gross premiums for the year 2013 from the respondents who are insurers. The results are summarised in Table 4.5.

Table 4.5: Gross premiums for the year 2013

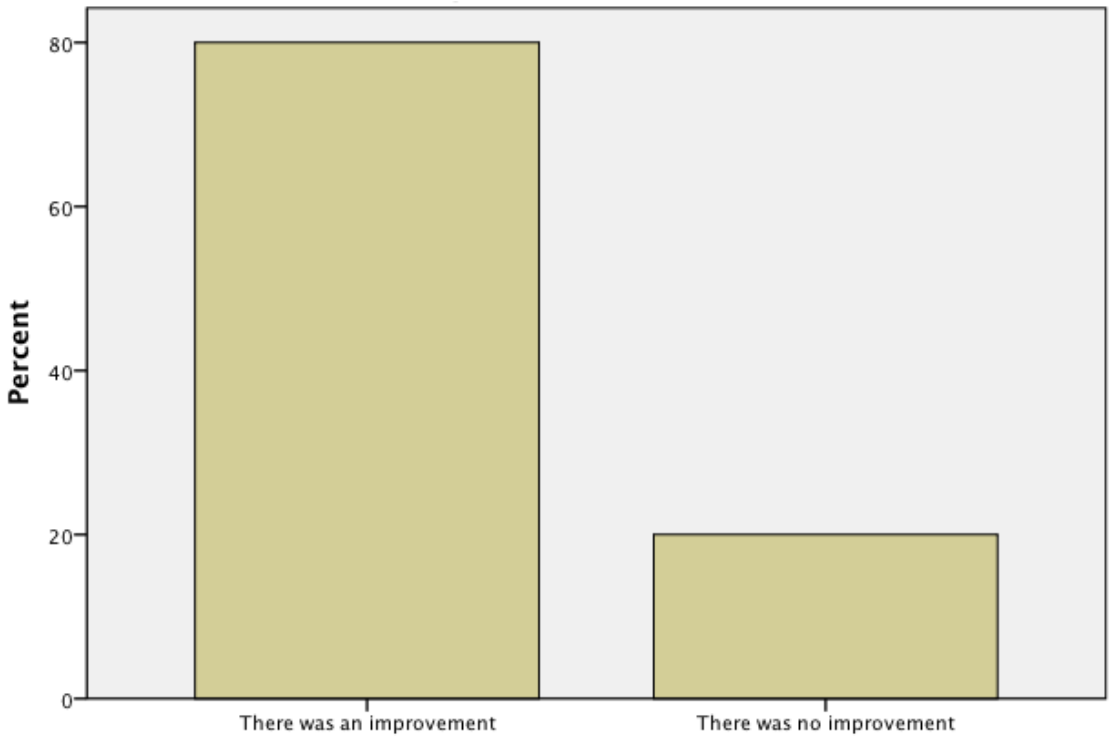
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	51-100 Million	3	20.0	20.0	20.0
	101-500 Million	1	6.7	6.7	26.7
	501-1 Billion	4	26.7	26.7	53.3
	Greater than 1 Billion	7	46.7	46.7	100.0
	Total	15	100.0	100.0	

Only 20% of the respondents collected premiums below 100 million.6.7% of the respondents collected premiums between 101 and 500 million while 26.7% collected premiums between 501 million and 1 billion.46.7% of the respondents collected premiums above 1 billion. Generally, 80% of the respondents collected premiums above 100 million while 20% collected premiums below 100 million and this may mean that uptake of medical insurance is on the rise or that premiums charged are quite high.

4.7 Gross premiums comparison

Respondents were asked whether there was an improvement on gross premiums for the year 2013 compared to the year 2012 and it is evident from Figure 4.1 that 80% of the respondents indicated that there was an improvement in year 2013 gross premiums figures compared to year 2012 figures.20% of the respondents indicated that there was no change in the year 2013 figures compared to those of year 2012.

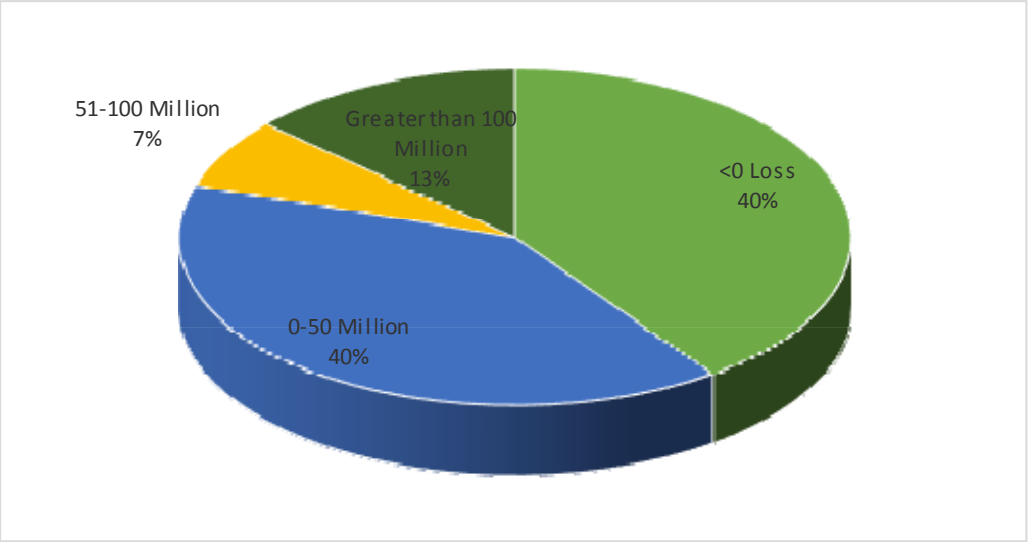
Figure 4.1: Improvement in gross premiums compared to previous year



4.8 Profitability

Respondents were asked to state the profits for the year 2013 and it is evident from figure 2 below that 60% of the respondents made a profit in the year 2013 while 40% of the respondents made a loss. The profits were generally low as only 13.3% of the respondents made a profit above 100 million yet 80% of the respondents collected premiums above 100 million as shown on Table 4.5.This maybe an indication of high cost of medical claims.

Figure 4.2: Profitability



4.9 Challenges in the uptake of medical insurance

This section looks at the challenges in the uptake of medical insurance in Kenya. The researcher asked the respondents to evaluate some factors based on their importance in the uptake of medical insurance in Kenya. The statements responses were Likert (ordinal) in nature and were coded as follows: 1 = Very important, 2 = Important, 3 = Moderately important, 4 = Slightly important, 5 = Not important

The results are summarised in table 4.6.

Table 4.6: Challenges in the uptake of medical insurance

Descriptive Statistics

	N	Mean	Std. Deviation
Cost of Medical Insurance	30	1.30	.466
Disposable income	30	1.5667	.50401
Marketing activities	30	1.5667	.50401
Lack of knowledge on insurance	30	1.7333	.78492
Peer influence	30	2.1000	.92289
Lifestyle diseases	30	2.5667	1.25075
Lack of flexible payment options	30	2.6667	1.02833
Indifference towards insurance	30	2.8667	.86037
Valid N (listwise)	30		

Results from table 4.6 show that Cost of medical insurance is considered a very important factor in the uptake of medical insurance in Kenya followed by disposable income and marketing activities with a mean score of 1.3, 1.56 and 1.56 respectively. Other important factors include lack of knowledge on insurance, peer influence, lifestyle diseases and lack of flexible payment options. Indifference towards insurance is considered the least important factor with a mean score of 2.86. The result also shows that respondents' opinions were very varied for questions on the effect of lifestyle diseases and lack of flexible payment options.

From the study, it is evident that in order to increase uptake of medical insurance in Kenya, cost of medical insurance will have to reduce so that it becomes more affordable to many. Similarly, the welfare of many individuals will need an improvement so as to increase the level of disposable income available. Marketing activities sensitising individuals on benefits of medical insurance can also play a great role of increasing uptake of medical insurance.

4.10 Challenges in the provision of medical insurance.

This section looks at the challenges in the provision of medical insurance in Kenya. The researcher asked the respondents to evaluate some factors based on their importance in the provision of medical insurance in Kenya. The statements responses were Likert (ordinal) in nature and were coded as follows: 1 = Very important, 2 = Important, 3 = Moderately important, 4 = Slightly important, 5 = Not important

The results are summarised in the table 4.7.

Table 4.7: Challenges in provision of medical insurance

Descriptive Statistics

	N	Mean	Std. Deviation
Fraud	30	1.1000	.30513
Cost of health care	30	1.2000	.40684
Lack of knowledge on medical insurance	30	1.4667	.50742
Moral hazard	30	1.5000	.68229
Adverse selection	30	1.6000	.49827
Competition	30	1.6667	.47946
Information technology	30	1.7333	.44978
Skills and competencies of staff	30	2.5000	.73108
Claims management	30	3.5000	.62972
Legal and regulatory framework	30	3.57	.504
Delays in premium collection	30	3.6000	.49827
Valid N (listwise)	30		

Source: Author

From table 4.7, fraud and cost of healthcare are considered the most important factors affecting the provision of medical insurance with mean scores of 1.1 and 1.2 respectively. Other important factors include; lack of knowledge on medical insurance, moral hazard, adverse selection, competition, information technology, skills and competencies of staff and claims management. Legal and regulatory framework with a mean score of 3.57 and delays in premium collection with a mean score of 3.6 are considered the least import factors in the provision of medical insurance. From the study, it is evident that in order to improve provision of medical insurance in Kenya, the issue of fraud has to be tackled. Fraud results to increased claims cost which eventually cripples insurers and also forces them to charge higher premiums which ultimately keeps off potential customers. Similarly increased cost of health care forces insurers to increase premiums for medical insurance.

4.11 Discussion of findings

The results of the study pointed out that the Kenyan insurance market has many medical insurance products for both individuals and corporates. However, medical insurance providers concentrate on corporate clients at the expense of individual clients and this maybe one of the reason for the low uptake of medical insurance. The study revealed that insurers collected huge premiums for medical insurance yet they earned very little profits which is an indication that cost are high.

Cost of medical insurance, disposable income and marketing activities stood out as the major factors affecting the uptake of medical insurance. This is in agreement with the findings of Cohen and Sebastad (2005) which indicated that many people do not understand the concept of insurance and that the views of poor people about insurance are negative. They also see it as a reserve for the rich because of the cost.

Fraud, cost of healthcare and lack of knowledge on medical insurance stood out as the major factors affecting provision of medical insurance. This findings are in congruency with the findings of Sekhri and Savedoff (2004) which indicated that the problem of moral hazard is compounded because it can be practised by patients and doctors and also the findings of Cutler and Zeckhauser (1997) which indicated that adverse selection can lead any insurance plan to be unprofitable and eventually fail as a result of the insurer having a pool of more risky cases.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Introduction

This chapter presents a summary of the study, conclusions, recommendations as well as suggestion for further study

5.2 Summary

The purpose of the study was to establish challenges in the uptake and provision of medical insurance in Kenya. All the medical insurance providers were selected for the study and a descriptive survey design was used. The main instrument used to collect data was a semi-structured questionnaire targeting senior managers of the medical insurance providers. The data was analysed to find out the characteristics of the medical insurance providers and also establish the challenges in the uptake and provision of medical insurance.

The parameters that were analysed included experience and profitability of respondents, types of covers offered, business mix and gross premiums underwritten on medical insurance. Responses to questions on the importance of specific factors in the uptake and provision of medical insurance were also analysed. Data was then presented in tables, pie charts and bar charts. The study revealed that majority of insurers and also medical insurance providers have been proving medical insurance for over ten years. It is therefore clear that majority of the medical insurance providers are experienced.

The study also revealed that some insures do not underwrite individual business and those who do, prefer to offer only individual inpatient insurance covers. Also only few insurers provide fund management services. Medical insurance providers provide comprehensive covers to both individuals and corporates but only a handful of them offer fund management services. It is therefore in order to conclude that there is a wide choice of medical insurance covers available for both individuals and corporates.

It also emerged that a big portion of medical insurance business for both insurers and medical insurance providers is from corporate clients who interestingly pay less (per person) compared to individuals. More so, corporates enjoy enhanced benefits because of their bargaining power. Individuals therefore join or form groups so as to enjoy the reduced rates and enhanced benefits. Medical insurance providers also benefit because of reduced administrative cost as a result of dealing with groups or corporates compared to dealing with individuals.

The study showed that 73.4% of the respondents who are insurers collected premiums of over 500 million. 80% of the respondents considered this an improvement compared to previous year's collections. The cause of this could either be that there was an increase in the uptake of medical insurance or that premiums charged by insurers were adjusted upwards. It is interesting to note that only a handful of insurers reported profits of over 100 million for the year 2013 yet majority of them collected premiums of over 500 million in the same year. It may therefore be concluded that cost (including claims cost) incurred by medical insurance providers were very high and thus the little profits. Therefore, insurers have to find ways of reducing costs for this class of business if there are to make good profits.

The study revealed that cost of medical insurance and disposable income were considered to be the most significant challenges in the uptake of medical insurance in Kenya while lack of flexible payment options and indifference towards insurance were considered to be the least significant. Fraud and cost of healthcare were considered to be the most significant challenges in the provision of medical insurance in Kenya. Legal and regulatory framework and delays in premium collection were considered to be the least significant challenges.

The findings of this research have brought to light an understanding of the challenges in the uptake and provision of medical insurance in Kenya. It is clear that most of the medical insurance providers are experienced and offer a wide range of medical insurance products for both individuals and corporates. The medical insurance providers cater mostly to corporate clients.

5.3 Conclusion

The study concludes that cost of medical insurance, marketing activities, disposable income, lack of knowledge on insurance, peer influence, lifestyle diseases, lack of flexible payment options and indifference towards insurance were the main challenges affecting uptake of medical insurance in Kenya. However, there were variations on opinions as to which of the factors had more importance and this was expected.

The study also concludes that fraud, cost of health care, lack of knowledge on medical insurance, adverse selection, competition, moral hazard, information technology and skills and competencies of staff were the main factors affecting the provision of medical insurance in Kenya. Other important factors affecting the provision of medical insurance in Kenya are delays in premium collection, claims management and legal and regulatory framework. Despite variations in opinions as to the importance of each factor, the study generally revealed that all the factors had an effect on the provision of medical insurance in Kenya.

5.4 Recommendation of the study

The researcher recommends that medical insurance providers should develop affordable products to avoid locking out many would be clients who cannot afford to pay costly premiums. They should also introduce flexible payment options such as monthly plans to enable more people get medical insurance covers. By collaborating with health care providers, medical insurance providers could negotiate cheaper health care costs for their members. Insurers should carry out marketing campaigns and should also open more branches in rural towns so as create more awareness on medical insurance and its benefits. Medical insurance providers should encourage prevention rather than cure and therefore should educate their members on health and other wellness programs. The ultimate effect of this will be reduced cost for insurers who in turn will pass this to the clients by reducing premiums.

Insurers should also introduce discounts for clients with few claims to encourage prudent usage of medical covers which are often misused resulting to increased costs. The introduction of discounts may also avert moral hazard. The medical insurance providers can also push for legislation that allows them to access would be client's medical data. This would help reduce adverse selection.

Information technology plays a key role in the provision of medical insurance and the researcher recommends that insurance companies adopt new technologies that will help them develop innovative ways of selling medical insurance. The new technologies will also help them curb fraud which is a major problem for medical insurance providers.

Claims management will also be effective with proper technology. Insurers should also ensure that they have competent staff who will be able to guide and recommend proper medical insurance covers for their would be clients.

5.5 Limitations of the study

The respondents were both insurers and medical insurance providers. Comprehensive information on premiums and profits for insurers is widely available and is usually collected and collated by the Association of Kenya Insurers and also the Insurance Regulatory Authority. However, this information is not available for brokers in general and medical insurance providers in particular. Efforts to obtain this information from the respondents were unsuccessful. The researcher also attempted to get this information from the Association of Insurance Brokers of Kenya (AIBK) but was unsuccessful. The information would have aided in presenting a more comprehensive study.

5.6 Suggestions for further research

There is still room to undertake further research on medical insurance which is very dynamic as a result of the very dynamic nature of human health. This study focused on the challenges in the uptake and provision of medical insurance in Kenya. The challenges identified were broad in nature and further studies can be conducted by narrowing down on specific challenges for instance on fraud or information technology. Similar studies could also be conducted in other countries since medical insurance requirements are likely to vary from one country to another.

5.7 Implications for Policy and Practice

The researcher recommends that insurance companies should strive for collaborations with health care providers so as to reduce health care cost and fraud. They should also lower the cost of medical insurance covers, increase the number of medical insurance products available so as to accommodate many, increase their marketing efforts and have country wide presence to improve the penetration of insurance in Kenya.

The researcher further recommends that policy makers in the insurance sector should strive to develop an Information Technology platform that allows for the sharing of relevant information among medical insurance providers. The sharing of information will help curb fraud and will also provide relevant data that may assist in the development of new medical insurance products.

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APPENDICES

Appendix I: Letter of Introduction Dear respondent,

I am a final year Master of Business Administration student at the University of Nairobi specializing in Insurance.

This questionnaire is intended to collect information about challenges in the uptake and provision of medical insurance in Kenya. The information is purely for academic purposes for the project proposal paper in partial fulfilment of the requirement for the degree of Master of Business Administration from University of Nairobi.

The information in the questionnaire will be treated with confidentiality and at no instance will your name be mentioned in this research. The information provided will not be used for any other purpose other than for this research and a copy of the final report will be made available to you on request.

Your assistance in filling in the questionnaire will be highly appreciated.

Thank you in advance.

Yours faithfully,

Muiruri Sammy Kuria

Appendix II: Questionnaire

This questionnaire aims to obtain information on the Challenges in the Uptake and Provision of Medical Insurance in Kenya. Please respond to all items.

Part A: General Information (Answer/Tick (√) the appropriate answer)

1. Name of the Medical Insurance Provider _____

2. Designation of the respondent _____

3. Number of years the company has been providing medical insurance cover.

1. Less than 2 Years	
2. 2-5 Years	
3. 6-10 Years	
4. 11-20 Years	
5.Greater than 20Years	

4. Types of cover offered under each category

i) Individuals
- ☐ Inpatient Cover
- ☐ Outpatient Cover

ii) Corporates
- ☐ Inpatient Cover
- ☐ Outpatient Cover
- ☐ Fund Management

5. Volume of medical insurance business written in the year ended 31st Dec 2013 (in percentage)

1. Individual Business	
2. Corporate Business	
Total	100%

6. What was the gross premium on medical insurance business in the year ended 31st Dec 2013?

1. Less than 20 Million	
2. 21-50 Million	
3. 51-100 Million	
4. 101-500 Million	
5. 501Million-1Billion	
6. Greater than 1Billion	

7. Was there an improvement in gross premiums compared to the previous year (2012)?

1. Yes	
2. No	
3. No Change	

Please explain ……...
……..

8. Medical profits for the year ended 31st Dec 2013

1. <0 Loss)	
2. 0 – 50 Million	
3. 51 - 100 Million	
4. Greater than 100 Million	

Part B: Challenges in the Uptake of Medical Insurance in Kenya

9. How important are the following factors in the uptake of medical insurance?
   Kindly tick (√) where appropriate) Use a 5-point scale where:-
   1= Very important 2= Important 3= Moderately important 4= Slightly important
   5= Not important

	1	2	3	4	5
Cost of medical insurance					
Lack of flexible payment options					
Indifference towards insurance					
Lack of knowledge on insurance					
Lifestyle diseases					
Marketing activities					
Peer influence					
Disposable income					

10. What are the other challenges in the uptake of medical insurance in Kenya?

i. …… ……

ii. …… ……..…

iii. ……

iv. . ……

v. . ……

vi. …….

Part C: Challenges in the Provision of Medical Insurance in Kenya

11. How important are the following factors in the provision of medical insurance?

Kindly tick (√) where appropriate) Use a 5-point scale where:-

1= Very important 2= Important 3= Moderately important 4= Slightly important

5= Not important

	1	2	3	4	5
Legal and regulatory framework					
Competition					
Adverse selection					
Moral hazard					
Fraud					
Information Technology					
Lack of knowledge on medical insurance					
Cost of health care					
Claims management					
Delays in premium collection					
Skills and competencies of staff					

12. What are the other challenges in the provision of medical insurance in Kenya?

i. …… ……

ii. …… ……

iii. ……

iv. . ……

13. Any other comment;

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THANK YOU FOR YOUR RESPONSES AND TIME

Appendix III: Licensed Health Insurance Companies in Kenya

1) GA Insurance Limited
2) Saham Assurance Company Limited
3) Pacis Insurance Company Limited
4) Madison Insurance Company Kenya Ltd
5) UAP Insurance Company Limited
6) The Co-operative Insurance Co. Of Kenya Ltd
7) Kenindia Assurance Company Limited
8) British-American Insurance Co. (K) Ltd
9) The Jubilee Insurance Company of Kenya Limited
10) APA Insurance Limited
11) Trident Insurance Company Ltd
12) Real Insurance Company Ltd
13) Heritage Insurance Company Ltd
14) Gateway Insurance Company
15) First Assurance Company Ltd
16) AAR Insurance Kenya
17) Resolution Insurance Kenya

Appendix IV: Licensed Medical Insurance Providers in Kenya

1	Acropolis Insurance Brokers Limited
2	Afrocentric Health Solutions Limited
3	Btb Insurance Brokers Limited
4	Chester Insurance Brokers Limited
5	Executive Healthcare Solutions Limited
6	Aon Kenya Insurance Brokers Limited
7	Changamka Microinsurance Limited
8	Clarkson Insurance Brokers Limited
9	Goldstar Healthcare Limited
10	H. S. Jutley Insurance Brokers Limited
11	Kenbright Nbc Healthcare Administrators Ltd
12	Liaison Healthcare Limited
13	Lifecare International Insurance Brokers Limited
14	Mic Global Risks Insurance Brokers Limited
15	Mutual Trust Insurance Agencies Limited
16	Pacific Insurance Brokers (Ea) Limited
17	Plan & Place Insurance Brokers Limited
18	Planned Health Care Limited
19	Pelican Insurance Brokers Limited
20	Sobhag Insurance Brokers Limited
21	Starlit Insurance Brokers Limited
22	Health Line Solutions