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Determinants of delays in the payment of private health insurance claims in Kenya

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DETERMINANTS OF DELAYS IN THE PAYMENT OF PRIVATE HEALTH INSURANCE CLAIMS IN KENYA

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DECLARATION

I declare that this work has not been previously submitted and approved for a degree by this or any other university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

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May 2018

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ABSTRACT

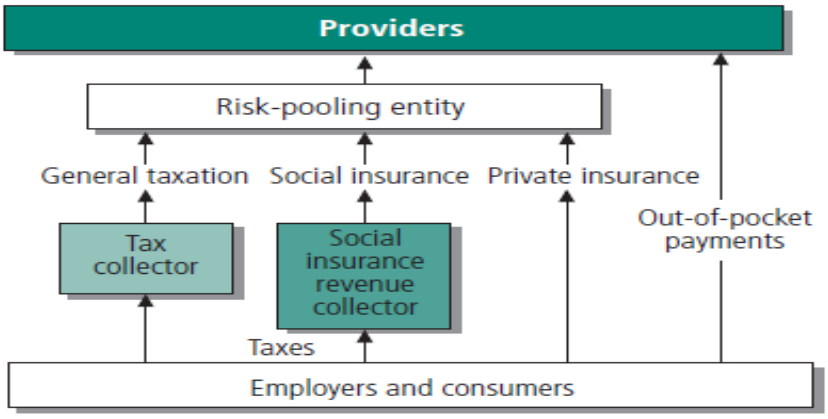
This study sought to investigate determinants of delays in the payment of private health insurance claims in Kenya. The study was guided by the following research questions: What is the influence of internal industry practices on the payment of private health insurance claims processing in Kenya? What is the influence of systems availability on the payment of private health insurance claims in Kenya? What is the influence of laws and regulations on the payment of private health insurance claims in Kenya? What is the influence of insurance fraud on the payment of private health insurance claims in Kenya? The study was anchored to the agency and moral hazard theories. A survey research design to collect primary data from the field in this study where questionnaires which were administered to 105 respondents. Research assistants were used to collect data from the respondents. The data was analyzed using descriptive and inferential statistics. The descriptive methods used comprised of the percentages, frequencies, means and standard deviations that showed the trends in the data. Inferential methods which included correlation analysis and regression analysis were also used. In addition, statistical assumptions were made prior to regression analysis. The study found out that internal industry practices had a negative significant influence on delay in payment of health insurance claims. This was the same for systems availability and to laws and regulation. However, insurance fraud showed a positive significant influence with coefficients. The study concluded that the information available in the policy claim process was un-clear and could not be easily understood for instance when filling in the claim forms. The study also concluded that the hospitals had not adopted an integrated IT system to enhance claim processing and that systems failure in hospitals often led to loss of data relevant to claims thus that led to delay in processing. The study recommended that a universally agreed standard for loss calculation was needed and also the need for merging the organizational regulations with those of the country.

CHAPTER ONE

INTRODUCTION

This chapter discussed the background of the study, problem statement, research objectives, and research questions, hypothesis, significance of the study, scope of the study, limitations of the study and operational definitions of variables. The term health insurance can be broadly defined as a health care financing plan in order to reduce the financial burden associated with illness for households (Cole & McCullough, 2014). According to Normand and Busse (2002), the practice originated in Germany without significant intervention by the state. It was motivated by the coming to being of large firms where workers organized themselves to trade unions who built sickness funds. The employers supported these funds by contribution based on employees' salaries scales, as they valued the benefits of a healthy workforce, and the state came in later to formalize these arrangements under Chancellor Otto Bismarck.

Today, health financing payments to providers is from contribution of funds to a risk pooling entity primarily from employers and consumers through either the social revenue collector, tax collector, private insurance or out of pocket payments and ultimately into the risk-pooling entity. Figure 1.1 demonstrates this framework.



Adapted from: Normand C, Busse R. Social health insurance financing. In: Mossialos E, Dixon A, Figueras J, Kutzin J, editors. *Funding health care: options for Europe*. Buckingham (PA): Open University Press; 2000. p. 59–79.

Figure 1.1: Health Financing Options

Source: Sekhri and Savedoff (2005)

Public insurance usually is funded through the state using taxation, social security while private the money is channeled paid directly to the risk pooling entity. This is the primary difference between public and private insurance schemes. The figure above also demonstrates the stakeholders in the health services sector. These are namely the consumers such as patients, service providers (hospitals, pharmacies, laboratories, and professionals), government and suppliers.

1.1 Background of the Study

In most insurance laws, policyholders cannot recover damages from an insurer who fails to pay a valid claim within a reasonable time (or at all) and can only recover the value of the claim plus interest (Dobbyn & French, 2015). In the UK for instance, this position is inconsistent with the ordinary principles of contract law and arises from the archaic legal fiction that an insurer's primary obligation is to prevent its insured from suffering a loss in the first place. Very often the payment of interest and costs where a claim has not been paid in a timely manner (or at all) is insufficient to compensate an insured for its loss (Feinman, 2012).

A properly managed claims process is guided by a written corporate philosophy setting out the broad approach aiming to provide high quality service. It specifies the nature of claims service at each stage, the speed of claims service and assigned responsibilities (Machui, 2015). The relationship between an insurer and a client is largely influenced by the accuracy, speed and efficiency with which claims are settled (Mahlow et al, 2016). Managing events like settlement, dispute resolution and arbitration form part of claims management and is a marketing tool. A dissatisfied customer is a bad publicity and has the potential to damage the reputation of a company. Claims management has a social service angle (Sakurai, 2011). It therefore becomes imperative that claims management at insurance level is enhanced.

Muriuki (2013) covered internal industry practices, systems availability, laws and regulation and insurance fraud and argued that there is a clear distinction between claims handling and proper claims management using these factors. Claims management is wider in scope and involves not only processing but also the strategic role, service aspect, cost monitoring role, and the role of people handling the claim. Yusuf and Dansu (2014) observed that a good claims management should be proactive in recognizing and paying legitimate claims, reporting regularly, assessing accurately the reserve associated with each claim, minimizing unnecessary costs, dealing with claimants courteously, avoiding protracted legal dispute and handling claims expeditiously.

According to Callahan (2010), claim management includes the review of the claims performance, legal costs, monitoring of claims expenses, settlement costs, avoiding delay and disputes in the payment of claims and planning for future payments. Machui (2015) also discussed internal industry practices, laws and regulation and insurance fraud and observed that the need to shift from claims handling to efficient claims management has been recognized by insurers in recent times.

In Ghana, Sodzi-Tettey et al. (2012) determined that there have been no formal documented studies focusing on the challenges accounting for delays in provider payment and claims rejection. Questions therefore arose as to the administrative and management challenges related to managing claims as part of strategic purchasing within the National Health Insurance Scheme (NHIS). The majority of the schemes had no clearly defined organizational structure, and no defined job descriptions and responsibilities for their permanent staff. None of the schemes had an instituted career development structure (Jehu-Appiah et al., 2011).

The regulator of the insurance industry in Kenya, the Insurance Regulatory Authority (IRA) identifies the medical insurance as a high-risk class in considerations of the payment of claims. Healthcare providers are paid through various means for both outpatient and inpatient care (Chuma & Maina, 2012). The mode depends primarily on the amount of money involved. In outpatient service, most payments are made though cash, debit/credit cards and recently mobile money such as MPESA. The later has according to Haas and Nagarajan (2011) been instrumental in facilitating access and bridging the financial deficit for healthcare providers in rural areas. Inpatient services are also settled by the methods above regardless of the amount.

The exception is however patients who are have a health insurance cover, either through private or public schemes (Mutua, 2004). The health insurance companies cover the cost up to a stipulated limit based on the premiums paid. The healthcare provider then settles the accounts with the insurance provider. This, theoretically is a straight forward process in an ideal world, however the medical insurance sector financial performance is an indication that all may not be well. The medical insurance sector all over the globe has regularly has historically performed below par, and sometimes with very heavy losses for some firms and their agents (Victora et al., 2011; Nair, 2016). In the quest to stem this loses, scrutiny into claims is extreme and considering it is essentially manual with weak control on both ends it takes long to pay a claim (Nandi, Ashok & Laxminarayan, 2013). According industry players in Kenya, a simple standard

legitimate claim settlement may take 60 days upon presentment of a physical invoice if, there is no dispute. This is against the standard of 30 days accepted in most standard contracts in the sector.

1.2 Statement of Research Problem

Studies have determined that pre-payment and risks sharing only play a marginal role in the payment of insurance claims in most countries (Drechsler & Jutting, 2005; Victora et al., 2011). Coverage rates are generally below 10 % of the population while private risk sharing programs only have wider significance in a number of countries such as South Africa, Uruguay, and Lebanon. The main problem being addressed by the study is the delay in claim processing beyond the set limit of 30 days by the IRA attributed to challenges in claims management arising from internal industry practices, systems availability, existing laws and regulations in the industry and current status of insurance fraud in the industry. The Authority envisages that an efficient claims management process will result to improved service delivery to the public which will in turn create confidence hence improving the image of the industry and eventually lead to a deeper penetration level of insurance service (Mwangi & Murigu, 2015).

Mwangi and Murigu (2015) observed that the internal industry practices have led to serious delay in insurance compensation with some claims reporting as late as 90 days in waiting for the compensation. The regular industry practice is blind to the growing number of insurance services and the dynamism of insurance claims to the industry that makes urgent claims worthless to the insurance industry. Kiana (2010) observed that delays in insurance claims are caused by lack of proper accounting system that captures every insurance transaction at the health service providers and the insurance service providers where most claims still have to go through the manual process during processing stage. The need for proper systems remains a wish in the insurance industry. Insurer conduct throughout the claims process must be considered and a defense will be available if reasonable grounds exist for disputing a particular claim. What is reasonable in this context has been left deliberately open, but clearly insurers are allowed ample time to investigate legitimate areas of concern.

A study by Victora et al., (2011) observed that there is a problem that the existing laws and regulations for insurance industry players are not adequate and require reviews particular with respects to claims processing. The existing laws have not given sufficient weight to the claims process and the claims requirements; further, the current status of insurance fraud in the country

makes claim process a nightmare for most clients as fraudsters would delay the claim process for the clients to give up and then have the benefits channeled to their way. The fraudulent claims are usually with the both insurance staff and the health care providers staff where there exists some degree of collusion between the parties. However, there is a gap as there is a death in literature explaining the link between the determinants of insurance payment claims and delay in payment claims with respect to internal industry practices, systems availability, laws and regulation and insurance fraud. With the problem of delays in payment of insurance claims clearly observed in Kenya, this study therefore sought to investigate the determinants of delay in the settlement of health insurance claims in Kenya.

1.3 Objectives of the Study

The main objective of the study was to investigate determinants of delays in the payment of private health insurance claims in Kenya.

1.3.1 Specific Objectives

The study was guided by the following specific objectives;

1. To explore the influence of internal industry practices on the payment of private health insurance claims in Kenya
2. To find out the influence of systems availability on the payment of private health insurance claims in Kenya
3. To establish the influence of laws and regulation on the payment of private health insurance claims in Kenya
4. To investiage the influence of insurance fraud on the payment of private health insurance claims in Kenya

1.4 Research Questions

The following research questions guided the study;

1. What is the influence of internal industry practices on the payment of private health insurance claims in Kenya?
2. What is the influence of systems availability on the payment of private health insurance claims in Kenya?
3. What is the influence of laws and regulations on the payment of private health insurance claims in Kenya?

4. What is the influence of insurance fraud on the payment of private health insurance claims in Kenya?

1.5 Scope of the Study

The study covered the insurance providers and other relevant players of the industry. The population of this study comprised of the staff in the payment of private health insurance claims of big private hospitals in Nairobi and the finance managers of the top ten insurance agencies in Kenya. Both primary and secondary data were used in this study.

1.6 Significance of the Study

This study will be beneficial to academia and theoretical formulation in informing debates on this subject. The debates will be on the positive and negative influences by some variables on delays on payment of insurance health claims. Further, there will be debates why the results tend to differ in hospitals and insurance companies. The study will also provide a platform for further research in the various areas of study. The findings will act as a reference point to other researchers in the same field thus facilitating their studies. To academicians and scholars, the findings of this study will be useful to forming the basis for future research on the subject, providing a critical examination of the field.

This study will be beneficial to all stakeholders in insurance providers by providing the knowledge on determinants of delays in the payment of private health insurance claims in Kenya. The study outcome will be of significance to the insurance agencies or companies in addressing current challenges and strategic design of future processes that will boost performance and growth. This is expected to improve returns to investors in the health sector in general.

The study will also benefit policy makers and decision makers and contribute to the current body of knowledge in the medical insurance sector. The government will have the holistic equipment of ensuring there are no delays in payment of public health insurance claims using lessons from this study. The study will provide relevant information that will help the government to formulate and implement such policies that will facilitate timely payments in of health insurance claims.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents theoretical review, conceptual framework and the empirical literature review. The theoretical and empirical literature on the topic related to research question has been reviewed to determine the research gaps inherent in the studies.

2.2 Theoretical Review

This section presents the theories that were relevant in the study. The agency theory and the moral hazard theory were reviewed. The applicability of the theories to the study is also discussed.

2.2.1 The Agency Theory

The agency theory adopted in this study was proposed by Jensen and Meckling (1976). According to the agency theory, a firm consists of a nexus of contracts between the owners of economic resources (the principals) and managers (the agents) who are charged with using and controlling those resources (Jensen and Meckling, 1976). The theory posits that agents have more information than principals and that this information asymmetry adversely affects the principals' ability to monitor whether or not their interests are being properly served by agents. As such, the theory describes firms as necessary structures to maintain contracts, and through firms, it is possible to exercise control which minimizes opportunistic behavior of agents (Jensen and Meckling, 1976).

According to the theory, in order to harmonize the interests of the agent and the principal, a comprehensive contract is written to address the interest of both the agent and the principal. The agent-principal relationship is strengthened more by the principal employing an expert and systems (auditors and control systems) to monitor the agent (Jussi & Petri, 2004). Jussi and Petri as well as Farooq and Sajid (2015) applied this theory in their studies and determined that the theory recognizes that any incomplete information about the relationship, interests or work performance of the agent described could lead to selection problem. Adverse selection and moral hazard impact on the output of the agent in two ways; not possessing the requisite knowledge about what should be done and not doing exactly what the agent is appointed to do respectively.

The agency theory, therefore, works on the assumption that principals and agents act rationally and use contracting to maximize their wealth (Jensen and Meckling, 1976). This theory is applicable to this study simply because investment decision making is one of many mechanisms used in business to address the agency problem by reducing agency costs that affects the overall performance of the relationship as well as the benefits of the principal (Abdel-Khalik, 1993). The agency theory posits that agents have more information than principals and that this information asymmetry adversely affects the principal's ability to monitor whether or not their interests are being properly served by agents. As such, the theory describes firms as necessary structures to maintain contracts, and through firms, it is possible to exercise control which minimizes opportunistic behavior of agents. The agency theory will offer guidance in this study on the determinants of delays in the payment of private health insurance claims, and therefore touches on all the objectives of the study.

This should end here as it talks about AT as the title stipulates.

Prior to intellectual fragmentation of organizational theories in 1970's, structural contingency theory dominated. In order to achieve optimal performance, organizations structurally adjusted to contingent factors meaning size, technology and strategy. Although indeterminate, managerial role was perceived positively. Development of diverse paradigms started in 1970's (Donaldson & & Davis, 1993). Novel theories critically studied organizational rationality and managerial benevolence. Population-ecology theory, institutional theory, resource dependency theory and organizational economics (Jensen & Meckling, 1976), explicitly and/or implicitly contradicted structural contingency theory.

Agency and stewardship theory were developed as alternative theories and numerous researches focus on their differences. Both theories are constructive given that they describe possible situations among owners and managers and enlighten governing relations from different perspective. Stewardship theory rejects the agency theory assumptions and presupposes context in which managers perceive that satisfying shareholders goals is also in their personal interest. Separation of ownership and corporate control does not automatically lead to the conflict of goals and interests between owners and managers (Podrug, Filipovic & Milic, 2010).

Agency and stewardship relation are opposite relations among owners and managers. In agency relation the emphasis is on building institutional and contractual mechanisms so that managers cannot achieve their own goals at the expense of the owner's goals, while in the stewardship

relation, if it is successfully achieved, there are no such problems: the goals are shared, so the manager's activities are also in the interest of the organization. According to Donaldson and Davis (1993) central difference between agency and stewardship theory is in model of human behavior: the socio-psychological model of human behavior for stewardship theory and economic model of human behavior for agency theory.

Economic model of human behavior proposes divergence of interests between principal and manager, and therefore agency theory develops effective system for constructive agent's behavior due to the difference in risk propensity, information asymmetry etc. The socio-psychological model of human behavior for stewardship theory proposes that manager's behavior is pro-organizational and collectivistic, achieving higher utility by serving a group (organization), than by satisfying personal goals. A stewardship relation implies convergence of interests between principal and steward. Therefore, the relation is based on trust so principal supports and empowers manager-steward since the fundamental postulate of stewardship theory is that managers always act in such way to maximize the interests of a company, even if the control is completely absent (Podrug, Filipovic & Milic, 2010).

2.2.2 Moral Hazard Theory

The moral hazard has been discusses by various scholars (Holmstrom, 1979; Mirrlees, 1999; Barzel, 1987). The severity of the financial crisis which first became apparent in 2007 provoked widespread public discussion about the structure and behavior of the financial sector (Jarque, 2010). A moral hazard is where one party is responsible for the interests of another, but has an incentive to put his or her own interests first (Holmstrom, 1979). The term moral hazard is a term that has been used over more than two centuries in discussions of insurance to refer to the possibility that insurance would encourage the insured party to take on additional risk in a way which could not effectively be monitored (Arrow, 1963). Moral hazard is also a concept which is employed in mainstream analysis which focuses on rational behavior, usually with respect to information asymmetry. The core concepts of the moral hazard theory are perverse incentives, negative precedents, norms, and provocation (Mirrlees, 1999).

It is opportunistic behavior which takes advantage of an opportunity for personal benefit even if it is at the expense of others (Gachter & Fehr, 2002). Moral hazard therefore involves the risk that an individual or group will behave immorally, flouting moral conventions and breaching

trust (Barzel, 1987). Problems of getting people to choose hidden actions appropriately are called moral hazard while the problems of getting people to share hidden information honestly are called adverse selection.

The question of moral hazard in healthcare insurance has been studied widely. Koc (2005) elaborates moral hazards as ex post or ex ante. The ex post moral hazard effect occurs when a consumer overstates the severity of illness thereby ending up consuming more services than required since they are insured. In the ex-ante moral hazard, it refers to the effects of insurance on preventative actions taken before sickness set in such as healthy lifestyle, preventative care, or early detections it may affect health care spending. The ex-post moral hazard definitely creates a gap between the cost of health care and price that leads to heavy welfare loss (Koc, 2005).

Koc (2005) demonstrates that moral hazard has two parts, efficient and inefficient. Additional consumption by insured patients is generally considered to be inefficient from a conventional moral hazard view point. However, if an individual is in a critical state, moral hazard spending will save a life making it worthwhile. Thus individual who pay insurance for the purpose of income transfer when they fall ill will have a portion of it in conventional moral hazard effect. It is however efficient as the consumer pays willingly and exceeds the marginal cost of producing the care. The opportunistic use of health services by a healthy person say for consumer oriented healthcare e.g. cosmetic surgery, unnecessary outpatient visit is considered to be an inefficient moral hazard (Koc, 2005).

Moral hazard theory postulates opportunistic behavior on the part of health insurers who conceal their increased risk exposure from the insurance providers were insurance providers able to stipulate contracts to cover all the behavior of insurers, they could otherwise increase the interest charge in compensation (Holmstrom, 1979; Mirrlees, 1999). They may conceal information, and insurers may find it difficult to assess risk. But even if there were no concealment, insurance providers are unable to identify true risk, and therefore can only arrive at a judgment to which they attach higher weight. Since neither party can have full understanding of the future path of the conditions under which the contract is made, the insurer-provider relationship relies on trust (Easterly, Islam & Stiglitz, 2001). Moral hazard is the danger that these understandings break down, eroding trust. The theory will be important in the present study in determining whether the private health insurance providers are opportunistic by taking advantage of an opportunity for personal benefit even if it is at the expense of their clients. The classical theories provide a

background on the historical drivers of the health insurance sector and especially the modeling of the health products we have today.

Economists also viewed moral hazard negatively because, under the conventional theory, the additional health care spending generated by insurance represents a welfare loss to society (Nyman, 2004). When people become insured, insurance pays for their care. In economists' view, insurance is reducing the price of care to zero. When the price is reduced in this way, consumers purchase more health care than they would have purchased at the normal market prices - this is the moral hazard. But because consumers purchase care when the price drops to zero that they would not have purchased at the market price, economists interpret this behavior as revealing that the value of this care to consumers is less than the market price. The additional care, however, is still costly to produce. The difference between the high cost of the resources devoted to producing this care (reflected in the high market price) and its low apparent value to insured consumers (reflected in the low insurance price) represents an inefficiency. Thus, health care spending increases with insurance, but the value of this care is less than its cost, generating inefficiency that economists call the "moral-hazard welfare loss."

Conventional insurance theory also provided the policy solution: Impose coinsurance payments and deductibles to increase the price of medical care to insured consumers and reduce these inefficient expenditures (Cutler & Zeckhauser, 2000). In the 1970s many insurers adopted copayments to reduce health care spending. In the 1980s and 1990s economists also promoted utilization review and capitated payments to providers as further ways to reduce moral hazard. The managed health care system we have now is largely a product of this theory.

Many economists have therefore concluded that moral hazard entails market failures; it brings about a different allocation of resources than the one that would exist in the absence of moral hazard (Moe, 1984). Conventional economic theory explains moral hazard as a consequence of the fact that market participants are unequally well informed about economic reality. In other words, moral hazard results from "asymmetries of information" and the theory of moral hazard is therefore considered to be a part of the economics of information.

The theory section need to focus only on the two theories – agency and moral hazards. Take out all other theories which are not directly linked with the objectives. These are stewardship, Conventional insurance theory and structural contingency theory

2.3 Empirical Review

Various studies have been done to determine the determinants of delays in the payment of private health insurance claims. Literature review was done through first reviewing developed countries, under developed and developing countries such as Kenya to establish the determinants of delays in the payment of private health insurance claims. The section therefore reviews literature that relate to the study, based on the objectives and research questions of the study.

2.3.1 Internal Industry Practices and Payment of Health Insurance Claims

Zeithaml and Bitner (2003) while studying internal industry practices in North Carolina, USA, determined that in a service industry such as insurance, contact employees are the face of the organization, and can directly influence customer satisfaction. Employees in claims department are in close contact with the customer and/or intermediary from the time a claim is reported, throughout its processing, until it is eventually settled or rejected. The study also posited that the difference between one service supplier and another often lies in the attitude and skills of their employees. Further, the study observed that the best defenses against claim fraud are well-trained claims staff.

According to Morley, Ball and Ormerod (2006) who studied health insurance claims in the UK, the process of uncovering and battling fraud begins in the claims department. The study found that that it is the responsibility of the claims manager to recruit, train and retain intelligent and competent staff. He should also delegate responsibilities within the department in a way that whereas a substantial proportion of claim advices do not have to be referred to his office, decisions with serious ramifications on the business are not left to inexperienced or incompetent staff. However, due to various factors, some of which are not within the manager's control, study determined that claims staff leave employment and have to be replaced. Whereas direct costs associated with loss and replacement of employees is measurable, there are also indirect costs associated with loss of employees, including loss in customer service and customer satisfaction.

Drechsler and Jutting (2005) sought to analyze the characteristics of private health insurance (PHI) in low and middle-income countries in Africa, Middle East and South America and evaluate its significance for national health systems. The study findings indicated that PHI involving pre-payment and risk sharing only played a marginal role in the developing world. Coverage rates are generally below 10 % of the population while private risk sharing programs

only have wider significance in a small number of countries such as South Africa, Uruguay, and Lebanon. The study however determined that PHI could undermine the objective of universal coverage. Opening up markets for private health insurance without an appropriate regulatory framework might lead to rising inequalities in the access to health care: it may lead to cost escalation, a deterioration of public services, a reduction of the provision of preventive health care and a widening of the rich-poor divide in a country's medical system. Given these risks, the study argued that the crucial challenge for policy makers is to develop a regulatory framework that is adapted to a country's institutional capacities and that, at the same time, sets the rules and standards in which PHI can efficiently operate and develop.

2.3.2 Systems Availability and Payment of Health Insurance Claims

Drechsler and Jutting (2005) studied private health insurance in low and middle-income countries in Africa, Middle East and South America. The study found that information on small and regional-specific schemes often did not enter official data on health care expenditure. Only few countries have steadily recorded and collected data on their health systems. The study did a comparison of available National Health Accounts from the WHO database and revealed that households bore the largest burden of health costs in African countries. Specifically, one third of total health expenditure was out of pocket. Other important sources included the Ministry of Health (MoH), provincial and local governments, and NGOs. Private health insurance only played a minor role, especially bearing in mind that the average value of 5 % of total health expenditure primarily originated from the large PHI sector in developing countries.

Sodzi-Tettey et al. (2012) studied the challenges in provider payment under the Ghana National Health Insurance Scheme. The study findings showed that technical challenges from the provider's perspective resulted in the rejection of unverifiable claims mainly as a result of poor filing systems resulting in missing folders of treated clients. Claims forms were often incompletely filled especially portions on claim number and procedures done. There were challenges with verifying compliance with Standard Treatment Guidelines for non-medical billing officers e.g. transcription of doctor's diagnosis on claims form by accounting officers. The study concluded that attention to the capacity to administer as an essential part of strategic purchasing appears to be a neglected part of the current interest in national health insurance as an alternative to out of pocket payment. The study therefore recommended that the Ghana National

Health Insurance Scheme needed to reform its provider payment system to ensure simpler claims submission and processing systems, computerization and investment to improve and support the capacity to administer for both purchasers and providers.

Kiana (2010) studied the challenges in management of general insurance claims in Kenya and determined that claims managers need to maximize the use of information technology, in order to reduce claims processing cycle, thus enhancing efficiency and customer satisfaction. The study further determined that ineffective IT governance and control is likely to be the main cause of the negative experiences many organizations and especially insurance firms have had with the use of IT, including lost business, damaged reputations, weakened competitive position, inability to meet deadlines, failed or aborted projects, budget overruns and poor returns on investments.

2.3.3 Laws and Regulation and Payment of Health Insurance Claims

Orszag and Emanuel (2010) studied Health Care Reform and Cost Control and found that in March 2010, president Obama of the USA signed into law the Affordable Care Act (ACA) with an objective to modernize the healthcare system and provide universal affordable healthcare. The act was expected to reduce the federal budget deficit by over $100 billion by the year 2020. In order to achieve these reforms to the care delivery and long term growth in cost has to be addressed. This means eliminating unnecessary costs in the system including fraud/abuse of programs, developing cost effective plans lower in premium and investment in the three “I”s. These three represent infrastructure, information and incentive required for the industry to reform.

Kumaranayake (1998) found that that even with an institutional framework in place, regulation was a critical issue as the implementation of adequate legislation was costly; that is regulation induced transaction costs were estimated to account for 30% of the total premium revenue in Chile. This may be one reason that the costs of administering insurance are estimated to be ten times higher for PHI as compared to social insurance. Apart from efficiency aspects, the Chilean experience with private health insurance also offers evidence for apparent cream skimming on the side of the insurers. The study reported that the older population of Chile was strongly underrepresented in PHI schemes. Although the share of people over 60 years accounted for 9.5% of the Chilean population, only 3.2% of all people with private insurance belonged to this age group.

Drechsler and Jütting (2005) studied the role for private health insurance in developing countries in Africa, Middle East and South America and determined that the need for regulation is not only fueled by potentially negative outcomes of the private insurance industry; regulation may be equally important as the introduction of PHI will also affect other forms of health care financing. Specifically, PHI may only leave bad-risk patients for public coverage or it may indirectly affect public provision of health care by raising health care costs. The study recommended that policy makers should take into consideration the whole impact of allowing private risk-sharing arrangements into the market. The state needs to be able to respond to the manifold challenges that will arise when PHI is introduced into a health care system. Furthermore, it should ensure transparency of the system and be clear about public and private responsibilities. This will not only be important for potential consumers of PHI as it allows them to adjust their health expenditure. It also enables providers of PHI to offer adequate insurance packages that take account of the specific needs of their clientele.

2.3.4 Insurance Fraud and Payment of Health Insurance Claims

Cole and McCullough (2014) studied the barriers and challenges facing insurance fraud investigators in the USA. The study determined that claims departments find it necessary to investigate, since if a fraudulent claim is paid, the insurer loses a lot of money to fraudsters. This may result to increase in premiums, which affects both the good and bad customers. In addition, if a fraudster gets away with the act, he may be tempted to continue this practice in the future. However, a lot of time and money is wasted in trying arrest the menace, thus the need for the insurance industry and the government to give it attention, with the intention of wiping it out.

Mohapatra and Tiwari (2009) determined that the claims function involves speedy and effective handling of claims, while at the same time guarding against fraud in India. Hasty claim settlement can result in increased fraud-related costs. On the other hand, slow fraud detection can increase the overall claim cycle time. If claims are processed efficiently and effectively, customers are more satisfied and likely to be retained. Thus, value is created and transferred to the next level of value chain, the customer relationship management. Usually, a customer's experience at claim stage determines whether he will be retained or not.

Kiana (2010) studied the challenges in management of general insurance claims in Kenya. From the findings, weak underwriting standards form the highest challenge in management of general

insurance claims in Kenya. At the same time, there is a high level of fraud in the Kenyan general insurance industry. It is clear that claims departments are more likely to find it necessary to investigate a claim when circumstances of accident are unclear and when vehicle is not valued prior to commencement of cover. Claimant advocates and agents/brokers are the ones highly used to perpetrate fraud. Moreover, delay in reporting a claim and high work load of staff were the main factors found to contribute to delay in claim payment.

2.4 Summary of Literature and Gap

From the findings of literature, it can be summarized that acknowledged scholars have tried to reach at a common consensus that delays in payment of insurance claims are contributed by a number of factors among them insurance fraud. It is argued that institutions without a proper way of tracking claims payment claims will experience delays in payments. In this study, literature has shown that the concepts of internal industry practices, systems availability, fraud and laws and regulation have been related to the delays in payment of claims. The literature review has also shown several theories underpinning the need to embrace these factors.

From the findings of empirical studies conducted locally and internationally clearly indicate conceptual, contextual and methodological gaps. From a methodological point, most of the studies have either been quantitative or qualitative. Further, studies conducted interpreted concepts from different perspective by using different theories and variables to make deductive arguments which cannot be adopted fully in this study. Methodologies adopted by different researchers varied in terms of research design, population, sampling design, and research instruments and data analysis methods. Whereas some studies adopted causal, longitudinal and cross-sectional research designs; the current study adopted survey research design based on quantitative research paradigm. Secondly, each study carried out focused on different contextual environments ranging from developed to developing countries. However in this study focused on payment of health claims in Kenya.

2.5 Conceptual Framework

The conceptual framework guiding the study is as shown in Figure 2.1. The study adopted four independent variables and one dependent variable. The dependent variable for the study was payment of health insurance claims which is likely to be affected by the independent variables which include internal industry practices, systems availability, laws and regulations and insurance fraud.

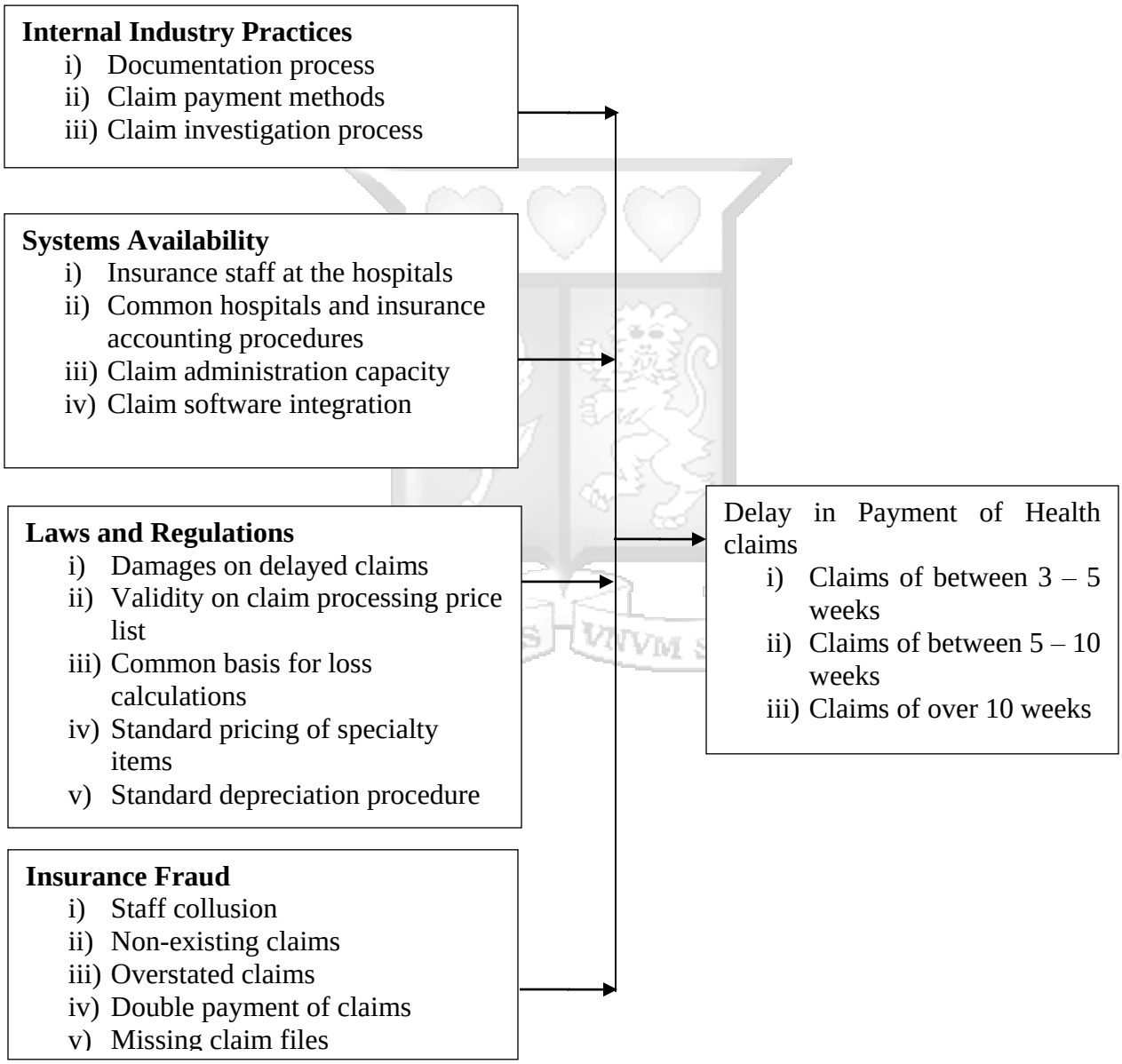


Figure 2.1 Conceptual Framework

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

The third chapter of this research presents the overview of research methodology that was used in the study and gives procedures that were used to carry out the research work. The discourse in this chapter was structured around the research design, research population, sampling design of the study, data collection methods and data analysis.

3.2 Research Design

This study adopted a survey research design as it entails the collection of primary data in order to answer questions concerning the current status of the subject which is the determinants of delays in the payment of private health insurance claims in Kenya. Its main role is to describe the state of affairs as it is now by quantitatively synthesizing the empirical evidence of a specific field of research.

3.3 Study Setting and Population

3.3.1 Target Population

The target population for the study was members of the hospital and insurance companies who are engaged in the day to day running processing of insurance claims in their respective hospital and insurance companies. Due to the very nature of the specific skills and experience required for this type of research, this study engaged individuals with the expert in payment of health claims. The target population of this study comprised of the staff in the payment of private health insurance claims of big private hospitals in Nairobi and the finance managers of the top ten insurance agencies in Kenya where in every hospital, there is an average of 2 persons dealing with insurance claims under medical division while insurance companies have at least 5 persons handling insurance claims under medical division indicated in Table 3.1. The staff in both in the insurance companies and the hospitals will help give information on the delays in payments of health claims. The research was conducted in 15 insurance companies in the country which is 30% of the total number of insurance companies in Kenya as given by IRA (2016) report. Mugenda and Mugenda (2003) allows for 30% sampling of the population under study.

Table 3.1 Target Population

Category	Target population
Hospital staff on claim	30
Insurance companies staff on claim	75
Total	**105**

3.3.2 Sampling Determination

The sampling frame of this study was derived from the selected insurance firms and selected hospitals administration report or obtained from a pre-site visit data to the intended study area. This study used convenient sampling method in identifying insurance companies and hospitals to participate in the study while stratified random sampling technique was used to select the respondents to obtain a suitable unit of study in the identified institutions. The convenient sampling was relevant for the study due to the specific expertise required from the respondent. This method is cost effective, fast track data collection, and access to the unit of analysis and elements of the study.

The study recognized that the total target population for the study was 105 respondents with 75 hospital staff members under medical division on claims and 30 insurance company staff members under medial division on claims. Since the target population is less than 200, the researcher conducted a census study for the population to ensure that every relevant person as given in the target population has an equal chance of participating in the study. The study adopted a census study in line with Israel (1992) recommendations that sample sizes of less than 200 are studied as a whole to cater for any non-response that may be encountered in the study. Therefore, 75 hospital staff on insurance claims and 30 staff members on insurance claims from the insurance companies participated in the study. The researcher examined the respondents' perceptions with regards to the objectives of the study (internal industry practices, systems availability, laws and regulation and insurance fraud).

3.5 Definition of Variables

On the measurement of the study variables, Table 3.2 shows how the variables were measured.

Table 3.2 Measurement of Variables

Variable	Type of Variable	Indicators	Scale of Measurement	Tools of Analysis
Payment of Health Insurance Claims	Dependent	i) Claims of between 3 – 5 weeks ii) Claims of between 5 – 10 weeks iii) Claims of over 10 weeks	Ordinal	Descriptive and Inferential
Internal Industry Practices	Independent	i) Documentation process ii) Claim payment methods iii) Claim investigation process	Ordinal	Descriptive and Inferential
Systems Availability	Independent	i) Insurance staff at the hospitals ii) Common hospitals and insurance accounting procedures iii) Claim administration capacity iv) Claim software integration	Ordinal	Descriptive and Inferential
Laws and Regulations	Independent	i) Damages on delayed claims ii) Validity on claim processing price list iii) Common basis for loss calculations iv) Standard pricing of specialty items v) Standard depreciation procedure	Ordinal	Descriptive and Inferential
Insurance Fraud	Independent	i) Staff collusion ii) Non-existing claims iii) Overstated claims iv) Double payment of claims v) Missing claim files	Ordinal	Descriptive and Inferential

3.5 Data Collection

The study used questionnaires in data collection since they are easy to administer and time-saving. Each item on the questionnaire was developed to address a specific objective, research questions or hypotheses of study containing both closed-ended and open questions using scaled questions. The questionnaires have their limitations, which the study overcame. If one forgets to ask a question, you cannot usually go back to respondents. The study therefore made sure that confidentiality was ensured for respondents and therefore questions were answered accordingly. Further, respondents may ignore certain questions which also were overcome by ensuring their confidentiality. The researcher obtained an introductory letter from the Strathmore University Business School in order to collect data from the field and then delivered the questionnaires to the respondents.

The researcher engaged the help of two research assistants in the data collection process who were briefed and trained by this researcher on the purpose of this study and the modalities of the data collection process. Specifically, the research assistants were trained on ethics to ensure that they approached respondents in a polite way. In addition, their knowledge about the purpose of the study was to enable them guide the respondents appropriately so as to achieve the required information.

3.6 Data Analysis

The data was analyzed by use of descriptive and inferential statistics. Specifically, frequencies and percentages were employed by the researcher in descriptive analysis. The data was presented using tables, charts and graphs. Data was first coded and organized into concepts from which generalization were made of entire population. Data was then tabulated and descriptive statistics calculated on each variable under study and interpretations made from the field findings. Percentages were also calculated and interpretation made.

This study also used inferential statistics to show the relationship that existed between the study variables that included correlation analysis and regression analysis after the factor analysis. The study used Pearson correlation matrix which was used to indicate the direction, strength and significance of the relationships. Pearson correlation helped in predicting and describing the association between the variables in terms of magnitude and direction. The correlation test was conducted at the 5% level of significance with a 2-tailed test. Thus, the significance critical value

is 0.025 above which the association is deemed to be insignificant and vice versa. The strength of the correlation is measured based on the Pearson correlation scale. The correlation coefficient ranges from -1.0 to +1.0 and the closer the coefficient is to +1 or -1, the more closely the two variables are related.

The study finally conducted regression analysis where coefficient of determinations (R^2) was used to estimate the percentage of variation in the dependent variable that can be explained by the set of independent variables. The error in the estimate of the dependent variable from multiple independent variables was measured by the multiple standard error of estimate. This was a measure of variability in predicting the dependent variable from a number of independent variables. The following simple linear regression model was adopted in the study where ordinary least squares (OLS) was used in estimating the unknown parameters in the model.

$$Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon$$

Where:

Y = Delay in Payment of Health Insurance Claims

i. $\{\beta_i; i=1,2,3,4\}$ = The coefficients for the various independent variables.

ii. X_i for;

X_1 = Internal Industry Practices

X_2 = Systems Availability

X_3 = Laws and Regulation

X_4 = Insurance Fraud

ε = error term

In the model, *a* is the constant term while the coefficient β_1 to β_4 are sensitivity of the dependent variable (Y) to unit change in the independent variable (X_1, X_2, X_3, X_4). To help in the analysis section in the study, Statistical Software for Social Sciences (SPSS) was used as the main tool for analysis in the study.

Diagnostic tests of multicollinearity, homoscedascity, linearity and normality were carried out in the study. Prior to analyzing data using inferential statistical techniques, it is mandatory to check the normality of the data set by looking at some descriptive values such as skewness and

kurtosis. The study also conducted linearity test to determine whether the relationship between delay in payment of health insurance claims and the independent variables was linear or not. If the significant deviation from linearity is greater than 0.05, then the relationship between the independent variable is linearly dependent. If the significant deviation from linearity is less than 0.05, then the relationship between the independent variable and the dependent variable is not linear.

Further, autocorrelation gave the researcher the relationship between values of the dependent and independent variables based on the repeated patterns in the regression analysis process. Multicollinearity in the study was done using variance inflation factors (VIF) for the variables. Finally, the test for homoscedasticity required that the independent variables as given in the regression equations be non-metric and the dependent variable be metric (interval or ordinal) which is the case for this particular study. The study findings had the homoscedasticity test evaluated for pairs of variables using the Levene statistic for the test of homogeneity of variances. In addition, the study applied ANOVA test which was used to triangulate OLS estimation applied in the study. Finally, the study introduced a dummy variable to capture whether being in a hospital makes a difference to being with an insurance company. This helped to show the cause of the delay.

The measurement of delay in payment of health insurance claims was through a summation score where it identified key elements in delay in payments such as the delay in within 30 days, 30-60 days, 60- 90 days and 90-120 days. The other independent variables such as internal industry practices, system availability, laws and regulations and insurance fraud were measured in a Likert scale of 1-5 after which the summation score and weighted average was obtained through computation of means in SPSS for the constructs for each variable.

CHAPTER FOUR

DATA ANALYSIS

4.1 Introduction

This chapter presents an analysis of data that was collected, interpretation and discussion of the findings. The study used both descriptive and inferential statistics. Specifically, frequencies and percentages were employed by the researcher in descriptive analysis. In inferential analysis, the study used Pearson correlation matrix and autocorrelation which was used to indicate the direction, strength and significance of the relationships. Further, the study conducted regression analysis where coefficient of multiple determinations (R2) was used to estimate the percentage of variation in the dependent variable that can be explained by the set of independent variables.

Presentations of the results are on tables and figures where appropriate. Both descriptive and inferential analysis techniques have been employed in the analysis. The results are presented according to the research objectives; the influence of internal industry practices on the payment of private health insurance claims in Kenya; the influence of systems availability on the payment of private health insurance claims in Kenya; the influence of laws and regulation on the payment of private health insurance claims in Kenya and the influence of insurance fraud on the payment of private health insurance claims in Kenya. The response rate and the demographic characteristics of the study respondents are also highlighted as a background to the analysis.

4.2 Response Rate

The section presents the results on the response rate. This is an illustration of the response rate from the respondents who were sampled as a representative of the target population as presented in Figure 4.1;

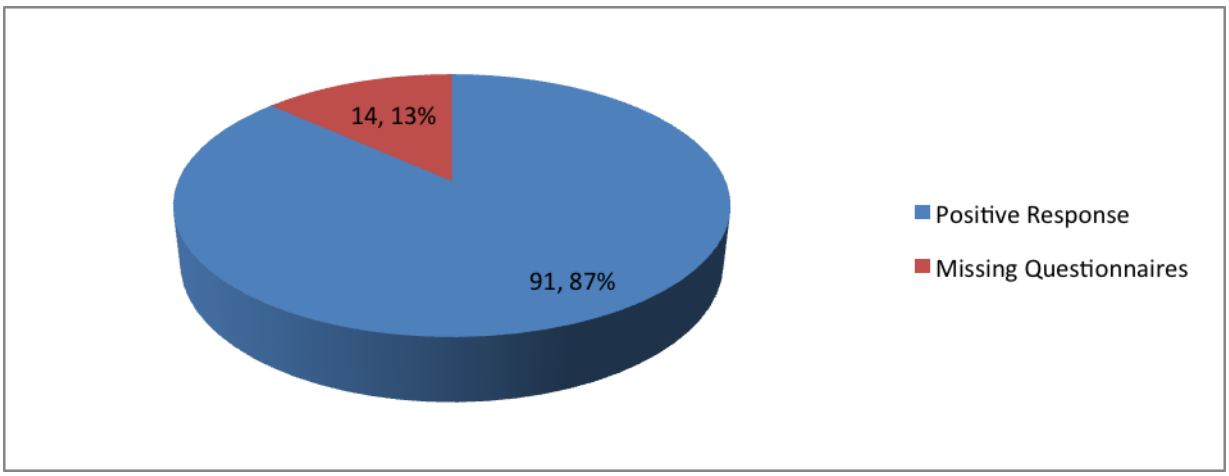


Figure 4.1 Response Rate

The study aimed to collect data from 105 hospital staff on insurance claims and staff members on insurance claims from the insurance companies. However, the study did not achieve a response of 100% as there were some non-response incidences where the researcher could not access all the respondents or the information given was found insufficient to be utilized in the study. Therefore, out of the 105 responses targeted, 91 gave adequate information through answering the questions completely. However, 14 respondents did not give response to the study making a non-response of 13%. Thus, the study realized a response rate of 87% as shown in Figure 4.1. According to Saunders, Lewis and Thorn (2007), an average response rate of more than 30% is reasonable for a study. Therefore, the response in the study was good.

4.3 General Information of the Respondents

The section gives the study findings on the general characteristics of the respondents. The characteristics include the age range of the respondents, gender of respondents, length of work in the current organization, highest level of education and the role of the organization in the claims process.

4.3.1 Age Range of Respondents

The study sought to determine the age range of the respondents who participated in the study. The findings obtained in the study indicate that the majority of the respondents were aged 30-39 years forming 78% of the responses, those aged 20-30 years formed 12% of the responses, 9% were aged 50-59 years while 1% were aged 40-49 years. The findings obtained in the study

imply that most workers in the hospital on insurance claims and members on insurance claims from the insurance companies are of age 30-39 years. The findings obtained in the study are presented in Figure 4.2.

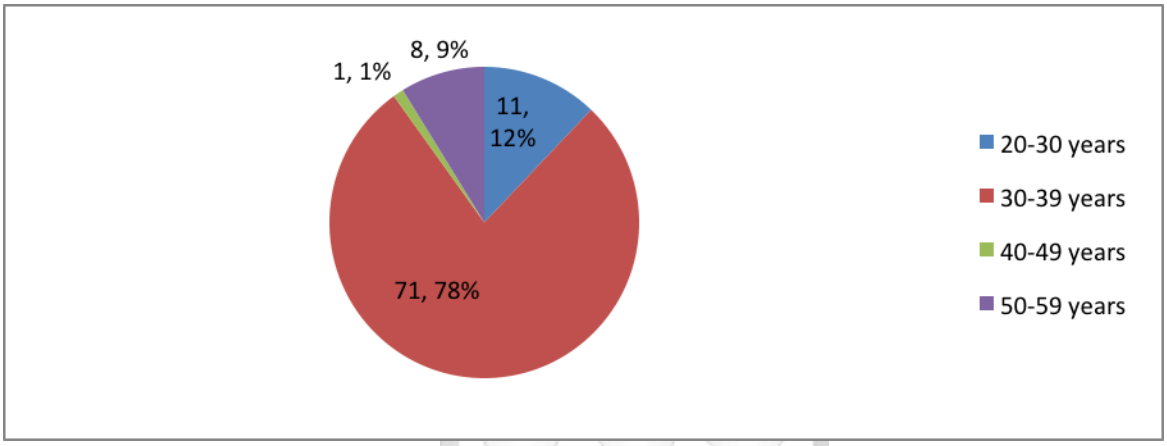


Figure 4.2 Age of Respondents

4.3.2 Gender of Respondents

The study also sought to determine the gender of the respondents who participated in the study. The findings obtained indicate that 57% of the respondents were female while 43% were male. This implies that majority of the workers in the hospital on insurance claims and members on insurance claims from the insurance companies are female. However, there was good presentation of both gender in the study as shown in Figure 4.3.

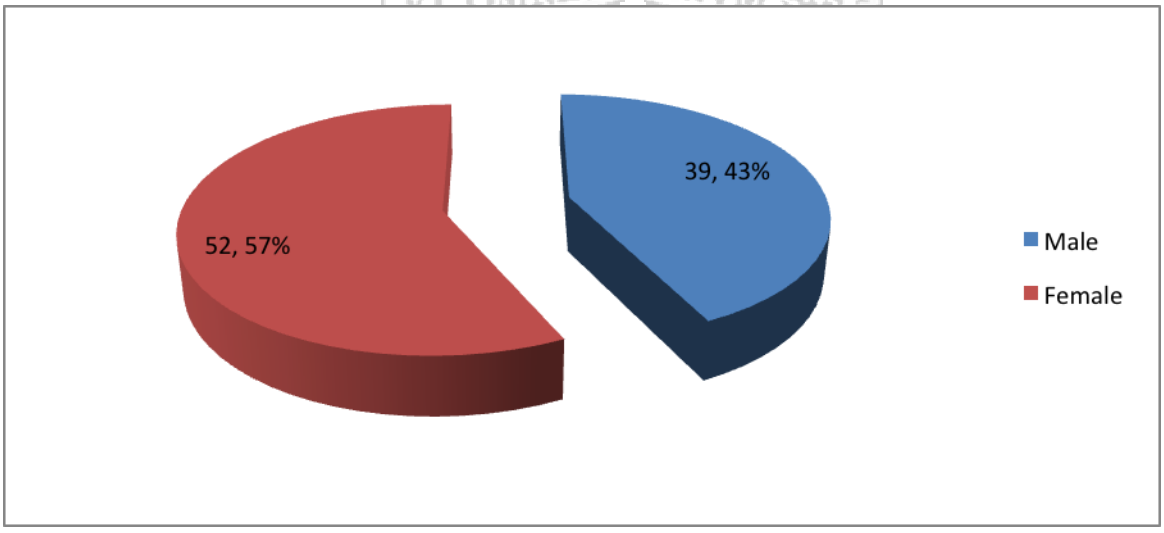


Figure 4.3 Gender of Respondents

4.3.3 Length of Work in the Current Organization

The study sought to determine the length in which the respondents had worked in their current organization. The study found out that 43% of the respondents had worked in their current for 9 years and more, 34% had worked for 2-4 years, 18% of the respondents had worked for 6-8 years, 4% had worked in their organizations for 1 year or less while 1% had worked for 5-7 years. The findings obtained imply that the majority of the respondents had considerable experience in insurance matters as shown in Figure 4.4.

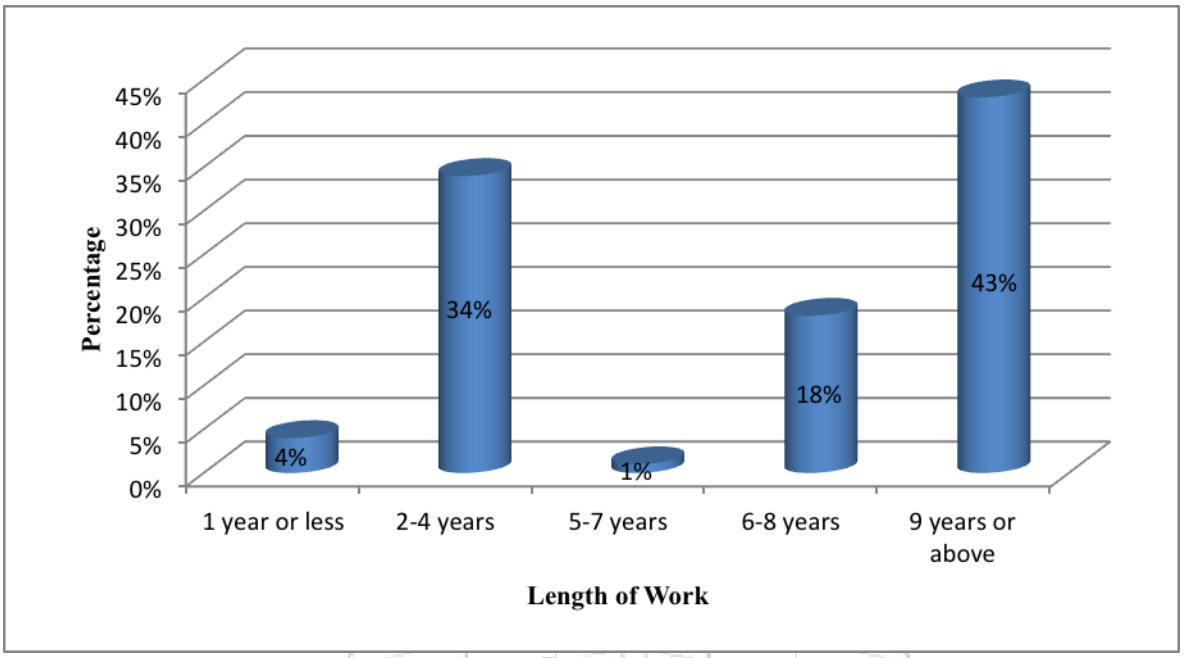


Figure 4.4 Length of Work in the Current Organization

4.3.4 Highest Level of Education

The study also aimed to determine the highest level of education of respondents who participated in the study. The study determined that 54% of the respondents were holders of Bachelor's degree, 36% of the respondents had Master's degree, 7% were holders of doctorate degree, 2% had diploma while 1% had secondary school education as shown in Figure 4.5. The results imply that the majority of the respondents had the required education required in the sector.

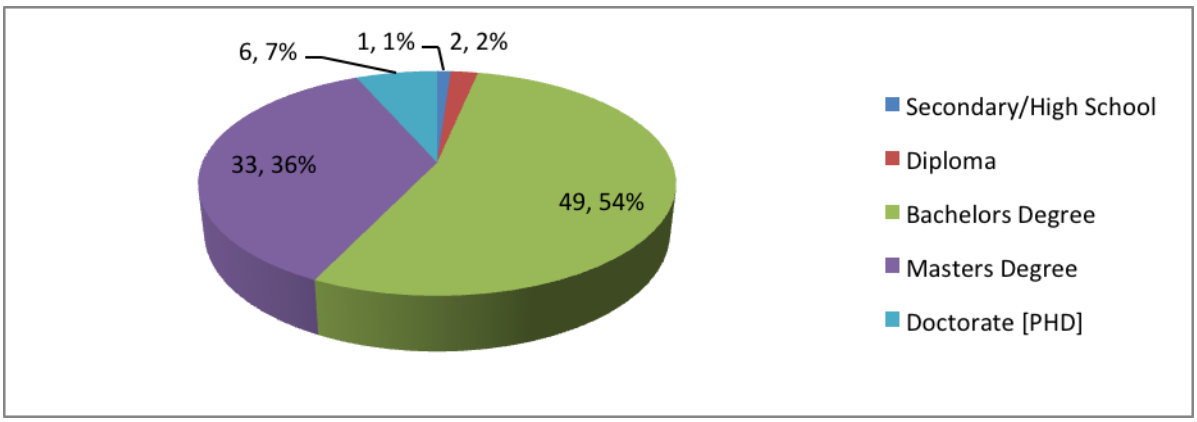


Figure 4.5 Highest Level of Education

4.3.5 Role of Organization in the Claims Process

The study further sought to determine the role of the respondents' organization in the claims process. The findings of the study indicated that 71% of the organizations were health service providers while 29% were insurance service providers as shown in Figure 4.6.

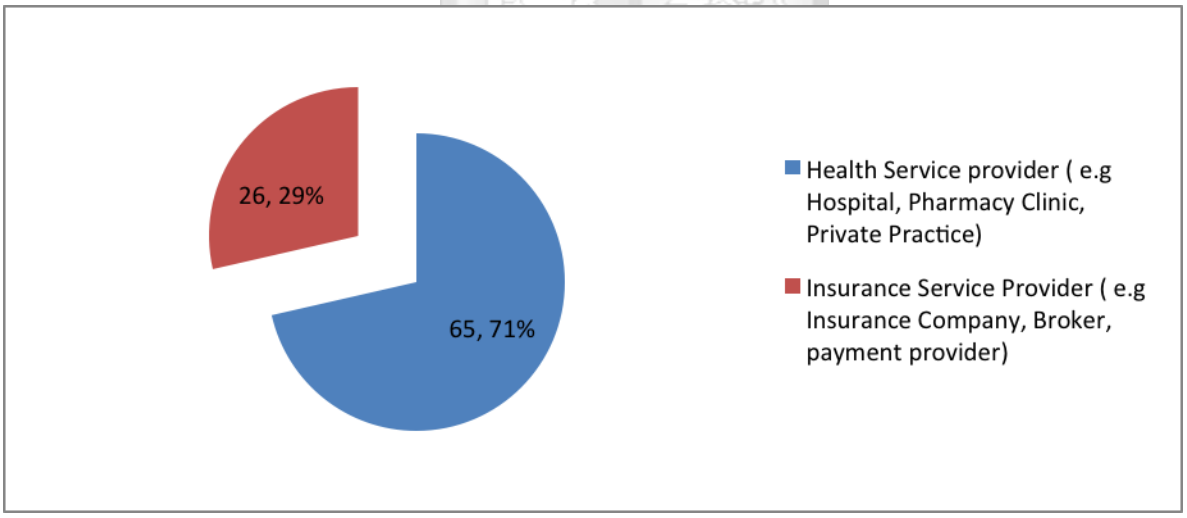


Figure 4.6 Role of Organization in the Claims Process

4.4 Influence of Internal Industry Practices On the Payment of Private Health Insurance Claims

The first objective was to determine the influence of internal industry practices on the payment of private health insurance claims in Kenya. The study findings obtained indicate that 30% of the respondents agreed that the information available in the policy claim process is un-clear and

cannot easily understood when filling in the claim forms, 33.3% neither agreed nor disagreed, 16.7% strongly disagreed while 12.2% disagreed. 40% of the respondents agreed that the documentation processes in claims are too much thus people submit incomplete claim documents, 22.2% neither agreed nor disagreed, 21.1% strongly agreed, 10% disagreed while 6.7% strongly disagreed. 50.6% of the respondents agreed that the claim requirements and conditions adopted by the insurance providers are not favorable to every health service provider, 31.5% strongly agreed, 11.2% neither agreed nor disagreed while 4.5% strongly disagreed. Also, 33.5% of the respondents strongly agreed that the price list adopted by the insurance in settling claims is not updated regularly and does not reflect the true value of compensation, 32.2% neither agreed nor disagreed while 25.6% agreed.

The study also determined that 40% of the respondents strongly agreed that there is not a universally agreed standard for loss calculation, 31.1% neither agreed nor disagreed while 26.7% agreed. 37.1% neither agreed nor disagreed that the claims manager delegates responsibilities within the department in a way that decisions with serious ramifications are left to inexperienced or incompetent staff, 27% agreed and 16.9% strongly agreed. Finally, 37.8% of the respondents neither agreed nor disagreed that when the claims staff leave employment, they are usually replaced by inexperienced persons and the process of replacements contributes to delays in payments of the claims, 30% strongly agreed while 16.7% agreed. The findings of the study are shown in Table 4.1.

Table 4.1 Internal Industry Practices and Payment of Private Health Insurance Claims

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
The information available in the policy claim process is un-clear and cannot easily understood when filling in the claim forms	Frequency (f)	15	11	30	27	7	90
	Percentage (%)	16.7%	12.2%	33.3%	30.0%	7.8%	100%
The documentation processes in claims are too much thus people submit incomplete claim documents.	Frequency (f)	6	9	20	36	19	90
	Percentage (%)	6.7%	10.0%	22.2%	40.0%	21.1%	100%
The claim requirements and conditions adopted by the insurance providers are not favorable to every health service provider.	Frequency (f)	4	2	10	45	28	89
	Percentage (%)	4.5%	2.2%	11.2%	50.6%	31.5%	100%
The price list adopted by the insurance in settling claims is not updated regularly and does not reflect the true value of compensation	Frequency (f)	8	0	29	23	30	90
	Percentage (%)	8.9%	0%	32.2%	25.6%	33.3%	100%
There is not a universally agreed standard for loss calculation	Frequency (f)	2	0	28	24	36	90
	Percentage (%)	2.2%	0%	31.1%	26.7%	40.0%	100%
The claims manager delegates responsibilities within the department in a way that decisions with serious ramifications are left to inexperienced or incompetent staff	Frequency (f)	4	13	33	24	15	89
	Percentage (%)	4.5%	14.6%	37.1%	27.0%	16.9%	100%
When the claims staff leave employment, they are usually replaced by inexperienced persons and the process of replacements contributes to delays in payments of the claims.	Frequency (f)	6	8	34	15	27	90
	Percentage (%)	6.7%	8.9%	37.8%	16.7%	30.0%	100%

Further, the study sought to determine whether the respondents agreed with the statement that the failure by the insurance firms to provide pricing in the special items does bring in delays in

payment of insurance claims. The findings obtained indicated that 75.8% of the respondents agreed with the statement while 22% did not. Also, 89% of the respondents agreed that there is a serious bureaucracy in the claim processing that has led to delays in the payment of insurance claims while 11% did not as shown in Table 4.2.

Table 4.2 Internal Industry Practices

	Recruitment Involvement	**Frequency**	**Percentage**
Do you agree with the statement that, the failure by the insurance firms to provide pricing in the special items does bring in delays in payment of insurance claims	Yes	69	75.8%
	No	20	22.0%
	Don't know	2	2.2%
There is a serious bureaucracy in the claim processing that has led to delays in the payment of insurance claims	Yes	81	89.0%
	No	10	11.0%
	Don't know	0	0%

The study sought to establish correlation between the dependent variable and the independent variable. The dependent variable for the study was internal industry practices while the dependent variable was delay in payment of insurance claims. The correlation test was conducted at the 5% level of significance with a 2-tailed test. Thus, the significance critical value is 0.025 above which the association is deemed to be insignificant and vice versa. The strength of the correlation is measured based on the Pearson correlation scale. The correlation coefficient ranges from -1.0 to +1.0 and the closer the coefficient is to +1 or -1, the more closely the two variables are related. A correlation of +1 implies that there is perfect positive linear relationship between variables (Sekran, 2003). The findings illustrated in Table 4.3 show that internal industry practices had a significant association with delay in payment of health insurance claims. The correlation coefficient for internal industry practices to payment of insurance claims is -0.622 with a significance value of 0.002 which is less than 0.025 at the 5% level.

Table 4.3 Correlation between Internal Industry Practices and Delay in Payment of Health Insurance Claims

		Delay in Payment of Health Insurance Claims
Delay in Payment of Health Insurance Claims	Pearson Correlation	1
	Sig. (2-tailed)	
	N	90
Internal Industry Practices	Pearson Correlation	-.622**
	Sig. (2-tailed)	.002
	N	90

4.5 Influence of Systems Availability on the Payment of Private Health Insurance Claims

The study also sought to determine the influence of systems availability on the payment of private health insurance claims in Kenya. A table of frequencies and percentages was adopted to present the findings of the study as shown in Table 4.4.

The study found out that 25.3% of the respondents neither agreed nor disagreed that there is insufficient insurance staff at the hospitals for effective claim processing, 23.1% strongly disagreed, 19.8% strongly agreed, 17.6% agreed while 14.3% disagreed. The study also found out that 47.3% of the respondents agreed that the insurance and the hospitals do not have standard accounting system for effective implementation of claims, 24.2% strongly agreed, 17.6% neither agreed nor disagreed while 8.8% strongly disagreed. The study findings also indicate that 50.5% of the respondents strongly agreed that the insurance and the hospitals have not adopted an integrated IT system to enhance claim processing, 27.5% agreed while 12.1% disagreed. Further, 33.3% of the respondents agreed that systems failure in hospitals often leads to loss of claim data that leads to delay in claims processing, 30% strongly agreed while 23.3% neither agreed nor disagreed. In addition, the findings indicate that 58.9% of the respondents strongly agreed that most insurance companies in Kenya are operating in different platform of systems that make it difficult to process joint claim, 24.4% agreed while 16.7% neither agreed nor disagreed.

Table 4.4 Systems Availability and Payment of Private Health Insurance Claims

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
There is insufficient insurance staff at the hospitals for effective claim processing	Frequency (f)	21	13	23	16	18	91
	Percentage (%)	23.1%	14.3%	25.3%	17.6%	19.8%	100%
The insurance and the hospitals do not have standard accounting system for effective implementation of claims	Frequency (f)	8	2	16	43	22	91
	Percentage (%)	8.8%	2.2%	17.6%	47.3%	24.2%	100%
The insurance and the hospitals have not adopted an integrated IT system to enhance claim processing	Frequency (f)	8	11	1	25	46	91
	Percentage (%)	8.8%	12.1%	1.1%	27.5%	50.5%	100%
Systems failure in hospitals often leads to loss of claim data that leads to delay in claims processing	Frequency (f)	5	7	21	30	27	90
	Percentage (%)	5.6%	7.8%	23.3%	33.3%	30.0%	100%
Most insurance companies in Kenya are operating in different platform of systems that make it difficult to process joint claim	Frequency (f)	0	0	15	22	53	90
	Percentage (%)	0%	0%	16.7%	24.4%	58.9%	100%

The study also sought to determine whether the weak and poor systems in hospitals and insurance companies in Kenya often lead to delay in insurance claims. The findings obtained indicate that 94.4% agreed while 5.6% of the respondents disagreed with the statement as shown in Table 4.5. In line with these findings, Kiana (2010) determined that ineffective IT governance and control is likely to be the main cause of the negative experiences many organizations and especially insurance firms have had with the use of IT, including lost business, damaged reputations, weakened competitive position, inability to meet deadlines, failed or aborted projects, budget overruns and poor returns on investments.

Table 4.5 Systems and Delay in Claims

	Frequency	Percentage
Yes	85	94.4
No	5	5.6
Total	90	100.0

The study sought to establish correlation between systems availability and delay in payment of insurance claims. The correlation test was conducted at the 5% level of significance with a 2-tailed test. Thus, the significance critical value is 0.025 above which the association is deemed to be insignificant and vice versa. The coefficient for the association between systems availability and delay in payment of insurance claims is -0.764 with a p-value of 0.012 which is less than 0.025 indicating a significant relationship between the variables. The findings are shown in Table 4.6.

Table 4.6 Correlation between Systems Availability and Delay in Payment of Health Insurance Claims

		Delay in Payment of Health Insurance Claims
Delay in Payment of Health Insurance Claims	Pearson Correlation	1
	Sig. (2-tailed)	
	N	90
Systems Availability	Pearson Correlation	-.764*
	Sig. (2-tailed)	.012
	N	90

4.6 Influence of Laws and Regulation on the Payment of Private Health Insurance Claims

The study sought to determine the influence of laws and regulation on the payment of private health insurance claims in Kenya. The findings obtained in the study indicate that 43.2% of the respondents agreed that the existing laws on claims are not exhaustive on the award of claim damages concerning the delays, 28.4% neither agreed nor disagreed, 20.5% strongly agreed while 5.7% disagreed. 50% of the respondents agreed that the claim processing methods are not clearly defined in the laws thus leaving the insurance firms with discretion hence the delay, 25.6% strongly agreed, 16.7% neither agreed nor disagreed while 5.6% disagreed. 41.1% of the

respondents agreed that the depreciation procedure adopted by the insurance firms are not standard thus difficulty in obtaining common rates at times of claim, 30% strongly agreed while 23.3% neither agreed nor disagreed. In addition, 52.2% of the respondents strongly agreed that there is need for merging the organizational regulations with those of the country, 34.4% agreed while 6.7% disagreed. The findings are shown in Table 4.7.

Table 4.7 Laws and Regulation and Payment of Private Health Insurance Claims

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
The existing laws on claims are not exhaustive on the award of claim damages concerning the delays	Frequency (f)	2	5	25	38	18	88
	Percentage (%)	2.3%	5.7%	28.4%	43.2%	20.5%	100%
The claim processing methods are not clearly defined in the laws thus leaving the insurance firms with discretion hence the delay	Frequency (f)	2	5	15	45	23	90
	Percentage (%)	2.2%	5.6%	16.7%	50.0%	25.6%	100%
The depreciation procedure adopted by the insurance firms are not standard thus difficulty in obtaining common rates at times of claim	Frequency (f)	0	5	21	37	27	90
	Percentage (%)	0%	5.6%	23.3%	41.1%	30.0%	100%
There is need for merging the organizational regulations with those of the country	Frequency (f)	2	6	4	31	47	90
	Percentage (%)	2.2%	6.7%	4.4%	34.4%	52.2%	100%

Further, the study sought to determine whether the existing laws and regulations have lots of weaknesses that give room for delay of payment of health insurance claims. The study found that 93.3% of the respondents while 4.4% of the respondents disagreed as shown in Table 4.8.

Table 4.8 Existing Laws and Delays in Payment of Claims

	Frequency	Percentage
Yes	84	93.3
No	4	4.4
Other	2	2.2
Total	90	100.0

The study sought to establish correlation between laws and regulation and delay in payment of insurance funds. The correlation test was conducted at the 5% level of significance with a 2-tailed test. Thus, the significance critical value is 0.025 above which the association is deemed to be insignificant and vice versa. From Table 4.9, the correlation coefficient for the association between laws and regulation and delay in payment of insurance claims is -0.806 with a p-value of 0.003 less than 0.025 depicting a significant correlation between the variables.

Table 4.9 Correlation between Laws and Regulation and Delay in Payment of Health Insurance Claims

		Delay in Payment of Health Insurance Claims
Delay in Payment of Health Insurance Claims	Pearson Correlation	1
	Sig. (2-tailed)	
	N	90
Laws and Regulation	Pearson Correlation	-.806**
	Sig. (2-tailed)	.003
	N	90

4.7 Influence of Insurance Fraud on the Payment of Private Health Insurance Claims

The study sought to determine the influence of insurance fraud on the payment of private health insurance claims in Kenya. The study determined that majority of the respondents agreed that insurance and health staff collusion is the main cause of insurance fraud thus delay in insurance claims forming 35.2% of the responses, 29.7% strongly agreed, 16.5% disagreed while 6.6% strongly disagreed. 30.8% of the respondents agreed that lodging of non-existing claims is the main cause of delay in processing of insurance claims, 20.9% strongly agreed while 23.1% disagreed. 37.4% of the respondents agreed that overstatement of claims is a key factor that promotes the delay in insurance claims, 27.5% strongly agreed while 15.4% neither agreed nor disagreed. 38.9% of the respondents strongly agreed that there is no hasty claim settlement in the

firm to avoid increased fraud-related costs while 37.8% agreed. The study also determined that 43.3% the respondents neither agreed nor disagreed that there is also no slow claim settlement to avoid increase in the overall claim cycle time, 38.9% neither agreed nor disagreed that there are weak underwriting standards in the firm which form the highest challenge in management of general insurance claims and 41.1% strongly agreed that usually, delay in reporting a claim and high work load of staff are the main factors contributing to delay in claim payment. The findings of the study are shown in Table 4.10.

Table 4.10 Insurance Fraud and Payment of Private Health Insurance Claims

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Insurance and health staff collusion is the main cause of insurance fraud thus delay in insurance claims	Frequency (f)	6	15	11	32	27	91
	Percentage (%)	6.6%	16.5%	12.1%	35.2%	29.7%	100%
Lodging of non-existing claims is the main cause of delay in processing of insurance claims	Frequency (f)	8	21	15	28	19	91
	Percentage (%)	8.8%	23.1%	16.5%	30.8%	20.9%	100%
Overstatement of claims is a key factor that promotes the delay in insurance claims	Frequency (f)	5	13	14	34	25	91
	Percentage (%)	5.5%	14.3%	15.4%	37.4%	27.5%	100%
There is no hasty claim settlement in the firm to avoid increased fraud-related costs.	Frequency (f)	1	4	16	34	35	90
	Percentage (%)	1.1%	4.4%	17.8%	37.8%	38.9%	100%
There is also no slow claim settlement to avoid increase in the overall claim cycle time	Frequency (f)	4	7	39	24	16	90
	Percentage (%)	4.4%	7.8%	43.3%	26.7%	17.8%	100%
There are weak underwriting standards in the firm which form the highest challenge in management of general insurance claims	Frequency (f)	2	4	35	31	18	90
	Percentage (%)	2.2%	4.4%	38.9%	34.4%	20.0%	100%
Usually, delay in reporting a claim and high work load of staff are the main factors contributing to delay in claim payment.	Frequency (f)	4	9	13	27	37	90
	Percentage (%)	4.4%	10.0%	14.4%	30.0%	41.1%	100%

Further, the study sought to determine whether the cases of double payment of claims usually prompt the insurance company to order for investigations on huge claims hence the delay in insurance claims. The findings indicate that 60% of the respondents agreed while 40% disagreed. Further, 93.3% of the respondents agreed that missing claim files is also a serious contributor to the delay in the insurance claims, while 6.7% disagreed as shown in Table 4.11.

Table 4.11 Other Aspects of Insurance Fraud

	Recruitment Involvement	**Frequency**	**Percentage**
The cases of double payment of claims usually prompt the insurance company to order for investigations on huge claims hence the delay in insurance claims	Yes	54	60%
	No	36	40%
	Don't know	0	0%
Missing claim files is also a serious contributor to the delay in the insurance claims	Yes	84	93.3%
	No	6	6.7%
	Don't know	0	0%

The study sought to establish correlation between insurance fraud and delay in payment of insurance claims. The correlation test was conducted at the 5% level of significance with a 2-tailed test. Thus, the significance critical value is 0.025 above which the association is deemed to be insignificant and vice versa. The correlation coefficient for the association between insurance fraud and delay in payment of insurance claims is 0.813 with a p-value of 0.000 which is less than 0.025 indicating a significant relationship between the variables as shown in Table 4.12.

Table 4.12 Correlation between Insurance Fraud and Delay in Payment of Health Insurance Claims

		Delay in Payment of Health Insurance Claims
Delay in Payment of Health Insurance Claims	Pearson Correlation	1
	Sig. (2-tailed)	
	N	90
Insurance Fraud	Pearson Correlation	.813**
	Sig. (2-tailed)	.000
	N	90

4.8 Delay in Payment of Private Health Insurance Claims

The study sought to determine the length that was taken in the payment of private health insurance claims in Kenya. According to the findings obtained in the study, majority of the respondents (40%) agreed that the claim processing was made on time, 50.6% agreed that it was done between 3 and 5 weeks, 33.3% strongly agreed that it was done between 6-10 weeks while 40% strongly agreed that it was done for more than 10 weeks as shown in Table 4.13.

Table 4.13 Delay in Payment of Private Health Insurance Claims

		Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total
Majority of claims we process are made on time	Frequency (f)	6	9	20	36	19	90
	Percentage (%)	6.7%	10.0%	22.2%	40.0%	21.1%	100%
Most of the claim processing usually take 3-5 weeks	Frequency (f)	4	2	10	45	28	89
	Percentage (%)	4.5%	2.2%	11.2%	50.6%	31.5%	100%
Most of the claim processing usually take 6-10 weeks	Frequency (f)	8	0	29	23	30	90
	Percentage (%)	8.9%	0%	32.2%	25.6%	33.3%	100%
Most of the claim processing usually take above 10 weeks	Frequency (f)	2	0	28	24	36	90
	Percentage (%)	2.2%	0%	31.1%	26.7%	40.0%	100%

4.9 Regression Analysis

The study carried out inferential statistics to determine the relationships between the study variables. This was done through regression analysis. Table 4.14 presents a summary of regression model results. The value of r and r^2 are .660 and .514 respectively. This shows that there is a positive linear relationship between determinants of delay and delay in payment of insurance claims. The r^2 is the coefficient of determination which indicates that explanatory power of the independent variables which in the study was obtained as 0.514. This means that 51.4% of the variation in the variable delay in payment of health insurance claims is explained by the variation of the variables insurance fraud, laws and regulation, internal industry practices, and systems availability in the model $Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon$. The remaining 48.6% of the variation in the dependent variable is unexplained by these predictor variables but by other factors not studied in the present study.

Table 4.14 Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.660[a]	.514	.501	.813

a. Predictors: (Constant), Insurance Fraud, Laws And Regulation, Internal Industry Practices, Systems Availability

Adopting a linear regression model: $Y = \beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \beta_4 X_4 + \varepsilon$

Where Y = Delay in Payment of Health Insurance Claims

i. $\{\beta_i; i=1,2,3,4\}$ = The coefficients for the various independent variables.

ii. X_i for;

X_1 = Internal Industry Practices

X_2 = Systems Availability

X_3 = Laws and Regulation

X_4 = Insurance Fraud

ε = error term

Ordinary least square (OLS) was used in estimating the unknown parameters in the model.

Table 4.15 Coefficients Table

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.	Collinearity Statistics	
		B	Std. Error	Beta			Tolerance	VIF
1	(Constant)	.354	.712		4.497	.000		
	Internal Industry Practices	-.248	.119	-.202	2.081	.011	.749	1.336
	Systems Availability	-.174	.154	-.151	1.981	.023	.586	1.706
	Laws And Regulation	-.145	.130	-.105	4.119	.000	.579	1.727
	Insurance Fraud	.623	.133	.480	4.674	.000	.465	2.151

a. Dependent Variable: Delay in Payment of Health Insurance Claims

The linear equation for the study will therefore become:

Y= 0.354 - 0.248X1 - 0.174X2 - 0.145X3 + 0.623X4 + 0.712

The findings obtained in the study imply that for every unit increase in internal industry practices, delay in payment of health insurance claims decreases by 0.248 delays; for every unit increase in systems availability, delay in payment of health insurance claims decreases by 0.174 delays, for every unit increase in laws and regulation, delay in payment of health insurance claims decrease by 0.145 delays and for every unit increase in insurance fraud, delay in payment of health insurance claims increases by 0.623 delays.

The study determined the beta coefficients of the independent variables of the study. Table 4.15 shows the results of coefficients internal industry practices, systems availability, laws and regulation and insurance fraud. According to the results, internal industry practices had a significant influence on delay in payment of health insurance claims as shown by the coefficient (β = -0.202, t = 2.081, p = 0.011). Systems availability also showed a significant influence on delay in payment of health insurance claims with the coefficients (β = -0.151, t = 1.981, p = 0.023). Laws and regulation as well showed a significant influence with a coefficient of (β = -0.105, t = 4.119, p = 0.000) showing a negative and significant relationship. Further, insurance fraud showed a positive significant influence with coefficients (β = 0.480, t = 4.674, p = 0.000). The findings of the study do not align with the findings of Muriuki (2013) and Yusuf and Dansu

(2014) who found a negative relationship between insurance fraud and delay in payment of health claims. Further, Callahan (2010) and Machui (2015) found negative significant relationships between laws and regulation, systems and industry practices. This could be attributed to their studies being conducted in public hospitals, whereas this study was conducted in private hospitals.

Since there was a significant relationship between the determinants of delays and payment of private health insurance claims in Kenya, the study introduced a dummy variable to capture whether being in a hospital makes a difference to being with an insurance company. Because any variable that has only codes 0 and 1 is a ratio variable, the study included them in the regression model. In the study, the variable delay in payment of insurance claims is the dependent variable and being in hospital (0 = being in insurance company, 1= being in hospital) as predictor.

In the study OLS regression model, this leads to the following equation:

Yi = a + b*being in hospital

Reference category: being in insurance company (code 0)

From the regression, it is assumed that there is no difference in delay in the target population, so b is assumed to be 0. The research hypothesis is that being in a hospital on average has a lower delay compared to being in an insurance company, so b is hypothesized to be lower than 0. In the study, the delay difference b amounts to -.35. This probability (or p- value) is lower than .01 which is lower than standard test criteria (α) of .05. The outcome of -.35 is therefore statistically significant; implying that delays in payment in insurance claims in with respect to hospitals is lower than in insurance companies. The findings are shown in Table 4.16.

Table 4.16 Estimated delay for being in insurance company (*a*) and being in hospital (*b*)

	Coefficients	Standard error	t-value	p-value
a b *hospital* (0= insurance company, 1= hospital)	18.62 -.35	.14 .18	170.22 -4.65	<.01 <.01

The study also conducted diagnostic tests to examine the regression model for indications that statistical assumptions have been violated or not. The diagnostic tests carried out included multicollinearity, normality, homoscedascity and linearity tests.

Table 4.17 Multicollinearity Test Results

	Collinearity Statistics	
	Tolerance	VIF
Internal Industry Practices	.749	1.336
Systems Availability	.586	1.706
Laws And Regulation	.579	1.727
Insurance Fraud	.465	2.151

The results in table 4.16 give the variance inflation factors (VIF) for each variable. The results imply that their level of collinearity that exists in the analysis is not problematic in any way as the VIFs values are more than 1 and not greater than 10. Internal industry practices had a VIF value of 1.336, systems availability had a VIF value of 1.706, laws and regulation had a VIF value of 1.727, and insurance fraud had a VIF value of 2.151. Formally, variance inflation factor (VIF) measures how much the fluctuation assessed coefficient is expanded over the instance of no relationship among the independent factors. If no two independents are associated, the VIFs will be 1. If VIF for one of the factors is around or more prominent than 5, there is collinearity related with a variable. If there are at least two factors that will have VIF around or more prominent than 5, one of these factors must be removed from the regression model to address collinearity. In the case of this model VIFs indicate no real collinearity issues in the information close by other analytic tests consequently uncovering no such seriousness. The general confirmation from the different collinearity diagnostics led in this study shows that collinearity has not caused issues for the basic impact of transfer in both these informational collections and that the presence of low-level collinearity can't make the outcome factually unique in any capacity. In this manner, there is no huge collinearity in the informational collection that can frustrate relapse investigation as given in the procedure.

Normality of the data was done by looking at descriptive values such as skewness and kurtosis. Table 4.18 gives the results from the study.

Table 4.18 Normality Test Results

	N	Skewness		Kurtosis	
	Statistic	Statistic	Std. Error	Statistic	Std. Error
Internal Industry Practices	90	-.128	.227	-1.337	.451
Systems Availability	90	-.500	.227	-1.400	.451
Laws And Regulation	90	.273	.227	-1.002	.451
Insurance Fraud	90	-.544	.227	-.388	.451

The skewness values indicate that the scores are skewed as many are negatively skewed and not that much closer to zero. However, because all the skewness values fall within the range of -1 to +1, there is no case of excessive skewness in the data as the skewness values fall within the acceptable range of -3 and +3. The kurtosis values also fall within the range of -2 to 0, and therefore do not display excessive kurtosis as well. These results suggest that the normality assumption is not violated in the study.

The study conducted linearity test to determine whether the relationship between determinants of delay and delay in payment of insurance claims was linear or not. If the significant deviation from linearity is greater than 0.05, then the relationship between the independent variable is linearly dependent. If the significant deviation from linearity is less than 0.05, then the relationship between the independent variable and the dependent variable is not linear.

Table 4.19 Linearity Test Results

			Sum of Squares	df	Mean Square	F	Sig.
Determinants of delay * Delay in Payment of Health Insurance Claims	Between Groups	(Combined)	11.274	5	2.379	10.982	.000
		Linearity	.220	1	.220	1.016	.316
		Deviation from Linearity	10.053	4	2.811	12.975	.143
	Within Groups		22.962	80	.217		
	Total		37.236	90			

According to the results shown in Table 4.19, the significant deviation from linearity is 0.143 which is greater than 0.05 implying than there is a linear relationship between determinants of delay and delay in payment of insurance claims.

Homoscedasticity test was evaluated for pairs of variables using the Levene statistic for the test of homogeneity of variances. The results are shown in Table 4.20.

Table 4.20 Homoscedasticity Test Results

	Levene Statistic	df1	df2	Sig.
Internal Industry Practices	13.213	3	87	.189
Systems Availability	39.572	3	87	.098
Laws And Regulation	62.086	3	87	.111
Insurance Fraud	20.012	3	87	.153

The null hypothesis for the test of homogeneity of variance states that the variance of the dependent variable is equal across groups defined by the independent variable, i.e., the variance is homogeneous. From the study findings of test for homogeneity, the probability associated with the Levene Statistic for all variables is more than the level of significance (0.05) testing at 1%-tail test 5% significance level; the study concludes that the variance is homogeneous.

Finally, the study conducted ANOVA test to help triangulate within the OLS estimation method used. Table 4.21 shows the results of the Analysis of Variance (ANOVA) on the variables insurance fraud, laws and regulation, internal industry practices and systems availability and delay in payment of health insurance claims.

Table 4.21 ANOVA Table

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	25.392	4	6.348	9.600	.000[b]
	Residual	55.542	86	.661		
	Total	80.934	90			

a. Dependent Variable: Delay in Payment of Health Insurance Claims

b. Predictors: (Constant), Insurance Fraud, Laws And Regulation, Internal Industry Practices, Systems Availability

The test reveals that insurance fraud, laws and regulation, internal industry practices and systems availability jointly have significant effect on the delay in payment of health insurance claims. The P value is actually 0.000 which is less than 5% level of significance implying that the

coefficient of delay in payment of health insurance claims is at least not equal to zero and therefore the model was reliable.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary, conclusions and recommendations made based on the findings of the study. The chapter is divided into four sections. Section 5.1 presents the introduction; section 5.2 presents the summary of the findings and section 5.3 presents the conclusions whereas section 5.4 presents the recommendations and areas of further research.

5.2 Discussions

The main objective of the study was to investigate determinants of delays in the payment of private health insurance claims in Kenya. The study was guided by the following objectives: To determine the influence of internal industry practices on the payment of private health insurance claims in Kenya; to assess the influence of systems availability on the payment of private health insurance claims in Kenya; to determine the influence of laws and regulation on the payment of private health insurance claims in Kenya and to determine the influence of insurance fraud on the payment of private health insurance claims in Kenya.

The research design used in the study was survey research design. Questionnaires which were administered to 105 respondents were used to collect data. The response rate was good. Both descriptive and inferential statistics were used in analyzing the data collected. Descriptive methods used comprised the percentages and frequencies, means and standard deviations that showed the trends in the data. Inferential methods which included correlation analysis and regression analysis were also used and presentations made in tables and figures. In addition, prior to regression analysis, statistical assumptions were done.

5.2.1 Internal Industry Practices and Payment of Private Health Insurance Claims

The study findings obtained indicate that the respondents agreed that the information available in the policy claim process is un-clear and cannot easily understood when filling in the claim forms; the documentation processes in claims are too much thus people submit incomplete claim documents but strongly agreed that the claim requirements and conditions adopted by the insurance providers are not favorable to every health service provider. Based on the hypothess,

the study found that internal industry significantly influenced the payment of private health insurance claims in Kenya.

The findings obtained in the study are dissimilar with the findings obtained by Zeithaml and Bitner (2003) who determined that in a service industry such as insurance, contact employees directly influence customer satisfaction. Nevertheless, Drechsler and Jutting (2005) agrees with the findings of the study when the authors determined that coverage rates are generally below 10 % of the population in the Middle East.

Also, the respondents agreed that the price list adopted by the insurance in settling claims is not updated regularly and does not reflect the true value of compensation. The study determined that the respondents strongly agreed that there is not a universally agreed standard for loss calculation; the respondents agreed that the claims manager delegates responsibilities within the department in a way that decisions with serious ramifications are left to inexperienced or incompetent staff and that when the claims staff leave employment, they are usually replaced by inexperienced persons and the process of replacements contributes to delays in payments of the claims. Further, the study found out that the majority of the respondents agreed with the statement that the failure by the insurance firms to provide pricing in the special items does bring in delays in payment of insurance claims. Also, the majority of the respondents agreed that there is a serious bureaucracy in the claim processing that has led to delays in the payment of insurance claims. The study found a significant relationship between internal industry practices and delay in payment of health insurance claims.

Drechsler and Jutting (2005) further agrees with the findings of the study when he determined that the crucial challenge for policy makers is to develop a regulatory framework that is adapted to a country's institutional capacities. Morley, Ball and Ormerod (2006) noted that it is the responsibility of the claims manager to recruit, train and retain intelligent and competent staff. Further, Morley, Ball and Ormerod (2006) agrees with the study when he determined that whereas direct costs associated with loss and replacement of employees is measurable, there are also indirect costs associated with loss of employees, including loss in customer service and customer satisfaction.

The findings of the study further agree with the findings obtained by Mahlow et al (2016) who determined that the insurance claims payment is largely influenced by the accuracy, speed and

efficiency with which claims are settled. Further, Mahlow et al (2016) also determined that managing events like settlement, dispute resolution and arbitration form part of claims management and is a marketing tool.

5.2.2 Systems Availability and Payment of Private Health Insurance Claims

The study found out that the respondents neither agreed nor disagreed that there is insufficient insurance staff at the hospitals for effective claim processing. The study also found out that the respondents agreed that the insurance and the hospitals do not have standard accounting system for effective implementation of claims. The study findings also indicated that the respondents strongly agreed that the insurance and the hospitals have not adopted an integrated IT system to enhance claim processing and agreed that systems failure in hospitals often leads to loss of claim data that leads to delay in claims processing.

In addition, the findings indicated that the respondents strongly agreed that most insurance companies in Kenya are operating in different platform of systems that make it difficult to process joint claim. The study found a significant relationship between systems availability and delay in payment of health insurance claims. In line with these findings, Kiana (2010) determined that ineffective IT governance and control is likely to be the main cause of the negative experiences many organizations and especially insurance firms have had with the use of IT, including lost business, damaged reputations, weakened competitive position, inability to meet deadlines, failed or aborted projects, budget overruns and poor returns on investments.

The findings of the study agree with the findings obtained by Sodzi-Tettey et al. (2012) who determined that technical challenges from the provider's perspective usually result in the rejection of unverifiable claims mainly as a result of poor filing systems resulting in missing folders of treated clients. Sodzi-Tettey et al. (2012) also agrees that claims forms were often incompletely filled especially portions on claim number and procedures done. In line with the findings of the study, Drechsler and Jutting (2005) determined that only few countries have steadily recorded and collected data on their health systems. Kiana (2010) also agrees with the findings when he determined that claims managers need to maximize the use of information technology, in order to reduce claims processing cycle, thus enhancing efficiency and customer satisfaction.

5.2.3 Laws and Regulation and Payment of Private Health Insurance Claims

The study determined that that the respondents agreed that the existing laws on claims are not exhaustive on the award of claim damages concerning the delays; the claim processing methods are not clearly defined in the laws thus leaving the insurance firms with discretion hence the delay and that the depreciation procedure adopted by the insurance firms are not standard thus difficulty in obtaining common rates at times of claim. In addition, the respondents strongly agreed that there is need for merging the organizational regulations with those of the country. Further, the respondents agreed that the existing laws and regulations have lots of weaknesses that give room for delay of payment of health insurance claims. The study found a significant relationship between laws and regulation and delay in payment of health insurance claims.

The findings agree with those earlier posited by Kumaranayake (1998) who determined that even with an institutional framework in place, regulation was a critical issue as the implementation of adequate legislation was costly; that is regulation induced transaction costs were estimated to account for 30% of the total premium revenue in Chile.

The findings of the study are similar to the findings of Drechsler and Jütting (2005) who determined that the need for regulation is not only fueled by potentially negative outcomes of the private insurance industry; regulation may be equally important. Orszag and Emanuel (2010) also agrees with the findings when he determined that eliminating unnecessary costs in the system including fraud/abuse of programs, developing cost effective plans lower in premium and investment is crucial. Further, Victora et al., (2011) observed that the existing laws and regulations for insurance industry players are not adequate and require reviews particular with respects to claims processing.

5.2.4 Insurance Fraud and Payment of Private Health Insurance Claims

The study determined that the respondents agreed that insurance and health staff collusion is the main cause of insurance fraud thus delays in insurance claims, lodging of non-existing claims is the main cause of delay in processing of insurance claims and that overstatement of claims is a key factor that promotes the delay in insurance claims. The respondents also agreed that there is no slow claim settlement to avoid increase in the overall claim cycle time; there are weak underwriting standards in the firm which form the highest challenge in management of general insurance claims and that usually, delay in reporting a claim and high work load of staff are the main factors contributing to delay in claim payment. The respondents strongly agreed that there

is no hasty claim settlement in the firm to avoid increased fraud-related. The study also determined that the respondents agreed that the cases of double payment of claims usually prompt the insurance company to order for investigations on huge claims hence the delay in insurance claims and that that missing claim files is also a serious contributor to the delay in the insurance claims. The study found a significant relationship between insurance fraud and delay in payment of health insurance claims.

The findings of the study are dissimilar to the findings posited by Mohapatra and Tiwari (2009) who determined that the claims function involves speedy and effective handling of claims, while at the same time guarding against fraud. The findings agree with those obtained by Kiana (2010) who found out that weak underwriting standards form the highest challenge in management of general insurance claims in Kenya. At the same time, there is a high level of fraud in the Kenyan general insurance industry.

Cole and McCullough (2014) agree with the findings of the study that the barriers and challenges facing insurance fraud investigators include claims departments finding it necessary to investigate, since if a fraudulent claim is paid, the insurer loses a lot of money to fraudsters. There is also missing files during investigations. This may result to increase in premiums, which affects both the good and bad customers. In addition, if a fraudster gets away with the act, he may be tempted to continue this practice in the future.

5.3 Conclusions

Based on the findings obtained in the study, the study made the following conclusions;

The study concluded that that the information available in the policy claim process was un-clear and could not be easily understood when filling in the claim forms; and that the documentation processes in claims were too much thus people submitted incomplete claim documents. This was attributed to delays in the payment of private health insurance claims.

The study also concluded that the hospitals had not adopted an integrated IT system to enhance claim processing and that systems failure in hospitals often led to loss of claim data that led to delay in claims processing.

In addition, the study concluded that the claim processing methods were not clearly defined in the laws thus leaving the insurance firms with discretion and that the existing laws and

regulations had lots of weaknesses that gave room for delay of payment of health insurance claims.

Finally, the study concluded that there were weak underwriting standards in the firms which formed the highest challenge in management of health insurance claims and that delay in reporting a claim and high work load of staff were the main factors contributing to delay in claim payments.

5.4 Recommendations

Based on the findings and conclusions of the study, the following recommendations for improvement and future studies were made.

5.4.1 Recommendations on Improvements

Based on the objectives of the study, the following recommendations for improvement were made in the study.

5.4.1.1 Internal Industry Practices and Payment of Private Health Insurance Claims

The lack of a universally agreed loss calculation standard among insurance companies is an issue and the study recommends investment of time and resources into this area. Further, the study recommended that the claims managers should delegate responsibilities within the department in a way that decisions are made competent and experienced staff

5.4.1.2 Systems Availability and Payment of Private Health Insurance Claims

The study also recommends that the implementation of standard accounting system for effective processing of claims for all insurance companies and the hospitals. This should be complemented by an integrated IT system to enhance claim processing.

5.4.1.3 Laws and Regulation and Payment of Private Health Insurance Claims

The study recommends harmonization the organizational regulations with those of the country. Further, the existing laws and regulations require review in order to seal loopholes and complement the health insurance claims process. This will contribute in reducing delay of payment of health insurance claims.

5.4.1.4 Insurance Fraud and Payment of Private Health Insurance Claims

The study recommends implementation of stronger measures to deal with fraud. This will be on the in addressing all recommendations above namely, industry practices, laws and regulations and front and improvement of systems. A reduction in fraud will have the most significance in reduction of payment delays of insurance claims.

5.4.2 Areas for Further Research

This study collected data from members of the hospital and insurance companies who are engaged in the day to day running processing of insurance claims. This limited the study to one group of respondents who gave feedback to the study. The study only measured the viewpoints of the members only; therefore, the views of the customers or clients who file insurance claims were not considered. The researcher therefore recommends that other studies be conducted on the same subject area using the views of clients of the firms.

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APPENDICES

Appendix I: Questionnaire

My name is Stanley Ngure Ndonga, I am a student of Masters in Business Administration. As part of my academic requirement at Strathmore University, I am conducting a research on the determinants of delays in the payments of private health insurance claims in Kenya. kindly provide your response as requested and the information provided shall be used purposely for research work and no one shall be victimized for any kind of repose given as the response obtained shall be treated as anonymous and with utmost confidentiality level.

Part A: General Information

Please give your answers to each of the following questions. Read all the answers first and choose the appropriate answer box by ticking (√) clearly or circling against one item for each question.

1. Please select your age range:

20-30	30-39	40-49	50-59	60 and above

2. Kindly indicate your gender

Male	
Female	

3. How long have you worked in your current organization? Please tick against the right response:

1 year or lower	
2-4 years	
3-5 years	
6 - 8 years	
9 years or more	

4. What is your highest level of education?
   - Secondary [ ]
   - Diploma [ ]
   - Bachelor's Degree [ ]
   - Master's Degree [ ]
   - PhD [ ]
   - Other [ ]

PART B: INFLUENCE OF INTERNAL INDUSTRY PRACTICES ON THE PAYMENT OF PRIVATE HEALTH INSURANCE CLAIMS

5. By ticking in the space provided, indicate your consideration to the influence of internal industry practices on the payment of private health insurance claims in Kenya

5 – Strongly agree 4 – Agree 3 – Neutral 2 - Disagree 1 – Strongly Disagree

	1	2	3	4	5
All the information contained in the policy process is very un-clear and cannot easily be read by anyone filling in the forms					
The documentation process in claims are too much for one that do make people submit incomplete documents for claims					
The claim payment method adopted by the insurance is not favorable to everyone as some people do not meet their conditions					
The claim investigation process is not clear and often leads to delay in claim processing					
The price list adopted by the insurance in settling claims is usually outdated and does not reflect the true value of the compensation					
There is not universally agreed standard for business calculation					
The claims manager delegates responsibilities within the department in a way that decisions with serious ramifications are left to inexperienced or incompetent staff					
When the claims staff leave employment, they are usually replaced by inexperienced persons and the process of replacements delays the payments of the claims.					

6. Do you agree with the statement that the failure by the insurance firms to price in the specialty items do bring in delays in payment of insurance claims?

Yes [ ] No [ ]

Explain……

…….

7. There is a serious bureaucracy in the claim processing that has led to delays in the payment of insurance claims

Yes [ ] No [ ]

Explain……

…….

8. What other internal industry practices promote the delay in payment of private health insurance claims in your organization?

……

……..……

……

……

PART C: INFLUENCE OF SYSTEMS AVAILABILITY ON THE PAYMENT OF PRIVATE HEALTH INSURANCE CLAIMS

9. By ticking in the space provided, indicate your consideration to the influence of systems availability on the payment of private health insurance claims in Kenya

5 – Strongly agree 4 – Agree 3 – Neutral 2 - Disagree 1 – Strongly Disagree

	1	**2**	**3**	**4**	**5**
There is insufficient insurance staff at the hospitals for effective claim processing					
The insurance and the hospitals do not have standard accounting system for effective implementation of claims					
The insurance and the hospitals have not adopted an integrated IT system to enhance claim processing					
Systems failure in hospitals often leads to loss of claim data that leads to delay in claims processing					
Most insurance companies in Kenya are operating in different platform of systems that make it difficult to process joint claim					

10. The weak and poor systems in hospitals and insurance companies in Kenya often leads to delay in insurance claims

Yes [ ] No [ ]

Explain……

…….

11. What other internal systems availability factors affect payment of private health insurance claims in your organization?

……

……..……

……

PART D: INFLUENCE OF LAWS AND REGULATION ON THE PAYMENT OF PRIVATE HEALTH INSURANCE CLAIMS

12. By ticking in the space provided, indicate your consideration to the influence of laws and regulation on the payment of private health insurance claims in Kenya

5 – Strongly agree 4 – Agree 3 – Neutral 2 - Disagree 1 – Strongly Disagree

	1	**2**	**3**	**4**	**5**
The existing laws on claims are not exhaustive on the award of claim damages concerning the delays					
The claim processing methods are not clearly defined in the laws thus leaving the insurance firms with discretion hence the delay					
The depreciation procedure adopted by the insurance firms are not standard thus difficulty in obtaining common rates at times of claim					
There is need for merging the organizational regulations with those of the country					

13. The existing laws and regulations have lots of weaknesses that give room for delay of payment of health insurance claims

Yes [ ] No [ ]

Explain……

…….

14. What other laws and regulation factors affect payment of private health insurance claims in your organization?

……
……..……
……

PART E: INFLUENCE OF INSURANCE FRAUD ON THE PAYMENT OF PRIVATE HEALTH INSURANCE CLAIMS

15. By ticking in the space provided, indicate your consideration to the influence of insurance fraud on the payment of private health insurance claims in Kenya

5 – Strongly agree 4 – Agree 3 – Neutral 2 - Disagree 1 – Strongly Disagree

	1	2	3	4	5
Insurance and health staff collusion is the main cause of insurance fraud thus delay in insurance claims					
Lodging of non-existing claims is the main cause of delay in processing of insurance claims					
Overstatement of claims is a key factor that promotes the delay in insurance claims					
There is no hasty claim settlement in the firm to avoid increased fraud-related costs.					
There is also no slow claim settlement to avoid increase in the overall claim cycle time					
There are weak underwriting standards in the firm which form the highest challenge in management of general insurance claims					
Usually, delay in reporting a claim and high work load of staff are the main factors contributing to delay in claim payment.					

16. The cases of double payment of claims usually prompt the insurance company to order for investigations on huge claims hence the delay in insurance claims

Yes [ ] No [ ]

Explain……

…….

17. Missing claim files is also a serious contributor to the delay in the insurance claims

Yes [ ] No [ ]

Explain……

…….

18. What other insurance fraud factors affect payment of private health insurance claims in your organization?

……

……..……

……

……

PART F: DELAY IN PAYMENT OF PRIVATE HEALTH INSURANCE CLAIMS

19. Are there delays in the payment of private health insurance claims?

	1	**2**	**3**	**4**	**5**
Majority of claims we process are made within 30 days					
Most of the claim processing usually take 30-60 days					
Most of the claim processing usually take 60-90 days					
Most of the claim processing usually take 90-120 days					
Most of the claim processing usually take more than 120days					

Appendix II: Big Private Hospitals

1. Aga Khan University Hospital
2. Nairobi Women Hospital
3. Moi Teaching and Referral Hospital
4. Gertrude Gardens Children's Hospital
5. Kenyatta National Hospital
6. Kijabe Mission Hospital
7. The Mater Hospital
8. Nairobi Hospital
9. Aga Khan Hospital – Mombasa
10. P C E A Kikuyu Hospital
11. Coptic Church Nursing
12. Nairobi West Hospital
13. Karen Hospital
14. MP Shah Hospital
15. Avenue Hospital

Appendix III: Top Ten Insurance Companies and Hospitals in Kenya

1. Jubilee Insurance
2. CIC Insurance
3. APA insurance
4. CFC Life Assurance Company
5. Blue shield insurance company
6. Pan Africa Life Insurance
7. British American Insurance
8. Insurance Company of East Africa
9. Pioneer Assurance Company
10. Kenindia Assurance Company
11. Madison Insurance Company of Kenya
12. Old Mutual Insurance Company
13. Geminia Insurance Limited
14. ICEA Lion
15. Liberty