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Insurer–provider contractual relationships and perceived healthcare service quality in Kenya.

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INSURER–PROVIDER CONTRACTUAL RELATIONSHIPS AND PERCEIVED HEALTHCARE SERVICE QUALITY IN KENYA

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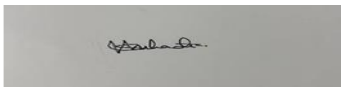
DECLARATION

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

Scarlet Muhadia



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ABSTRACT

The private health insurance sector in Kenya plays a growing role in enhancing access to healthcare, yet its effectiveness depends largely on the quality of relationships between insurers and healthcare providers. Despite constitutional guarantees of the right to health, insured clients frequently encounter service delays, contractual disputes, and weak communication mechanisms that compromise service quality. This study investigated the impact of insurer-provider contractual relationships on clients' perceptions of healthcare service quality in private health facilities across selected urban and peri-urban counties in Kenya. Anchored on the Gaps Model of Service Quality and the Donabedian Model of Healthcare Quality, the study will examine three sets of variables: terms and enforcement of insurer-provider contracts, the efficiency of communication and coordination mechanisms, and the timeliness of claims reimbursement and dispute resolution. Using a cross-sectional correlational design, data were collected from insured clients, private medical insurers, and facility administrators through structured questionnaires and key informant interviews. SPSS version 31 was used to compute descriptive and inferential statistics, while qualitative data were analyzed thematically. The findings revealed that insurer-provider contractual relationships have a positive and statistically significant influence on perceived healthcare service quality. Communication and coordination mechanisms had the strongest positive influence on healthcare quality ($\beta = .578$, $p < 0.01$), followed by insurer-provider contractual arrangements ($\beta = .472$, $p < 0.01$), and timeliness of claims reimbursement and dispute resolution ($\beta = .157$, $p < 0.05$). The three predictor variables jointly explained 57.7% of the variation in healthcare quality. The study further established that efficient digital communication systems, effective contractual enforcement, and timely reimbursement processes improve service responsiveness, reliability, and patient satisfaction, while reimbursement delays and contractual inefficiencies negatively affect continuity of care and operational efficiency within healthcare facilities. The study concludes that insurer-provider contractual relationships significantly influence healthcare service quality in Kenya, whereby communication and coordination mechanisms has the strongest effect, followed by contractual arrangements and reimbursement and dispute resolution processes. Based on the findings, the study recommends strengthening contractual enforcement frameworks, enhancing adoption of integrated digital communication and claims management systems, improving transparency in reimbursement processes, and institutionalizing efficient dispute resolution mechanisms in order to improve healthcare service quality and patient satisfaction within Kenya's private healthcare sector.

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LIST OF ABBREVIATIONS

IERC	Institutional Ethics Review Committee (Strathmore University)
IRA	Insurance Regulatory Authority
KES	Kenya Shillings
KIPPRA	Kenya Institute for Public Policy Research and Analysis
MIP(s)	Medical Insurance Provider(s)
NACOSTI	National Commission for Science, Technology, and Innovation
NHIF –	National Hospital Insurance Fund
SERVQUAL	Service Quality (Service Quality Measurement Model)
SPSS	Statistical Package for the Social Sciences
USD	United States Dollar
WHO	World Health Organization

DEFINITION OF KEY TERMS

Insurer–Provider Relationships

Insurer–provider relationships refer to the formal and informal interactions between medical insurance companies (insurers) and healthcare facilities (providers) that shape care delivery, reimbursement arrangements, and service coordination. These relationships are structured exchanges where the provider acts as supplier and the insurer as purchaser of health services (Côté, 2003).

Contractual Arrangements

Contractual arrangements are legally binding agreements between insurers and healthcare providers that outline the scope of services, reimbursement mechanisms, performance expectations, and dispute resolution procedures. Such contracts determine the level of reimbursement, the range of services, and quality obligations between providers and payers (Mühlbacher & Juhnke, 2018)

Communication and Coordination Mechanisms

Communication and coordination mechanisms refer to the systems and processes through which insurers and providers share information, authorize services, and coordinate care. These include collaborative frameworks that promote transparency, case management, and integrated care (American Hospital Association [AHA], 2020).

Claims Reimbursement

Claims reimbursement refers to the process through which insurers compensate healthcare providers for services delivered to insured clients. It is a core element of the third-party payer system, defining how financial transactions occur between insurers and providers following the delivery of care (Little Health Law, 2023).

Dispute Resolution Mechanisms

Dispute resolution mechanisms are formal or informal procedures established to resolve conflicts between insurers and providers over issues such as claims payment, coverage scope, or service authorization. They may involve arbitration, mediation, or independent review to ensure fairness in contractual relations (Centers for Medicare & Medicaid Services [CMS], 2023).

Clients' Perceptions of Service Quality

Clients' perceptions of service quality are subjective evaluations by insured individuals regarding the adequacy, reliability, and overall quality of healthcare services accessed under insurance coverage. In healthcare, service quality is an intangible construct assessed through patients' personal experiences and satisfaction (Strauss et al., 2022).

Service Quality Dimensions (SERVQUAL)

Service quality is examined using the SERVQUAL model, a multidimensional framework developed by Parasuraman, Zeithaml, and Berry. It captures clients' perceptions of service

performance across five core dimensions: reliability, responsiveness, assurance, empathy, and tangibles (Christia, 2021).

Donabedian Model

The Donabedian Model provides a conceptual framework for assessing healthcare quality through three interrelated components: structure, process, and outcomes. Improvements in structural quality are expected to enhance processes of care and ultimately improve patient outcomes (Donabedian, 1988; Moore, 2015).

Health Insurance Uptake

Health insurance uptake refers to the extent to which individuals or households enroll in and utilize private or public health insurance. It reflects the participation of populations in insurance programs and the effectiveness of health-financing schemes (James et al., 2022).

Regulatory Environment

The regulatory environment denotes the institutional, legal, and policy framework governing the operations of health insurance in Kenya. It includes oversight by the Insurance Regulatory Authority (IRA), the Ministry of Health, and constitutional provisions such as Article 43(1), which guarantees every Kenyan the right to the highest attainable standard of health (Republic of Kenya, 2010

CHAPTER ONE

INTRODUCTION TO THE STUDY

1.1 Introduction

Chapter One provides the foundation of the study by examining how insurer–provider contractual relationships influence clients' perceptions of healthcare service quality in Kenya's private health sector. It introduces the background on Kenya's evolving health insurance landscape, outlines the problem of weak insurer–provider coordination, and presents the study's objectives and research questions. The chapter emphasizes the study's significance in improving accountability, service reliability, and policy development. It further defines the study's scope across urban and peri-urban counties, highlighting methodological boundaries, while acknowledging limitations such as geographic concentration, reliance on self-reported data, confidentiality restrictions, and cross-sectional design constraints.

1.2 Background of the Study

1.2.1 Introduction: Universal Health Coverage and Healthcare as a Driver of Development

Health is a fundamental human right and a critical driver of social and economic development. Globally, the pursuit of Universal Health Coverage (UHC), which seeks to ensure that all individuals access needed health services without financial hardship, remains central to achieving Sustainable Development Goal 3 on good health and well-being. Effective health systems improve population welfare, enhance productivity, reduce poverty, and contribute to inclusive economic growth. Consequently, healthcare is increasingly viewed not merely as a social service but as an investment in human capital and national development. Strengthening healthcare financing and expanding health insurance coverage are therefore essential to

achieving both national and global health objectives.

Access to healthcare is founded on three interrelated dimensions: coverage, quality, and financial risk protection. Coverage entails the availability and accessibility of essential preventive, curative, and rehabilitative services. Quality ensures that healthcare services are safe, effective, and responsive to patient needs, while financial risk protection prevents households from suffering catastrophic health expenditures through insurance and prepayment mechanisms. These dimensions are mutually reinforcing and collectively underpin the realization of UHC.

Kenya operates a pluralistic health system involving public, private, and development partners in healthcare financing and service delivery. Since the late 1980s, private sector participation has expanded due to declining public resources and growing demand for healthcare services, resulting in increased utilization of private facilities and the emergence of private health insurance (Muthaka, 2004; Muthaka, 2005). Health insurance enables individuals and households to pool risks and resources to finance healthcare costs, thereby reducing out-of-pocket expenditures and improving access to services (World Health Organization, 2017; Munguti, 2020; Bruce, 2020). Prepayment schemes have become particularly important among Kenya's growing middle class (Beryl et al., 2022).

Kenya's health financing system has evolved from largely free healthcare in the 1960s and 1970s to cost-sharing arrangements introduced in 1989 under Structural Adjustment Programmes. These reforms encouraged private sector participation and the growth of private health insurance providers (Muthaka et al., 2004). Following regulatory reforms under the Finance Act of 2010, private medical insurance became a formally regulated industry, with approximately 45 accredited providers by 2025 (IRA, 2025). However, challenges persist, including delayed claims reimbursement, contractual disputes, weak purchaser–provider

relationships, and inefficiencies in claims management systems, all of which affect service quality and client satisfaction (IRA, 2024; Ministry of Health, 2023; Chepchirchir, Siele, & Kemboi, 2024; Mohamoud & Mash, 2020). The continued growth of private insurance has also been driven by longstanding inefficiencies within public insurance schemes such as NHIF, including delayed payments and administrative challenges (Kariuki & Koori, 2005).

Globally, the relationship between health insurers and healthcare providers has emerged as a critical determinant of healthcare service quality and the achievement of Universal Health Coverage (UHC). As countries increasingly adopt insurance-based financing mechanisms to enhance access and financial risk protection, effective contractual arrangements between purchasers of healthcare services and providers have become essential for ensuring efficiency, accountability, and quality of care. Studies from both developed and developing countries indicate that well-structured insurer–provider contracts facilitate timely reimbursement, improve provider performance, enhance patient satisfaction, and promote continuity of care. Conversely, weak contractual relationships characterized by delayed payments, disputes over claims, inadequate communication, and unclear contractual obligations often result in service disruptions, reduced provider commitment, and poor patient experiences (World Health Organization, 2023). Consequently, strengthening insurer–provider relationships has become a major policy concern in health systems seeking to improve service quality while containing healthcare costs.

At the regional level, many African countries have expanded health insurance schemes as part of broader health financing reforms aimed at achieving UHC. Countries such as Ghana, Rwanda, South Africa, and Kenya have introduced various public and private insurance models to improve healthcare access and reduce out-of-pocket expenditures. However,

evidence from Sub-Saharan Africa suggests that contractual challenges between insurers and healthcare providers continue to undermine the effectiveness of these schemes. Delayed reimbursement of claims, weak monitoring mechanisms, inadequate dispute resolution systems, and information asymmetries have been reported as common challenges affecting service delivery and client satisfaction. In Ghana's National Health Insurance Scheme, for example, reimbursement delays have been linked to reduced provider participation and compromised quality of care, while similar experiences have been documented in Rwanda and South Africa. These challenges highlight the growing importance of insurer–provider contractual relationships in shaping perceptions of healthcare quality across the region.

In Kenya, the expansion of private health insurance and the ongoing transition toward the Social Health Insurance Fund (SHIF) have intensified interactions between insurers and healthcare providers. While private insurance has played a significant role in improving access to healthcare among insured populations, concerns persist regarding delayed claims settlement, authorization procedures, contractual disputes, and communication gaps between insurers and healthcare facilities. These challenges have direct implications for healthcare service quality, influencing waiting times, treatment continuity, provider responsiveness, and patient satisfaction. Despite the increasing importance of private health insurance within Kenya's healthcare financing landscape, limited empirical attention has been given to how insurer–provider contractual relationships shape clients' perceptions of healthcare service quality. It is against this background that this study seeks to examine the influence of insurer–provider contractual relationships on perceived healthcare service quality in Kenya, with a view to generating evidence that can inform policy and practice in the health insurance sector.

1.3 Statement of the Problem

Private health insurance plays an increasingly important role in Kenya's healthcare financing system, particularly among urban and middle-income populations seeking access to private healthcare services. However, despite the growth of the private medical insurance sector to approximately 45 licensed providers by 2025, coverage remains limited to only about 3–4% of the national population, representing an estimated 1.5–2.0 million beneficiaries out of Kenya's 51.5 million people (IRA, 2024; IRA, 2025). Given this relatively small insured population, the effectiveness and sustainability of private health insurance depend heavily on the quality of relationships between insurers and healthcare providers. Any inefficiencies within these relationships directly affect healthcare access, continuity of care, and patient experiences among insured clients.

Recent evidence suggests that insurer–provider contractual relationships in Kenya continue to face significant operational challenges. The Insurance Regulatory Authority (IRA, 2024) identifies delayed claims reimbursement, contractual disputes, and weak coordination between insurers and healthcare providers as persistent sector-wide concerns. Similarly, the Ministry of Health's Kenya Health Financing Strategy Review (2023) reports that weak contract enforcement mechanisms and fragmented claims management systems continue to undermine service responsiveness and reliability in privately insured healthcare. Empirical evidence further indicates that reimbursement delays and contractual disagreements often result in service denial, longer waiting times, requests for additional out-of-pocket payments, and reduced willingness among providers to serve insured clients (Chepchirchir, Siele, & Kemboi, 2024). These challenges not only compromise service delivery but also undermine public confidence in private health insurance as a mechanism for achieving equitable access to quality healthcare.

Despite growing concern regarding the effects of insurer–provider interactions on healthcare outcomes, existing studies in Kenya have largely focused on health insurance coverage, financial protection, healthcare utilization, or provider performance in isolation. Limited empirical attention has been given to how specific insurer–provider contractual relationship dimensions, including contract enforcement, claims reimbursement processes, communication and coordination mechanisms, and dispute resolution systems, influence clients' perceptions of healthcare service quality. Consequently, there remains insufficient Kenya-specific evidence linking contractual arrangements to perceived service quality outcomes such as responsiveness, reliability, availability, and overall patient satisfaction. This knowledge gap constrains policymakers, regulators, insurers, and healthcare providers from designing evidence-based interventions to strengthen purchaser–provider relationships and improve service quality. The study therefore seeks to examine the influence of insurer–provider contractual relationships on perceived healthcare service quality in Kenya in order to generate empirical evidence for policy, regulatory, and managerial decision-making toward the realization of Universal Health Coverage.

1.4 Research Objective

1.4.1 Main Objective

To examine the relationship between insurer-provider contractual arrangements and clients' perceptions of healthcare service quality in private health facilities in Kenya.

1.4.2 Specific Objectives

i. To assess the relationship between the terms and enforcement of insurer-provider contracts and clients' perceptions of the availability and reliability of healthcare services in Kenya.

ii. To analyze the relationship between communication and coordination mechanisms between insurers and providers and clients' perceptions of healthcare service responsiveness.

iii. To examine the relationship between the timeliness of insurance claims reimbursement and dispute resolution mechanisms and clients' perceptions of healthcare service quality in Kenya

1.4.3 Research Questions

i. How do the terms and enforcement of insurer–provider contracts influence clients' perceptions of the availability and reliability of healthcare services in Kenya?

ii. How do communication and coordination mechanisms between insurers and healthcare providers shape clients' perceptions of healthcare service responsiveness in Kenya?

iii. How do claims reimbursement processes and dispute resolution mechanisms affect clients' perceptions of healthcare service quality in Kenya

1.5 Significance of the Study

This study deepens the understanding of how contractual relationships between private health insurers and providers affect the quality of care perceived by clients in Kenya. Specifically, the study focuses on three critical variables, the terms and enforcement of insurer-provider

contracts, the effectiveness of communication and coordination mechanisms, and the timeliness of claims reimbursement and dispute resolution.

By assessing how the variables influence client access to, satisfaction with, and trust in healthcare, the study offers insights into the operational dynamics shaping private health insurance delivery. The findings will be instrumental in informing the design and refinement of insurer-provider agreements, ensuring that contracts are clear, enforceable, and aligned with client-centred service delivery goals. The study will also shed light on the importance of streamlined communication and coordination practices between insurers and providers as a pathway to improving responsiveness and continuity of care. It will also highlight how delays in claims processing and unresolved disputes can undermine client confidence and compromise service quality.

The outcomes of this study is of practical value to health policymakers, insurance regulators, private insurers, and healthcare providers by providing actionable recommendations to enhance contractual compliance, foster mutual accountability, and strengthen the overall efficiency and quality of health service delivery in Kenya's private health sector.

1.6 Scope of the Study

1.6.1 Thematic Scope

The study focused on insurer–provider contractual relationships and their influence on clients' perceptions of healthcare service quality within Kenya's private health insurance sector. Specifically, the study examined four key dimensions of insurer–provider contractual relationships: contract terms and enforcement, communication and coordination mechanisms, claims reimbursement processes, and dispute resolution mechanisms. These dimensions were

analyzed in relation to healthcare service quality outcomes, including service availability, reliability, responsiveness, and overall client satisfaction. The focus on these variables was informed by their prominence in health financing literature and their direct relevance to contemporary challenges reported within Kenya's private health insurance sector.

1.6.2 Geographic Scope

The study was conducted in Nairobi and Kakamega Counties, representing urban and peri-urban contexts within Kenya's evolving private health insurance landscape. Nairobi was selected due to its high concentration of insurers, private healthcare providers, and insured populations, making it a suitable setting for examining mature insurer–provider contractual arrangements. Kakamega was selected because it represents a growing peri-urban market where private health insurance uptake and private healthcare provision are expanding but institutional arrangements remain comparatively less developed.

The inclusion of these contrasting settings enabled the study to capture variations in insurer–provider interactions across different market and service delivery environments while maintaining comparability within regions where private health insurance plays a significant role. The study did not include predominantly rural counties because private health insurance penetration remains relatively low in such areas and healthcare utilization patterns are largely influenced by public sector provision. Consequently, the findings are intended to provide insights into insurer–provider contractual relationships within urban and peri-urban private healthcare contexts and should be interpreted within these settings.

1.6.3 Periodic Scope

The study examined insurer–provider interactions and clients' experiences during the twelve months preceding data collection. This period was considered appropriate for capturing recent

contractual practices, service delivery experiences, and emerging trends within Kenya's private health insurance sector, particularly during a period of ongoing health financing reforms. The study relied on data collected from insured clients, healthcare providers, and insurers through questionnaires, interviews, and document reviews to facilitate triangulation and enhance the robustness of findings.

1.7 Limitations of the Study

This study was conducted in Nairobi and Kakamega Counties and therefore reflects insurer–provider contractual relationships and client perceptions within urban and peri-urban contexts characterized by relatively higher levels of private health insurance utilization. While these settings provide valuable insights into Kenya's private health insurance sector, the findings should be interpreted with caution when considering rural counties, where healthcare delivery systems, insurance penetration, provider networks, and client experiences may differ substantially. Consequently, the study's conclusions are most applicable to comparable urban and peri-urban settings rather than the entire national health system.

The study relied primarily on self-reported data obtained from insured clients, healthcare providers, and insurance personnel. Although such perceptions are central to understanding healthcare service quality, responses may have been influenced by recall limitations, personal experiences, or organizational interests. As a result, the findings reflect respondents' perceptions of contractual relationships and service quality rather than objective measurements of contractual performance or clinical outcomes. This distinction is important when interpreting the study's conclusions.

Access to insurer–provider contracts, claims reports, and other proprietary institutional records was constrained by confidentiality requirements. Consequently, the study was unable

to independently verify all contractual processes and instead relied on available documentation and stakeholder accounts. While triangulation enhanced the credibility of findings, the absence of unrestricted access to contractual records may limit the extent to which specific contractual provisions can be linked to observed service quality outcomes.

Finally, the cross-sectional design captured insurer–provider relationships and client experiences within a defined 12-month period. The findings therefore provide a snapshot of prevailing conditions during the study period and may not fully capture the long-term effects of ongoing health financing reforms, regulatory changes, or evolving insurer–provider arrangements. Future longitudinal studies may be necessary to assess how contractual relationships and perceptions of service quality change over time.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

Chapter Two presents the study's theoretical foundations and a synthesis of empirical literature on insurer–provider relationships and client perceptions of service quality. It begins by outlining the theoretical framework, anchored on the Gaps Model of Service Quality and the Donabedian Model of Healthcare Quality, which together explain how structural, process, and perceptual factors influence service quality outcomes. The chapter then reviews empirical studies addressing insurer–provider contracts, communication and coordination mechanisms, and claims reimbursement processes, linking them to client satisfaction and service delivery performance. It further identifies existing research gaps, emphasizing the limited integration of insurer, provider, and client perspectives in Kenyan studies. Finally, the chapter presents the conceptual framework, illustrating the hypothesized relationships between the independent, dependent, and moderating variables guiding this study

2.1 Theoretical Framework

This study is anchored on the Gaps Model of Service Quality and the Donabedian Model of Healthcare Quality. The two provide a helpful lens for examining insurer–provider relationships and how they shape client perception of health service quality in Kenya. While the Gaps Model looks at the expectation–perception schism in the context of quality, the Donabedian Model provides an analytic lens that enables a systematic exploration of the different domains of quality, being, structure, process, and outcome. Applying the two allows the study to examine clients' subjective views on one hand and obtain insights on how the

subjective perceptions of clients vary across the objectively defined healthcare quality domains.

2.1.1 The Gaps Model of Service Quality

The Model posits that service quality results from the alignment (or misalignment) between customer expectations and actual service experiences. The model identifies five critical gaps that hinder service quality, being, the Knowledge Gap, Standards Gap, Delivery Gap, External Communication Gap, and the Expectation–Perception Gap‖ (Parasuraman et al., 1985; Mauri et al., 2013). These gaps illustrate how managerial perceptions, operational inefficiencies, and communication failures create a schism between what clients expect and what they experience.

The Gaps Model's relevance stems from the study's underlying hypothesis that insurer–provider relationship shape client experiences. For instance, unclear or poorly enforced contractual terms between insurers and providers could create a Standards Gap, as providers may deliver services below what clients expect under their cover (Kariuki & Koori, 2025). Similarly, delays in claims processing may generate a Delivery Gap, as promised services are not delivered on time. The External Communication Gap may also emerge where insurers advertise comprehensive coverage, yet clients encounter hidden exclusions during treatment (Tindyebwa et al., 2023).

The SERVQUAL tool, developed within this model, operationalizes service quality into five measurable dimensions: tangibility, reliability, responsiveness, assurance, and empathy (Souca, 2011; Parasuraman et al., 1988). In this study, these dimensions will be used to assess how clients perceive the effectiveness of insurer–provider contracts, the responsiveness of

communication and coordination mechanisms, and the assurance and reliability of claims reimbursement systems. For example, *reliability* can capture whether services promised in insurance contracts are consistently delivered, while *responsiveness* measures timeliness in resolving claims and disputes. The Model provided a diagnostic tool for identifying where insurer–provider interactions fail to meet client expectations and how these failures shape perceptions of service quality.

2.1.2 The Donabedian Model of Healthcare Quality

The Donabedian Model complements the Gaps Model by situating healthcare quality within the three interdependent dimensions of structure, process, and outcome (Donabedian, 1988; Ibn El Haj, Lamrini, & Rais, 2013). Structure in the Donabedian model refers to the relatively stable attributes of the care environment, including facilities, equipment, staffing, and institutional arrangements (Donabedian, 1997; Garnerin, 2001). In the context of this study, insurer–provider contracts form a critical part of the structural dimension by defining the scope of services, provider networks, and authorization procedures available to clients. Well-structured contracts determine whether clients can access a wide range of facilities and services without financial or procedural barriers. For example, contracts that clearly stipulate coverage limits, reimbursement timelines, and dispute resolution mechanisms create predictability and accountability, thereby strengthening structural quality. Conversely, weak or ambiguous contractual terms may restrict service availability, limit provider participation, or lead to frequent conflicts, which erode clients' trust in the insurance system. By examining these contractual structures, this study will assess how the foundational arrangements between insurers and providers shape the accessibility and reliability of healthcare services delivered under insurance cover.

Process refers to the actual activities involved in care delivery, encompassing both technical and interpersonal dimensions (Ransom et al., 2005). The technical dimension involves the accuracy, timeliness, and appropriateness of medical interventions, while the interpersonal dimension relates to clinician–patient communication, respect, empathy, and shared decision-making. In this study, insurer–provider communication mechanisms and claims handling systems fall squarely within the process dimension. Efficient claims processing, transparent communication about benefit entitlements, and coordination between insurers and providers are critical for ensuring smooth service delivery. Failures in these processes— such as delayed authorizations, lack of clarity in coverage, or bureaucratic hurdles—often lead to long waiting times and client dissatisfaction. On the other hand, well-coordinated processes supported by digital claims systems and responsive communication platforms can improve service efficiency and foster positive client experiences. By focusing on process elements, this study highlights the operational link between insurer–provider dynamics and clients' perceptions of care.

Outcomes represent the effects of healthcare delivery on patients, including health status, client satisfaction, and trust in the healthcare system (Ammenwerth et al., 2007). In this study, outcomes will be primarily captured through clients' perceptions of service quality, measured using the SERVQUAL dimensions of reliability, responsiveness, assurance, empathy, and tangibility. These outcome indicators reflect not only the clinical effectiveness of care but also the subjective experiences of insured clients interacting with healthcare providers under insurance schemes. For instance, timely reimbursement of claims can enhance perceptions of reliability and assurance, while personalized attention and clear communication may improve empathy and responsiveness. Conversely, frequent disputes or service denials due to insurer-

provider conflicts can negatively influence clients' perceptions, even when the technical quality of care is high. By linking structural arrangements and process efficiency to perceived outcomes, the Donabedian model provides a holistic framework for understanding how insurer–provider relationships ultimately shape client satisfaction and confidence in Kenya's private healthcare system.

The Donabedian model is particularly applicable here because it enables the study to trace how insurer–provider arrangements (structure) and their implementation (process) ultimately shape clients' satisfaction and confidence (outcomes). For example, delays in insurer reimbursements (a process issue) may lead to service denial by providers, which negatively affects client satisfaction (an outcome). Conversely, strong contractual enforcement and streamlined claims processes may enhance reliability and assurance, strengthening clients' perceptions of service quality.

2.1.3 Integrating the Two Models

The integration of the Donabedian Model and the Gaps Model provides a clear theoretical basis for explaining how insurer–provider contractual relationships influence clients' perceptions of healthcare service quality. The Donabedian Model conceptualizes healthcare quality through three interrelated dimensions: structure, process, and outcomes. In this study, insurer–provider contractual relationship dimensions constitute the structural and process components of healthcare delivery. Specifically, contract terms and enforcement represent structural arrangements that define obligations, accountability mechanisms, and service expectations between insurers and providers. Communication and coordination mechanisms, claims reimbursement processes, and dispute resolution systems represent process dimensions

through which contractual arrangements are implemented and managed. According to Donabedian, weaknesses in these structures and processes are likely to negatively affect healthcare outcomes.

The Gaps Model complements this perspective by explaining how clients evaluate the quality of services received. The model suggests that perceived service quality is determined by the gap between client expectations and actual service experiences. In the context of this study, deficiencies in contract enforcement, communication and coordination, reimbursement processes, and dispute resolution mechanisms may create service delivery challenges that manifest as reduced service availability, reliability, responsiveness, and overall satisfaction. These outcome dimensions constitute the dependent variable of the study and reflect clients' perceptions of healthcare service quality.

The integration of the two models therefore provides an operational pathway linking the study variables. The Donabedian Model explains how insurer–provider contractual relationship dimensions (independent variables) influence healthcare delivery structures and processes, while the Gaps Model explains how clients interpret the resulting service experiences and form perceptions of quality (dependent variable). Consequently, contract terms and enforcement are expected to influence service availability and reliability; communication and coordination mechanisms are expected to influence service responsiveness; while claims reimbursement and dispute resolution processes are expected to influence overall perceptions of service quality, fairness, and satisfaction. This integrated framework provides a direct theoretical justification for the study variables, research questions, and conceptual framework. The integrated theoretical framework further guides the operationalization of variables, development of data collection instruments, and interpretation of findings. It enables the study to examine not only whether insurer–provider contractual relationships affect perceived

healthcare service quality, but also the mechanisms through which structural and process-related contractual arrangements translate into client experiences and perceptions within Kenya's private healthcare sector.

2.2 Empirical Review

The empirical review that follows is organized thematically to provide a coherent understanding of how insurer–provider relationships influence clients' perceptions of healthcare service quality. It begins by examining evidence on insurer–provider contractual arrangements, focusing on how contract clarity and enforcement affect service availability and reliability. The second part explores communication and coordination mechanisms, highlighting their role in responsiveness and continuity of care. The third theme addresses the timeliness of claims reimbursement and dispute resolution, which shape provider participation and client trust. Finally, the review discusses studies on client perceptions of service quality, analyzed through the SERVQUAL dimensions. This structure allows the review to build progressively from institutional arrangements to operational processes and, ultimately, to client-centered outcomes.

2.2.1 Insurer-Provider Contractual Arrangements and Service Availability

Empirical studies across African health systems generally suggest that the terms and enforcement of insurer–provider contracts significantly influence healthcare service availability and reliability. In Kenya, Kariuki and Koori (2025) found that unclear contractual provisions often generated disputes over coverage limits, resulting in delayed authorizations and denial of services to insured clients. Similarly, Mohamoud and Mash (2020) reported that contractual gaps between private insurers and primary care providers contributed to service

fragmentation and increased out-of-pocket expenditures among insured patients. While both studies support the argument that weak contractual arrangements undermine service delivery, their methodological scope limits broader conclusions. Kariuki and Koori (2025) concentrated primarily on urban private hospitals, whereas Mohamoud and Mash (2020) relied on a relatively small sample of primary care facilities. Consequently, neither study adequately captured variations in contractual relationships across different healthcare settings or examined how clients themselves perceived the resulting service quality outcomes.

Evidence from developed health systems presents a more nuanced perspective. Stolper et al. (2021) found that insurer–provider contracts improved healthcare quality when linked to measurable performance indicators and effective monitoring mechanisms. However, the effectiveness of such contractual arrangements was largely attributed to strong regulatory oversight and mature institutional frameworks. This raises questions regarding the transferability of these findings to low- and middle-income countries such as Kenya, where regulatory capacity, information systems, and enforcement mechanisms may be comparatively weaker. Moreover, while Stolper et al. (2021) demonstrated improvements in organizational performance and service outcomes, the study paid limited attention to patient perceptions, making it difficult to determine whether contractual effectiveness translated into improved client experiences.

Collectively, the reviewed studies demonstrate broad agreement that contract design and enforcement affect healthcare service delivery. However, they differ in their contextual settings, methodological approaches, and outcome measures. Most studies focus on operational efficiency, claims management, or provider performance, with limited attention to how contractual arrangements influence clients' perceptions of service availability and reliability. Furthermore, the literature rarely integrates contract enforcement, communication

mechanisms, reimbursement processes, and dispute resolution frameworks within a single analytical model. This leaves an important empirical gap regarding how multiple dimensions of insurer–provider contractual relationships collectively shape perceived healthcare service quality within Kenya's private health insurance sector, a gap that the present study seeks to address.

2.2.2 Communication and Coordination Mechanisms in Service Delivery

Communication and coordination between insurers and healthcare providers are widely recognized as critical determinants of healthcare service responsiveness and client satisfaction. In Uganda, Tindyebwa et al. (2023) found that inadequate coordination mechanisms frequently resulted in confusion over benefit entitlements, delays in treatment approvals, and prolonged waiting times for insured clients. Similarly, Nkatha, Wanjala, and Machio (2020) reported that weak communication channels between insurers and providers in Kenya contributed to mistrust, misinformation, and underutilization of insurance benefits. While both studies highlight the adverse effects of communication breakdowns on client experiences, their methodological approaches present limitations. Tindyebwa et al. (2023) conducted their study in a context characterized by relatively low insurance penetration, raising questions about the extent to which their findings can be generalized to more mature insurance markets. Likewise, Nkatha et al. (2020) relied predominantly on client self-reported experiences, providing limited insight into the internal communication structures and coordination processes that shape insurer–provider interactions.

However, not all studies portray communication challenges as inevitable. Mohamoud and Mash (2020) found that healthcare facilities utilizing electronic claims systems and real-time communication platforms with insurers recorded higher levels of patient satisfaction and

faster service delivery than facilities dependent on manual systems. These findings suggest that technology-enabled coordination mechanisms may improve service responsiveness and strengthen insurer–provider relationships. Nevertheless, the study focused primarily on primary healthcare clinics, limiting understanding of whether similar outcomes occur in larger private hospitals where service complexity, patient volumes, and contractual arrangements are often more extensive. This indicates that the effectiveness of communication systems may vary across healthcare settings and organizational contexts.

Taken together, the literature demonstrates broad consensus that communication and coordination mechanisms influence healthcare service responsiveness and client experiences. However, existing studies differ in context, level of analysis, and methodological focus. Most concentrate on either client experiences or provider operational efficiency, with limited examination of how communication and coordination processes jointly shape perceived healthcare service quality. Furthermore, few studies have investigated these relationships within Kenya's private health insurance sector while integrating insurer, provider, and client perspectives. This leaves an important empirical gap regarding the extent to which communication and coordination mechanisms between insurers and providers influence clients' perceptions of healthcare service responsiveness, which the present study seeks to address.

2.2.3 Timeliness of Claims Reimbursement and Dispute Resolution

Timely claims reimbursement and effective dispute resolution mechanisms are widely recognized as critical determinants of healthcare service quality and the sustainability of insurer–provider relationships. In Kenya, Muthaka and North (2020) found that delays in insurer payments often compelled healthcare providers to restrict, postpone, or deny services

to insured clients, thereby undermining confidence in private health insurance arrangements. Similarly, Chepchirchir, Siele, and Kemboi (2024) reported that reimbursement inefficiencies discouraged providers from participating in insurance panels, consequently reducing the range of healthcare facilities available to insured clients. While both studies demonstrate the adverse effects of reimbursement delays on service delivery, their analytical focus was largely provider-centered. Muthaka and North (2020) concentrated on large urban hospitals, while Chepchirchir et al. (2024) primarily examined provider experiences, leaving limited understanding of how such reimbursement challenges are perceived and experienced by insured clients themselves.

Evidence from other contexts generally supports the view that reimbursement and dispute resolution processes influence perceptions of healthcare quality. Cutler and Zeckhauser (2000), studying the United States health insurance market, found that prolonged claims disputes strained insurer–provider relationships and negatively affected clients' perceptions of fairness, reliability, and quality of care. However, the study was undertaken within a highly institutionalized and mature insurance system characterized by stronger regulatory oversight and administrative capacity than those found in many developing countries. Consequently, the transferability of these findings to emerging health insurance markets such as Kenya remains uncertain. Similarly, Tindyebwa et al. (2023) observed in Uganda that slow and opaque dispute resolution mechanisms diminished trust in both insurers and healthcare providers. Nevertheless, the study did not distinguish experiences across different categories of private insurers, limiting a more nuanced understanding of how organizational characteristics influence dispute resolution outcomes.

Taken together, the literature demonstrates considerable agreement that reimbursement delays and ineffective dispute resolution mechanisms adversely affect healthcare service delivery,

provider participation, and client trust. However, existing studies vary significantly in context, methodological focus, and outcome measures. Most research emphasizes financial and operational consequences for insurers and providers, with relatively limited attention to how reimbursement and dispute resolution processes shape clients' perceptions of healthcare service quality. Furthermore, few studies have examined these dimensions simultaneously within Kenya's private health insurance sector. This leaves an important empirical gap regarding the extent to which claims reimbursement processes and dispute resolution mechanisms influence clients' perceptions of healthcare service quality, a gap that the present study seeks to address.

2.2.4 Client Perceptions of Service Quality under Insurance

Several studies have applied service quality frameworks such as SERVQUAL and Donabedian's Structure–Process–Outcome Model to assess client satisfaction and healthcare quality. Souca (2011) and Sultan and Wong (2011) found that reliability, responsiveness, and assurance were among the most influential determinants of perceived service quality in insurance-mediated healthcare settings. Similarly, Mohamoud and Mash (2020) reported that patients attending private clinics in Kenya placed greater emphasis on interpersonal aspects of care, such as empathy and communication, than on technical efficiency. While these studies collectively demonstrate the multidimensional nature of healthcare service quality, they differ in their conceptual emphasis. SERVQUAL-based studies focus primarily on clients' subjective evaluations of service encounters, whereas Donabedian's framework incorporates structural and process factors that influence outcomes. This suggests that relying on a single framework may provide only a partial understanding of healthcare quality.

Evidence from international studies further indicates that accountability, transparency, and

operational efficiency within insurer–provider relationships positively influence clients' perceptions of healthcare services (Stolper et al., 2021). However, most of these studies were conducted in health systems characterized by mature insurance markets and stronger regulatory institutions. As a result, their findings may not fully reflect the realities of developing healthcare systems where resource constraints, weak enforcement mechanisms, and institutional inefficiencies shape service delivery. Moreover, although these studies establish associations between organizational performance and perceived quality, they often pay limited attention to the specific contractual processes through which insurer–provider interactions affect client experiences. This creates uncertainty regarding the mechanisms linking contractual relationships to perceived healthcare service quality.

Overall, the reviewed literature demonstrates broad consensus that healthcare service quality is influenced by contractual effectiveness, communication and coordination mechanisms, and reimbursement and dispute resolution processes. However, existing studies tend to examine these factors independently rather than as interconnected dimensions of insurer–provider relationships. Furthermore, much of the literature focuses either on provider performance, financial outcomes, or general client satisfaction, with limited attention to how insurer–provider contractual arrangements collectively shape clients' perceptions of healthcare service quality within the Kenyan context. This fragmentation leaves a significant empirical and contextual gap. Consequently, the present study seeks to integrate these dimensions within a single analytical framework to provide a more comprehensive understanding of how insurer–provider contractual relationships influence perceived healthcare service quality in Kenya.

2.3 Research Gap

The reviewed literature demonstrates that insurer–provider contractual relationships influence healthcare service delivery and client experiences. However, existing studies have largely examined these relationships in fragmented ways. Some studies have focused on health insurance financing and reimbursement systems (Kariuki & Koori, 2025; Chepchirchir et al., 2024), while others have concentrated on patient experiences and service quality within healthcare facilities (Mohamoud & Mash, 2020). Consequently, limited attention has been given to understanding how multiple dimensions of insurer–provider contractual relationships jointly influence perceived healthcare service quality.

Further, existing empirical studies tend to emphasize individual aspects of insurer–provider interactions, such as contract enforcement, communication and coordination, or claims reimbursement processes, without examining their combined effects within a single analytical framework. Most studies also adopt either provider-centered or client-centered perspectives, resulting in a limited understanding of how insurers, healthcare providers, and insured clients interact to shape healthcare service quality outcomes. This has created a gap in knowledge regarding the mechanisms through which insurer–provider contractual arrangements influence service availability, reliability, responsiveness, and overall client satisfaction.

In addition, there is limited Kenya-specific empirical evidence examining insurer–provider contractual relationships within the context of the country's expanding private health insurance sector. Existing studies have largely focused on specific healthcare facilities, insurance schemes, or operational challenges, with little attention to urban and peri-urban contexts where private health insurance utilization is most prevalent. Therefore, the influence of contract enforcement, communication and coordination mechanisms, claims

reimbursement processes, and dispute resolution systems on clients' perceptions of healthcare service quality remains insufficiently understood. This study addresses this gap by integrating insurer, provider, and client perspectives within a single analytical framework to generate comprehensive evidence on how insurer–provider contractual relationships shape perceived healthcare service quality in Kenya.

2.4 Conceptual Framework

This study is anchored on the premise that the quality of health services (as perceived by clients) is determined to a large extent by the nature of relationships between insurers and providers. Drawing upon the Gaps Model of Service Quality (Parasuraman et al., 1985) and the Donabedian Model of Healthcare Quality (Donabedian, 1988), the framework conceptualizes service quality as a product of structural arrangements, process efficiency, and outcome perceptions.

The proposed framework delineates three key (independent) variables: insurer–provider contractual arrangements, communication and coordination mechanisms, and the timeliness of claims reimbursement coupled with dispute resolution processes. The three are hypothesized to exert a direct influence on clients' perceptions of healthcare service quality (the outcome variable). The three independent variables may be systematically categorized as follows:

2.4.1 Insurer–Provider Contractual Arrangements

The nature and enforcement of contractual agreements determine the scope, reliability, and predictability of healthcare services delivered under insurance coverage. Robust and

consistently enforced contracts are anticipated to guarantee service availability, reduce operational uncertainties, and mitigate conflicts that might otherwise erode client trust in the insurance system.

2.4.2 Communication and Coordination Mechanisms

Effective communication channels and coordination frameworks between insurers and healthcare providers are critical for enhancing transparency, responsiveness, and overall system efficiency. Mechanisms such as real-time claims processing, structured feedback loops, and collaborative engagement platforms are posited to strengthen client satisfaction while ensuring continuity and quality of care.

2.4.3 Timeliness of Claims Reimbursement and Dispute Resolution

The prompt settlement of claims and the existence of fair, transparent procedures for resolving disputes constitute essential conditions for sustaining provider confidence and client trust. Conversely, delays in reimbursement or opaque dispute resolution processes are likely to undermine service reliability, weaken provider participation, and negatively shape clients' perceptions of fairness and quality.

2.5 Dependent (outcome) Variable

The dependent variable is client perception of health service quality, which captures the extent to which insured individuals evaluate the services provided under their insurance cover as meeting or exceeding expectations. Service quality is measured through the widely applied SERVQUAL model, which consists of five dimensions: reliability, responsiveness, assurance, empathy, and tangibles. Reliability refers to the consistency and accuracy with which

healthcare providers deliver promised services, ensuring patients receive care aligned with contractual obligations and medical standards. Responsiveness relates to the promptness and willingness of providers and insurers to address client needs, inquiries, and claims, reinforcing perceptions of efficiency and attentiveness. Assurance captures the competence, courtesy, and credibility of healthcare providers and insurers, which shape clients' trust and confidence in the system. Empathy emphasises the degree of individualized attention and sensitivity to clients' specific needs, highlighting the relational and human- centered aspect of care delivery. Tangibles encompass the physical facilities, medical equipment, and administrative processes that influence clients' impressions of the healthcare experience. Collectively, these dimensions provide a multidimensional construct for assessing service quality. By linking contractual arrangements, communication and coordination mechanisms, and claims management processes to the SERVQUAL dimensions, the framework highlights how systemic and structural factors shape not only the operational effectiveness of insurance schemes but also the subjective experiences and satisfaction levels of clients.

2.6 Moderating Factors

This study hypothesizes that insurer–provider contractual relationship dimensions—namely contract terms and enforcement, communication and coordination mechanisms, and claims reimbursement and dispute resolution processes—positively influence clients' perceptions of healthcare service quality. However, the strength and direction of these relationships may vary depending on contextual factors that shape how contractual arrangements are implemented and experienced. Accordingly, the study incorporates selected moderating variables that are theoretically and empirically linked to healthcare service delivery and service quality outcomes.

2.6.1 Regulatory Environment

The regulatory environment is expected to moderate the relationship between insurer–provider contractual relationships and perceived healthcare service quality. Strong regulatory oversight by institutions such as the Insurance Regulatory Authority (IRA) and the Ministry of Health is likely to strengthen the positive effects of effective contractual arrangements by promoting compliance, accountability, and timely dispute resolution. Conversely, weak enforcement and regulatory ambiguity may weaken the influence of contractual mechanisms on service quality outcomes by allowing contractual obligations to be inconsistently applied.

2.6.2 Socio-Economic Characteristics of Clients

Client's socio-economic characteristics, including income levels, educational attainment, and awareness of insurance entitlements, are expected to influence how healthcare services are perceived and evaluated. Clients with higher levels of education and insurance literacy may be better positioned to understand benefit packages, navigate healthcare systems, and evaluate service quality. Consequently, the positive relationship between insurer–provider contractual arrangements and perceived service quality may be stronger among clients with greater awareness and socio-economic capacity than among those with limited knowledge or resources.

2.6.3 Provider Capacity

TProvider capacity is expected to moderate the extent to which contractual arrangements translate into quality service delivery. Healthcare facilities with adequate infrastructure, skilled personnel, sufficient medical supplies, and efficient administrative systems are more

likely to effectively implement contractual requirements and deliver quality services. In contrast, facilities facing resource constraints may be unable to translate favorable contractual arrangements into improved client experiences, thereby weakening the relationship between insurer–provider dynamics and perceived healthcare service quality.

2.6.4 Cultural and Behavioral Expectations

iClients' cultural values, expectations, and previous healthcare experiences may influence how service quality is interpreted. Even where contractual arrangements facilitate technically efficient service delivery, clients may report lower levels of satisfaction if services do not align with their expectations regarding responsiveness, personal attention, or provider behavior. Therefore, cultural and behavioral expectations are expected to influence the strength of the relationship between contractual arrangements and perceived service quality.

2.6.5 Technological and Information Systems

Technological and information systems are expected to strengthen the relationship between insurer–provider contractual arrangements and healthcare service quality. Robust digital claims management systems, integrated information platforms, and real-time communication mechanisms facilitate efficient claims processing, reduce disputes, and improve coordination between insurers and providers. Consequently, healthcare facilities and insurers with stronger technological capabilities are expected to exhibit a stronger positive relationship between contractual arrangements and perceived healthcare service quality than those relying on manual systems.

2.7 Conceptual Framework

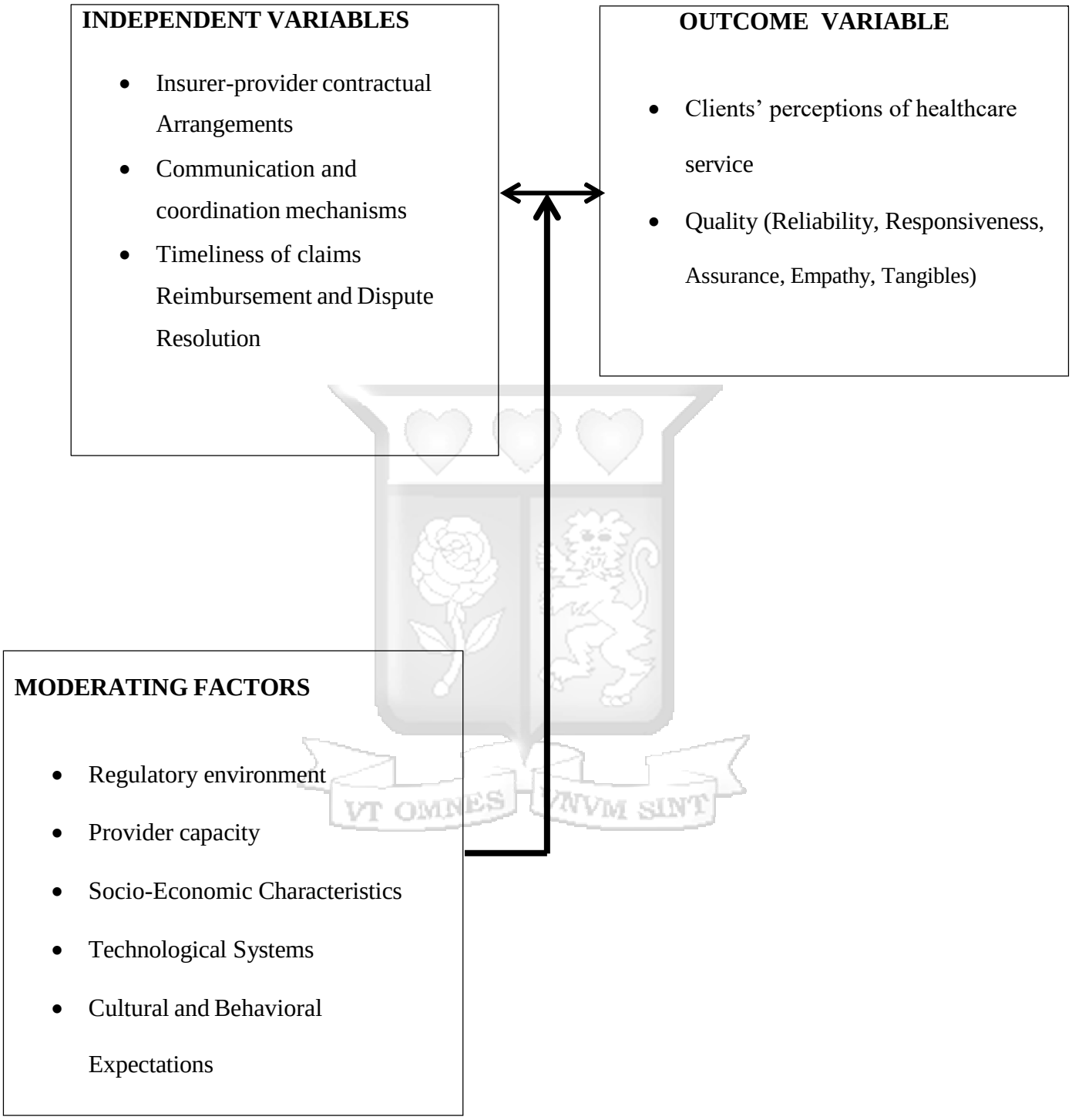

Figure 1: Conceptual Framework illustrating the relationship between insurer–provider dynamics, moderating factors, and clients' perceptions of healthcare service quality.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

Chapter Three outlines the study's research methodology, including its positivist philosophy, cross-sectional design, and mixed-methods approach. It details the study area, population, sampling techniques, data collection instruments, reliability and validity procedures, data analysis methods, and ethical considerations, ensuring methodological rigor, triangulation, and compliance with research ethics for credible and replicable findings.

3.1 Research Philosophy

This study adopted pragmatism as its overarching research philosophy. Pragmatism is particularly appropriate for mixed-methods research because it focuses on addressing research problems through the use of methods that best answer the research questions rather than adhering exclusively to a single philosophical tradition (Creswell & Plano Clark, 2018; Saunders, Lewis, & Thornhill, 2019). Given the complexity of insurer–provider contractual relationships and clients' perceptions of healthcare service quality, a pragmatic stance allows the study to draw on both quantitative and qualitative forms of evidence to develop a more comprehensive understanding of the phenomenon.

Within the pragmatic paradigm, quantitative methods were used to examine measurable relationships between insurer–provider contractual relationship dimensions and perceived healthcare service quality. These methods reflect positivist assumptions regarding objective measurement, statistical analysis, and the identification of patterns within the study population. At the same time, qualitative methods were employed to explore participants'

experiences, interpretations, and contextual perspectives regarding contractual relationships and healthcare service delivery. These methods reflect interpretivist assumptions concerning the socially constructed nature of perceptions and experiences.

Pragmatism therefore provides a coherent philosophical foundation that accommodates both objective measurement and subjective interpretation within a single study. Rather than treating positivism and interpretivism as competing philosophical positions, the study utilizes them as complementary methodological perspectives within a broader pragmatic framework. This approach enhances methodological rigor, facilitates triangulation of findings, and generates evidence that is both empirically robust and contextually meaningful for informing healthcare policy and practice in Kenya.

3.2 Study Area

This study was conducted in Nairobi and Kakamega Counties, selected to represent distinct socio-economic and infrastructural contexts within Kenya's healthcare landscape. The two counties were purposefully chosen to capture variations in insurer–provider relationships and clients' perceptions of healthcare service quality across urban and peri- urban settings.

Nairobi County, Kenya's capital and principal urban center, has the highest concentration of private healthcare providers and the largest share of insured clients. It serves as the country's financial and administrative hub, offering a mature and competitive health insurance market with well-established contractual, communication, and claims management systems between insurers and providers. Nairobi thus provides an ideal environment to examine how structured insurer–provider engagements influence service delivery efficiency, reliability, and client satisfaction in a highly urbanized context.

In contrast, Kakamega County represents a peri-urban region characterized by growing health infrastructure, expanding private healthcare investment, and increasing health insurance uptake. It offers insights into the evolving nature of insurer–provider interactions in emerging markets where institutional frameworks are still developing and service delivery systems are less formalized. Studying Kakamega enables analysis of how contextual factors such as limited provider capacity, uneven regulatory enforcement, and socio-economic disparities influence the quality and accessibility of insured healthcare services.

Focusing on these two counties allowed for a comparative analysis of insurer-provider dynamics in differentiated settings, which is urban Nairobi and peri-urban Kakamega, thereby enhancing the study's capacity to draw balanced conclusions about how context shapes the effectiveness of insurer–provider relationships and the experiences of insured clients.

3.3 Research Design

This study adopted a mixed-methods research design, integrating both quantitative and qualitative approaches within a cross-sectional framework. A mixed methods design was appropriate for this study because insurer–provider contractual relationships and clients' perceptions of healthcare service quality are complex phenomena that require both numerical measurement and contextual interpretation. By combining quantitative and qualitative data, the study achieves a more comprehensive and nuanced understanding of how contractual arrangements, communication mechanisms, and claims management processes influence perceived service quality in private health facilities in Kenya.

The quantitative component was designed to examine measurable relationships between insurer–provider contractual dynamics and clients' perceptions of healthcare service quality.

Structured questionnaires administered to insured clients will generate numerical data on service availability, reliability, responsiveness, assurance, empathy, and tangibility. This component enables statistical analysis of patterns, associations, and variations across urban (Nairobi County) and peri-urban (Kakamega County) contexts.

The qualitative component complements the quantitative findings by providing in-depth insights into the operational and institutional realities shaping insurer–provider relationships. Key informant interviews with private medical insurance providers and semi-structured interviews with administrators of accredited private health facilities will capture experiential, procedural, and contextual perspectives that cannot be fully explained through survey data alone. These qualitative insights will help explain why certain contractual practices, communication gaps, or reimbursement delays influence client experiences and perceptions.

The mixed methods design followed a convergent parallel approach, where quantitative and qualitative data are collected during the same phase of the study, analyzed separately, and then integrated at the interpretation stage. This integration allows for triangulation of findings, enhances validity, and strengthens the credibility of conclusions by cross-verifying evidence from insured clients, insurers, and healthcare providers.

Overall, the mixed methods research design was well suited to the study's objective of examining the relationship between insurer–provider contractual arrangements and clients' perceptions of healthcare service quality. It ensures both analytical rigor and contextual depth, supporting the generation of evidence-based and policy-relevant recommendations for improving private healthcare service delivery in Kenya.

3.4 Target Population

This study targeted three principal groups within Kenya's private health insurance ecosystem to comprehensively assess the impact of insurer-provider relationships on clients. The focus was in Nairobi County and Kakamega County, representing urban and peri-urban contexts respectively.

3.4.1 Insured Clients Seeking Services at Accredited Private Health Facilities

The primary target group comprised of insured individuals actively seeking healthcare services from accredited private health facilities in Nairobi and Kakamega Counties. These clients are the direct beneficiaries of health insurance and are therefore best positioned to provide insights into their experiences with service access, claims processing, and provider interactions.

According to available data from the Insurance Regulatory Authority (IRA, 2025) and Kenya Health Information System (KHIS, 2023), Nairobi has the highest concentration of insured clients due to its mature insurance market and wide array of private healthcare facilities. Kakamega, on the other hand, represents a growing peri-urban population with increasing health insurance uptake and expanding access to private healthcare services. Collectively, these clients will provide diverse perspectives that reflect both well-established and emerging insurance environments.

3.4.2 Registered Private Medical Insurance Providers

The secondary target group entailed registered private medical insurance providers operating within Nairobi and Kakamega Counties. Kenya has approximately 45 licensed health insurance companies (IRA, 2025), a significant number of which have contracted facilities in these two counties. These insurers are critical stakeholders in shaping contractual terms, claims authorization processes, reimbursement timelines, and client communication frameworks. Their participation made it possible for the study examine how policy and operational decisions within insurance firms influence service quality and client satisfaction.

3.4.3 Administrators and Managers of Accredited Private Health Facilities

The third target group consisted of administrators and managers of accredited private healthcare facilities in Nairobi and Kakamega Counties. According to the Kenya Health Facility Census (2023), Nairobi hosts approximately 429 accredited private facilities, while Kakamega has about 148. These facilities are directly engaged in implementing insurance contracts, coordinating service delivery, and managing claim reimbursements and authorizations. Their input will provide an operational perspective on insurer–provider coordination and the challenges that affect service quality and efficiency. By focusing on these three groups, insured clients (users), insurers (policy actors), and providers (service implementers), the study captures a tri-level perspective of Kenya's private health insurance ecosystem. This multidimensional approach ensures a comprehensive and contextually grounded understanding of how insurer-provider relationships influence the quality of healthcare experiences in both urban Nairobi and peri- urban Kakamega.

3.5 Sampling Techniques, Procedures, and Sample Size

To ensure representativeness and data quality, this study will employ a stratified multistage sampling approach tailored to the three target groups: insured clients, insurance providers, and healthcare facility administrators. Each group will require a specific sampling technique reflecting differences in population structure, accessibility, and functional role within the health insurance ecosystem. The sampling design focuses exclusively on Nairobi County (urban) and Kakamega County (peri-urban) to allow comparative analysis across these contrasting contexts.

3.5.1 Insured Clients Seeking Services at Accredited Private Health Facilities

A stratified multistage sampling procedure will be used to select insured clients. The two study counties (Nairobi and Kakamega) constituted the primary strata. Within each county, ten accredited private health facilities will be purposively selected based on two criteria: (i) active accreditation by at least one licensed medical insurer and (ii) consistently high outpatient volumes of insured clients. This will yield a total of twenty facilities.

The target sample of 300 insured clients was determined to provide sufficient statistical power for examining relationships between insurer–provider contractual relationship dimensions and perceived healthcare service quality. According to Cohen (1992), a sample of this size is adequate for detecting moderate effect sizes in multivariate analyses at conventional confidence and significance levels. The allocation of 15 respondents per facility ensured balanced representation across facilities and counties while minimizing clustering effects. This approach enabled meaningful comparison between urban and peri-urban settings and enhanced the precision and stability of statistical estimates.

At each selected facility, a systematic random sampling procedure were used to recruit insured outpatients during the data collection period. For each day of data collection, the research assistant first obtained an estimate of the expected number of insured outpatients from the facility's outpatient desk. Based on this estimate and the required number of interviews per facility, a fixed sampling interval (k) was applied. In this study, k was set at 3, meaning that every third insured outpatient presenting at the outpatient department was approached for screening and possible inclusion in the study.

To operationalize this approach, the first participant of the day was selected using simple random procedures from among the first three insured outpatients (e.g., selecting one number from 1-3). Thereafter, every 3rd eligible insured outpatient was invited to participate until the facility-specific quota is met. Only clients who (i) have active insurance cover, (ii) are seeking outpatient services on the day of data collection, and (iii) provide informed consent was included.

Each facility contributed 15 insured clients, giving:

20 facilities × 15 insured clients = 300 insured clients.

This systematic sampling strategy ensures randomization, minimizes selection bias, and provides adequate representation of insured clients across both urban (Nairobi) and peri- urban (Kakamega) settings.

Selecting 15 insured clients per facility (300 in total) provides adequate statistical power for the quantitative component, ensuring reliable estimation of relationships and subgroup comparisons. This sample size allowed for meaningful inferential analysis with acceptable

confidence levels and variability control across facilities and counties (Cohen, 1992; Saunders et al., 2019).

3.5.2 Registered Private Medical Insurance Providers

A purposive sampling strategy was employed to select private medical insurance companies actively operating in both Nairobi and Kakamega Counties. According to the Insurance Regulatory Authority (IRA, 2025), there are 45 licensed health insurers in Kenya. Following Mill and Gay's (2016) guideline that a purposive sample should typically constitute 10%-30% of the target population to ensure diversity and representativeness, 20 companies (approximately 44%) will be selected to provide robust coverage across different market segments.

The sample included a balanced representation of large, mid-tier, and small insurers based on market share, client portfolio, and operational scope. This stratification ensures that the perspectives captured reflect variations in resource capacity, provider networks, and client engagement models across the industry. Within each selected company, a key informant, such as a regional manager, claims officer, or medical director, were invited to participate in an in-depth interview.

Twenty insurance providers were purposively selected to ensure adequate representation of the diversity within Kenya's private health insurance sector. Selection was based on variation in market size, client portfolio, provider network coverage, and operational presence within the study counties. Rather than statistical representativeness, the sample was designed to capture a broad range of experiences and contractual practices relevant to insurer–provider relationships. The selected insurers were considered sufficient to generate diverse perspectives

while allowing in-depth exploration of organizational processes and experiences.

This purposive approach is justified because the study seeks contextually rich and expert-driven insights into insurer–provider dynamics rather than statistically generalizable outcomes. By targeting insurers with active operational presence in the two counties, the sample captures both urban and semi-urban healthcare financing contexts, thereby enhancing the credibility, relevance, and transferability of findings to the broader Kenyan health insurance landscape

3.5.3 Administrators and Managers of Accredited Private Health Facilities

A stratified purposive sampling approach was applied to select administrators and managers of accredited private health facilities operating in Nairobi and Kakamega Counties. This method allowedfor intentional inclusion of facilities that differ in size, service type (inpatient and outpatient), and insurance accreditation status, ensuring that diverse operational contexts are represented in the study.

According to the Kenya Health Facilities Regulatory Database (2025), there are 577 accredited private health facilities in the two counties, 429 in Nairobi and 148 in Kakamega. In alignment with Mill and Gay's (2016) recommendation that purposive samples should typically include 10%-30% of the population to capture adequate diversity while maintaining manageability, a total of 58 facilities (approximately 10%) will be purposively selected. This comprised 43 facilities from Nairobi and 15 from Kakamega, reflecting the proportional distribution of accredited facilities between the two counties.

From each selected facility, one administrator or manager-preferably an individual responsible

for insurance liaison, claims management, or service delivery coordination, was invited to participate in a semi-structured interview. This stratified purposive strategy ensures that perspectives from both urban and semi-urban healthcare contexts are captured, enhancing the representativeness, contextual validity, and credibility of the findings.

A total of 58 healthcare facility administrators were selected to ensure adequate representation of the diversity of accredited private healthcare facilities across the two counties. The sample was proportionately distributed according to the number of accredited facilities in each county to preserve contextual representation. Selection focused on facilities varying in size, service scope, and insurer accreditation arrangements to maximize variation and capture different operational experiences. The sample size was considered sufficient to achieve data saturation while providing a comprehensive understanding of institutional practices influencing insurer–provider relationships and healthcare service quality.

Purposive sampling is particularly appropriate for this study because the goal is not statistical generalization but rather the in-depth understanding of administrative experiences and institutional practices influencing insurer-provider relationships. The approach ensured that participants are information-rich cases with direct operational insights, aligning with the study's pragmatic philosophy and its focus on generating actionable and policy-relevant knowledge

Table 3.1: Summary of Samples Sizes

Population Category	**Sampling Method**	**Sample Size**
Insured Clients	Stratified Systematic	300
Insurance Company Representative	Purposive (10%-30% Mill & Gay, 2016)	20
Facility Administrators	Stratified Purposive (10%-30% Mill & Gay, 2016)	58
Total		378

This multi-level sampling strategy allows the study to obtain triangulated insights from diverse stakeholders across two contrasting contexts, which is urban Nairobi and peri-urban Kakamega. The approach enhances comparability, strengthens validity, and ensures that the findings accurately reflect the operational, institutional, and experiential dimensions of insurer–provider relationships in Kenya's evolving private healthcare sector.

3.6 Data Collection Methods

Table 3.2: Data Collection Methods

Study objective	**Methodological approach**	**Data collection and participants**	**Expected Outcomes / Types of Data**
Objective 1 To examine relationships between terms and enforcement of insurer–provider contracts and client perceptions on availability and reliability of health services	Mixed-method approach combining quantitative surveys and qualitative key informant interviews	**Quantitative:** Structured questionnaires administered to insured clients sampled systematically at 20 accredited private facilities (n = 300). **Qualitative:** Key informant interviews with senior representatives of selected private medical insurers (n = 20).	**Quantitative:** Numerical data on client perceptions of service availability, reliability, and contractual effects. **Qualitative:** Thematic insights on contractual practices, enforcement processes, and their implications for service delivery.

Objective 2To assess how communication and coordination	Mixed-method approach using client surveys and facility-level qualitative	**Quantitative:** Structured questionnaires for insured clients (n = 300).	**Quantitative:** Measurable indicators of responsiveness, communication quality, and

mechanisms between insurers and providers influence client perceptions of healthcare responsiveness	interviews	**Qualitative:** Semi-structured interviews with administrators/managers of accredited private health facilities (n = 58).	coordination. **Qualitative:** Narrative data capturing coordination challenges, communication channels, and relational dynamics influencing responsiveness

Objective 3To examine the relationship between timeliness of claims reimbursement and dispute resolution mechanisms, and client perception of service quality	Mixed-methods approach integrating surveys, insurer interviews, and facility administrator interviews	**Quantitative:** Structured questionnaires for insured clients (n = 300). **Qualitative:** Key informant interviews with insurance company representatives (n = 20) and semi-structured interviews with facility administrators/managers (n = 58).	**Quantitative:** Statistical data on perceived service quality, delays, and dispute frequency. **Qualitative:** Rich explanatory data on reimbursement processes, administrative constraints, and conflict resolution practices.

This study adopted a mixed-methods approach, integrating both quantitative and qualitative data collection techniques to provide a comprehensive, evidence-based understanding of insurer-provider relationships and their influence on clients' perceptions of healthcare service quality. Data was collected from three key stakeholder groups, namely, insured clients, private medical insurance providers, and administrators of accredited private health facilities, in Nairobi County (urban) and Kakamega County (peri-urban).

3.6.1 Structured Questionnaires for Insured Clients

Structured, face-to-face questionnaires were administered to insured clients actively seeking healthcare services at accredited private facilities in Nairobi and Kakamega Counties. The questionnaire collected quantitative data on: Accessibility of healthcare services under insurance cover, Efficiency and transparency of claims processing, Communication and coordination between clients, providers, and insurers, and Overall satisfaction with service quality.

A systematic random sampling approach was applied at each selected facility, for example, interviewing every third insured outpatient during the data collection period. A total of 20 health facilities (10 per county) were sampled, with 15 clients from each, yielding a total of 300 insured client respondents. This design ensures proportional representation across facilities and captures diverse client experiences from both urban and peri-urban settings.

3.6.2 Key Informant Interviews with Insurance Providers

Key Informant Interviews (KIIs) were conducted with senior representatives of private medical insurance firms operating in Nairobi and Kakamega Counties. Participants were selected through purposive sampling to ensure inclusion of insurers representing different market tiers, which are large, mid-tier, and small providers. Approximately 10 insurance company representatives were interviewed.

The interviews explored themes such as: Nature and enforcement of insurer-provider contractual arrangements, Mechanisms for claims authorization and reimbursement, Dispute resolution procedures, and Client communication and feedback mechanisms. These interviews provided valuable institutional insights into how insurance companies structure, manage, and monitor relationships with healthcare providers and clients, helping to interpret the quantitative findings on service quality and satisfaction.

3.6.3 Semi-Structured Interviews with Health Facility Administrators

Semi-structured interviews were conducted with administrators or managers of accredited private healthcare facilities selected through stratified purposive sampling. A total of 10 facilities (5 per county) were included, ensuring diversity in terms of facility type (inpatient or outpatient), size, and ownership structure. The interviews explored operational experiences in managing insurer relationships, focusing on: Claims processing procedures, Communication and coordination with insurance providers, Service delivery challenges and opportunities linked to insurance arrangements, and Perceived effects of insurer relationships on care quality and client satisfaction. This qualitative approach will yield rich, contextualized data from facility leadership to complement the quantitative findings from

clients and deepen understanding of insurer– provider interactions.

3.7 Reliability of the Study

To ensure the reliability of this study, standardized procedures were employed consistently throughout the data collection and analysis phases. The structured questionnaires and interview guides were pilot-tested in a county outside the main study area to refine question clarity, structure, and response consistency. The use of trained research assistants minimized interviewer bias and ensure uniform administration of tools. For quantitative data, reliability was assessed through internal consistency checks such as Cronbach's alpha, particularly for multi-item constructs related to client satisfaction and claims processing. In qualitative interviews, reliability was enhanced through careful transcription, the use of an interview protocol, and inter-coder agreement during thematic analysis. Triangulation across data sources, such as clients, insurers, and providers, further bolstered the reliability of the findings by cross-verifying insights. By incorporating these safeguards, the study aimed to produce dependable and replicable results that accurately reflect the insurer-provider-client dynamics in Kenya.

3.8 Validity of the Study

Validity refers to the extent to which research instruments accurately measure the concepts they are intended to measure. In this study, both content and construct validity were established through several procedures specifically aligned to the study variables and objectives.

Content validity was assessed during instrument development by ensuring that all questionnaire and interview items were directly derived from the study objectives, conceptual

framework, and theoretical foundations, namely the Donabedian Model and the Gaps Model of Service Quality. The draft instruments were subjected to expert review by two health policy scholars, one research methodology expert, and two practitioners from the health insurance sector. The reviewers evaluated the relevance, clarity, comprehensiveness, and alignment of the items with the study constructs, including contract enforcement, communication and coordination mechanisms, claims reimbursement processes, dispute resolution mechanisms, and perceived healthcare service quality. Their recommendations informed the revision, rewording, and removal of ambiguous items.

Construct validity was strengthened through pilot testing and data triangulation. A pilot study involving respondents drawn from healthcare facilities outside the study sample was conducted to assess whether the items adequately captured the intended constructs. Feedback from the pilot participants informed further refinement of questionnaire wording, sequencing, and response categories. In addition, construct validity was enhanced by collecting data from multiple respondent categories, namely insured clients, insurance providers, and healthcare facility administrators. Comparing findings across these groups enabled verification of key themes and reduced the likelihood of relying on a single source of evidence.

Further validity was achieved through methodological triangulation. Quantitative findings obtained from client surveys were compared with qualitative evidence from key informant interviews and documentary sources, including policy documents, insurer guidelines, and regulatory reports. Consistency of findings across these sources provided additional confidence that the instruments accurately captured the dimensions of insurer–provider contractual relationships and perceived healthcare service quality under investigation.

3.9 Pilot Testing

All instruments were subjected pilot testing in a county not included in the study area to assess clarity.

3.10 Data Analysis

This study employed a mixed-methods data analysis strategy that integrates both quantitative and qualitative approaches to provide a comprehensive understanding of insurer–provider contractual relationships and clients' perceptions of healthcare service quality in Kenya. The analysis was structured to correspond directly with the study's three specific objectives and will include descriptive, inferential, and interpretive procedures.

3.10.1 Quantitative Data Analysis

Quantitative data were obtained from structured questionnaires administered to insured clients and analyzed using the Statistical Package for the Social Sciences (SPSS) version 31. Prior to analysis, the data were cleaned, coded, and screened for completeness, consistency, and missing values. Descriptive and inferential statistical techniques were employed to address the study objectives and examine the relationships between insurer–provider contractual relationship dimensions and clients' perceptions of healthcare service quality.

The dependent variable was clients' perceptions of healthcare service quality, operationalized through three dimensions corresponding to the study objectives: (i) perceived availability and reliability of healthcare services, (ii) perceived healthcare responsiveness, and (iii) perceived overall healthcare service quality. These constructs were measured using Likert-scale items and combined into composite indices following reliability testing.

The independent variables comprised contract terms and enforcement mechanisms,

communication and coordination mechanisms, and claims reimbursement and dispute resolution processes. Contract terms and enforcement mechanisms were analyzed in relation to perceived availability and reliability of healthcare services. Communication and coordination mechanisms were examined as predictors of perceived healthcare responsiveness, while claims reimbursement and dispute resolution processes were analyzed as predictors of perceived overall healthcare service quality.

Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize respondent characteristics and key study variables. Chi-square tests were conducted to examine associations between selected demographic characteristics and study variables. Multiple linear regression analysis was performed to determine the extent to which insurer–provider contractual relationship dimensions predicted variations in perceived healthcare service quality outcomes. Multiple regression was considered appropriate because the study sought to examine the influence of several independent variables on specific dimensions of healthcare service quality while controlling for the effects of other variables.

Before conducting regression analysis, key statistical assumptions were assessed. Normality of residuals was examined using histograms, Q-Q plots, and the Shapiro-Wilk test. Multicollinearity was assessed using Variance Inflation Factors (VIF) and tolerance statistics. Homoscedasticity and linearity were evaluated through residual scatterplots, while model fitness was assessed using the coefficient of determination (R^2), adjusted R^2, F-statistics, and significance levels. Scale reliability was assessed using Cronbach's alpha coefficient, with a threshold of $\alpha \geq 0.70$ considered acceptable. Composite indices were subsequently developed for the principal constructs to facilitate multivariate analysis.

3.10.2 Qualitative Data Analysis

Qualitative data collected through key informant interviews with insurance company representatives and healthcare facility administrators were analyzed using thematic content analysis. Audio recordings were transcribed verbatim and reviewed for accuracy before analysis. The analysis process began with familiarization through repeated reading of transcripts, followed by open coding to identify significant concepts, patterns, and recurring ideas relevant to the study objectives.

Subsequently, axial coding was employed to group related codes into broader categories reflecting contractual enforcement practices, communication and coordination mechanisms, claims reimbursement processes, dispute resolution practices, and perceptions of healthcare service quality. These categories were then refined into themes that explained the nature and influence of insurer–provider contractual relationships within the private health insurance sector. Representative quotations were used to support key themes and enhance the credibility of interpretations.

3.10.3 Integration and Triangulation of Findings

The study adopted a convergent mixed-methods triangulation design in which quantitative and qualitative data were analyzed independently and integrated during the interpretation stage. The purpose of integration was to provide a more comprehensive understanding of how insurer–provider contractual relationships influenced perceived healthcare service quality.

Integration occurred through three complementary procedures. First, joint displays were developed to systematically compare quantitative findings with corresponding qualitative themes. For example, statistical results relating to communication and coordination mechanisms were presented alongside interview findings explaining how communication practices affected service responsiveness. Second, narrative integration was used to explain and contextualize quantitative relationships using qualitative evidence. Third, interpretive comparison was undertaken by triangulating quantitative results, qualitative findings, and documentary evidence from policy documents, contractual guidelines, and regulatory reports.

The integrated analysis specifically examined areas of convergence, where quantitative and qualitative findings supported one another; complementarity, where one dataset expanded or clarified the findings of the other; and divergence, where findings differed and required further interpretation. This approach enhanced the validity, credibility, and completeness of the study findings while providing deeper insight into the mechanisms through which insurer–provider contractual relationships influenced healthcare service quality in Kenya.

3.11 Ethical Considerations

This study adhered to the highest standards of ethical research involving human subjects. Before data collection, ethical clearance was obtained from an accredited Strathmore University Ethics Review Committee (IERC), and a research permit was secured from the National Commission for Science, Technology, and

Innovation (NACOSTI), per Kenya's research regulations. Copies of the ethical approval and NACOSTI permit was appended to this thesis. To uphold the voluntary nature of participation, all potential respondents were issued with detailed informed consent forms clearly outlining the study's purpose, expected duration, data collection procedures, potential risks (for example, emotional discomfort when reflecting on healthcare experiences), anticipated benefits, and their rights; including the right to refuse or withdraw at any point without penalty. Participants were encouraged to ask questions before signing the consent form.

To protect confidentiality and anonymity, each participant was assigned a unique code rather than using personally identifiable information. No real names appeared in the dataset or published results. If direct quotations or narrative responses were used, any potentially identifying details will was altered or removed. Additionally, all data both hardcopy and digital were securely stored and only accessible to the principal investigator and supervisory team. Audio recordings were transcribed, anonymized, and securely deleted thereafter.

The study further demonstrated respect and reciprocity toward participants by creating a comfortable and dignified research environment. Participants were informed of how the results were used and will be offered a summary of the study's findings upon request. No coercive incentives were offered, but participants were provided with modest tokens of appreciation, such as refreshments or travel reimbursement, in recognition of their time.

Participants were also provided the opportunity to review their responses upon

request or to clarify issues during the data collection process to ensure accuracy and integrity. In line with research ethics principles, the study ensured that no participant is exposed to harm, undue pressure, or negative consequences as a result of participation. All procedures will bewere designed to protect the dignity, autonomy, and well-being of every participant.

CHAPTER FOUR

PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

This chapter entails presentation of research findings emanating from analysis of data. It will be recalled that the aim of the study was to assess the impact of insurer-provider contractual relationships on clients' perceptions of healthcare service quality in private health facilities in Kenya. To achieve this overarching objective, the study sought to establish the relationship between terms and enforcement of insurer-provider contracts and client perceptions on availability and reliability of health services, the relationship communication/coordination mechanisms between insurers and providers influence client perception on healthcare responsiveness, and the relationship between timeliness of insurance claims reimbursement and dispute resolution mechanisms, and client perception of service quality. The rationale of the study was anchored on the fact that insured clients face service delays even though there are existing contracts between healthcare providers and medical insurance companies. The study employs a mixed methods approach in which the qualitative data was used to triangulate quantitative data for purposes of enhancing internal validity as well as possible generalizations to the larger population. SPSS version 31 was used to compute descriptive statistics, such as mean and standard deviation, as well as inferential statistics (chi-square and multiple linear regression). On the other hand, thematic approach was applied to analyzed qualitative data, which was presented using verbatims and narrations.

4.2 Response Rate

The target sample for the quantitative component comprised 300 insured clients drawn from accredited private healthcare facilities in Nairobi and Kakamega Counties. Within each county, ten facilities were purposively selected, after which systematic sampling with an interval of three was used to recruit eligible respondents. Data were successfully collected from 192 respondents, representing a response rate of 64.0%, while the non-response rate was 36.0%. The main reasons cited for non-participation included concerns about confidentiality, limited time, and unwillingness to discuss insurance-related experiences.

Although the response rate exceeds the average response rates reported in comparable survey studies (Wu et al., 2022) and was considered adequate for statistical analysis, the relatively high non-response rate warrants cautious interpretation of the findings. There is a possibility that individuals who declined participation may have held views or experiences that differed from those who participated, thereby introducing non-response bias. Consequently, the findings may slightly overrepresent or underrepresent certain perceptions regarding insurer–provider relationships and healthcare service quality.

In addition, the study relied substantially on self-reported data from insured clients. Such responses may have been influenced by recall bias, subjective interpretation of experiences, or social desirability effects. To minimize these limitations, quantitative findings were triangulated with qualitative interviews involving insurance representatives and healthcare facility administrators, as well as documentary evidence. This methodological triangulation enhanced the credibility of the findings by allowing validation and comparison of perspectives across multiple data sources.

For the qualitative component, 20 key informants comprising insurance representatives and healthcare facility administrators were purposively selected and interviewed to provide in-depth insights into insurer–provider relationships, claims management processes, and healthcare service quality.

Table 4.1 summarizes the response rate.

Table 4.1: Response Rate

Category	Frequency	%
Response	192	64.0
Non-response	108	36.0
Total	300	100.0

4.3 Demographic Profile of Respondents Disaggregated by Type of Health Insurance

The study sought to establish the distribution of respondents according to their socio-demographic characteristics and type of health insurance cover. Respondents were categorized according to whether they were enrolled under employer-based insurance schemes or individual/private health insurance plans. Since the study focused on insurer-provider contractual relationships and perceived healthcare service quality, it was considered important to determine whether socio-demographic attributes of the respondents were significantly associated with the type of health insurance utilized. To provide a deeper understanding of the relationship between respondents' background characteristics and insurance arrangements, the Chi-square (χ^2) test of association was applied. The test was used to establish whether there existed statistically significant

associations between selected socio-demographic variables and type of health insurance among the respondents. The socio-demographic variables examined included gender, age, county, facility type, duration of insurance cover, and frequency of healthcare visits under insurance. Table 4.2 presents the results of the cross-tabulation and Chi-square analysis.

Table 4.2: Demographic Profile of Respondents Disaggregated by Type of Health Insurance

Variable	Category	Type of health insurance		Total	Chi-square ($\chi 2$)
		Employer-based	Individual/private plan		
Gender	Male	52	10	62	$\chi 2$=0.19; df=1; p=0.010
	Female	108	22	130	
	Total	160	32	192	
Age	Up to 25 years	15	4	19	$\chi 2$=8.291; df=4; p=0.081
	26-35 years	59	8	67	
	36-45 years	54	10	64	
	45-55 years	22	10	32	
	56 years or older	10	0	10	
	Total	160	32	192	
County	Nairobi	91	27	118	$\chi 2$=8.514; df=1; p=0.004
	Kakamega	69	5	74	
	Total	160	32	192	
Facility type	Outpatient	48	3	51	$\chi 2$=6.978; df=3; p=0.073
	Inpatient	44	9	53	
	Both	67	20	87	
	Missing value	1	0	1	
	Total	160	32	192	
Duration of insurance cover	Less than 1 year	16	2	18	$\chi 2$=1.127; df=3; p= 0.771
	1-3 years	63	15	78	
	4-6 years	44	7	51	
	6 years or more	37	8	45	
	Total	160	32	192	
Frequency of healthcare visits under insurance	Once	14	0	14	$\chi 2$=6.804; df=3; p=0.078
	2–3 times	41	4	45	
	4–6 times	79	20	99	
	More than 6 times annually	26	8	34	
	Total	160	32	192	

The results indicate that gender was significantly associated with the type of health

insurance utilized by the respondents ($\chi^2 = 0.19$; df = 1; p = 0.010). The majority of male respondents (52 out of 62) and female respondents (108 out of 130) reported being enrolled under employer-based insurance schemes compared to individual/private insurance plans. The findings suggest that employer-based insurance was a notable form of health insurance among both male and female respondents. The statistically significant association implies that gender differences may influence the type of insurance cover utilized by respondents.

The findings further revealed that age was not significantly associated with type of health insurance ($\chi^2 = 8.291$; df = 4; p = 0.081). Most respondents across all age categories were enrolled under employer-based insurance schemes, particularly those aged between 26–35 years (59 out of 67) and 36–45 years (54 out of 64). Respondents aged 45–55 years also recorded relatively high enrollment under employer-based insurance (22 out of 32), while those aged 56 years and above had the lowest representation. These findings suggest that employer-based insurance was more prevalent among economically active age groups. However, the lack of statistical significance implies that age did not independently determine the type of health insurance utilized by respondents.

The Chi-square test revealed a statistically significant association between county of residence and type of health insurance ($\chi^2 = 8.514$, df = 1, p = 0.004). Respondents from Nairobi County were more likely to report employer-based insurance coverage (91 out of 118) than those from Kakamega County (69 out of 74), while Nairobi also recorded a higher number of respondents utilizing individual/private insurance plans (27 out of 32). The finding indicates that the distribution of health insurance types varied across the two counties and was unlikely to have occurred by chance. However, the Chi-square test only establishes the existence of an association and does not indicate its strength or causality.

The observed variation may reflect contextual differences between the counties, including employment structures, levels of urbanization, and the availability of private health insurance products. Consequently, while county of residence appears to be an important factor in health insurance uptake patterns, other socio-economic and institutional factors not examined in this analysis may also contribute to the observed differences.

The findings also showed that facility type was not significantly associated with type of health insurance ($\chi^2 = 6.978$; df = 3; p = 0.073). The majority of respondents utilizing both inpatient and outpatient services (67 out of 87) were enrolled under employer-based insurance schemes. Similarly, respondents utilizing inpatient services only (44 out of 53) and outpatient services only (48 out of 51) predominantly relied on employer-based insurance. These findings indicate that employer-based insurance remained the dominant form of cover regardless of the type of healthcare services utilized. However, the absence of a statistically significant association implies that facility type did not independently influence the type of health insurance utilized by respondents.

The results further revealed that duration of insurance cover was not significantly associated with type of health insurance ($\chi^2 = 1.127$; df = 3; p = 0.771). Most respondents who had been insured for between 1-3 years (63 out of 78), 4–6 years (44 out of 51), and more than 6 years (37 out of 45) reported being enrolled under employer-based insurance schemes. Similarly, respondents insured for less than one year (16 out of 18) were also predominantly covered under employer-based plans. The findings suggest that respondents generally maintained employer-based insurance coverage regardless of the duration of enrollment. Nonetheless, the lack of statistical significance indicates that duration of

insurance cover did not significantly influence the type of insurance utilized.

The findings additionally indicated that frequency of healthcare visits under insurance was not significantly associated with type of health insurance ($\chi^2 = 6.804$; df = 3; p = 0.078). Respondents who visited healthcare facilities between 4-6 times annually (79 out of 99) constituted the largest proportion of those enrolled under employer-based insurance schemes, followed by those who visited healthcare facilities 2-3 times annually (41 out of 45). Similarly, respondents who reported more than six healthcare visits annually (26 out of 34) were also largely covered under employer-based insurance. These findings imply that respondents with frequent healthcare utilization were more likely to rely on employer-based insurance schemes. However, the observed differences were not statistically significant.

Based on the foregoing findings, employer-based insurance emerged as the dominant form of health insurance across most socio-demographic categories. The Chi-square analysis revealed statistically significant associations between type of health insurance and both gender and county of residence, whereas age, facility type, duration of insurance cover, and frequency of healthcare visits showed no statistically significant relationships. These findings suggest that variations in health insurance utilization are not uniformly distributed across all respondent characteristics. However, while gender and geographical location appear to be associated with the type of insurance coverage held, the results do not imply causation and should be interpreted within the context of broader socio-economic and institutional factors. The findings further indicate that factors such as employment structures, income levels, insurance affordability, and access to insurance providers, which were not directly examined in this analysis, may also contribute to observed differences in

health insurance uptake patterns.

4.4 Insurer-Provider Contractual Arrangements

4.4.1 Descriptive Statistics

The study sought to assess the relationship between the terms and enforcement of insurer-provider contracts and clients' perceptions of the availability and reliability of healthcare services in Kenya. To achieve this objective, respondents were required to indicate their level of agreement with statements relating to accessibility of healthcare services under insurance cover, acceptance of insurance plans by healthcare facilities, adequacy of healthcare providers, adherence to contractual service standards, delays in claims approvals, and consistency in healthcare service quality. Responses were measured on a five-point Likert scale ranging from strongly disagree to strongly agree. The findings are presented in Table 4.3.

Table 4.3: Insurer-Provider Contractual Arrangements

Statement	Strongly Disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly Agree n (%)	Mean	Std Dev.
I can easily access healthcare services when needed under my insurance plan.	3	18	43	72	56	3.8	1.00
	1.6%	9.4%	22.4%	37.5 %	29.2%		
The facility always accepts my insurance cover without unnecessary restrictions.	5	9	41	58	79	4.0	1.03
	2.6%	4.7%	21.4%	30.2 %	41.1%		
There are sufficient healthcare providers (doctors, nurses, specialists) available when I visit.	6	24	58	54	50	3.6	1.10
	3.1%	12.5%	30.2%	28.1 %	26.0%		
My insurer and provider adhere to agreed contractual service standards (e.g., authorization timelines, payment agreements).	5	25	63	43	56	3.6	1.11
	2.6%	13.0%	32.8%	22.4 %	29.2%		
Delays in claim approvals affect my access to healthcare services.	3	48	62	51	28	3.3	1.04
	1.6%	25.0%	32.3%	26.6 %	14.6%		
I am confident that the insurance–provider relationship ensures consistent service quality.	4	29	55	60	44	3.6	1.07
	2.1%	15.1%	28.6%	31.2 %	22.9%		
Average						3.7	1.06

The findings revealed that a majority of respondents agreed that they could easily access healthcare services when needed under their insurance plans (mean = 3.8; S.D. = 1.00). Specifically, 37.5% of the respondents agreed while 29.2% strongly agreed with the statement. These findings suggest that insurer-provider contractual arrangements had positively enhanced accessibility of healthcare services among insured clients. The relatively high mean score further indicates that respondents generally perceived healthcare

services to be available whenever required under their insurance plans.

Similarly, the study established that most respondents believed healthcare facilities accepted their insurance cover without unnecessary restrictions (mean = 4.0; S.D. = 1.03). A majority of respondents either agreed (30.2%) or strongly agreed (41.1%) with the statement. This implies that contractual agreements between insurers and healthcare providers were largely effective in facilitating smooth service access by minimizing restrictions associated with insurance acceptance. The findings therefore suggest that respondents perceived insurer-provider contractual enforcement mechanisms as supportive of reliable healthcare service provision.

The results further showed that respondents generally perceived the availability of healthcare providers to be adequate during healthcare visits (mean = 3.6; S.D. = 1.10). More than half of the respondents agreed (28.1%) or strongly agreed (26.0%) that there were sufficient healthcare providers, such as doctors, nurses, and specialists, available when needed. However, a considerable proportion remained neutral (30.2%) while others disagreed (12.5%). These findings imply that although insurer-provider contractual arrangements may have contributed to improving healthcare provider availability, some respondents still experienced challenges relating to staffing adequacy and access to specialized healthcare services.

The findings also indicated moderate agreement regarding adherence to contractual service standards between insurers and healthcare providers (mean = 3.6; S.D. = 1.11). Specifically, 22.4% of the respondents agreed while 29.2% strongly agreed that insurers and providers adhered to agreed contractual obligations such as authorization timelines and

payment agreements. Nevertheless, 32.8% of respondents remained neutral, while 13.0% disagreed with the statement. These findings suggest that although contractual terms and enforcement mechanisms were generally perceived positively, some respondents may have encountered inconsistencies in the implementation of insurer-provider contractual obligations.

Regarding delays in claim approvals, the findings revealed that respondents moderately agreed that such delays affected their access to healthcare services (mean = 3.3; S.D. = 1.04). While 25.0% of respondents disagreed with the statement, a substantial proportion agreed (26.6%) or strongly agreed (14.6%) that delays in claim approvals negatively influenced healthcare access. In addition, 32.3% of the respondents remained neutral. These findings imply that inefficiencies in claims approval processes may undermine the reliability and timeliness of healthcare service delivery despite the existence of insurer-provider contractual arrangements.

The study further established that respondents were generally confident that insurer–provider relationships ensured consistent healthcare service quality (mean = 3.6; S.D. = 1.07). The majority of respondents agreed (31.2%) or strongly agreed (22.9%) with the statement, indicating positive perceptions regarding the role of insurer-provider contractual relationships in maintaining reliable healthcare services. However, some respondents expressed reservations as reflected by those who disagreed (15.1%) or remained neutral (28.6%). This suggests that while insurer-provider contracts were largely perceived as supporting service consistency, variations in service quality experiences still existed among some clients.

Overall, the findings yielded an aggregate mean score of 3.7 and a standard deviation of 1.06, which indicates that respondents generally held positive perceptions regarding the terms and enforcement of insurer–provider contractual arrangements. The findings suggest that effective contractual terms and enforcement mechanisms contributed positively to clients' perceptions of healthcare service availability and reliability. Nonetheless, concerns relating to delays in claims approvals, inconsistencies in contractual implementation, and occasional service access challenges remained evident among some respondents.

Beyond the descriptive findings, the results suggest that clients' perceptions of healthcare service availability and reliability are strongly influenced by the effectiveness of insurer–provider contractual arrangements. The relatively high ratings on service accessibility and insurance acceptance indicate that contractual agreements may have reduced administrative barriers that commonly impede healthcare utilization. However, the comparatively lower ratings relating to claims approvals and adherence to contractual service standards suggest that operational implementation remains less consistent than contractual design. This implies that the mere existence of contractual agreements does not automatically translate into positive service experiences; rather, the effectiveness of contract enforcement, communication mechanisms, and claims management processes appears to determine whether contractual commitments are realized in practice. These findings are consistent with the Donabedian Model, which posits that structural arrangements and operational processes directly influence service outcomes. They also support the Gaps Model of Service Quality by suggesting that inconsistencies in contract implementation create gaps between client expectations and actual service experiences, thereby affecting perceptions of healthcare quality and reliability.

4.4.2 Contractual Relationship between Healthcare Facilities and Insurance Providers

At the beginning of the interviews, the respondents were asked to describe the contractual relationship between their healthcare facilities and insurance providers. The question sought to establish the nature, stability, and operations of insurer-provider contractual arrangements in Kenya's healthcare sector. Through inductive coding as proposed by Braun and Clarke (2006), a number of themes emerged from the qualitative data regarding the contractual relationships between healthcare providers and insurers. The themes are summarized in Table 4.4.

Table 4.4: Contractual Relationship between Healthcare Facilities and Insurance Providers

Theme	Code	References/Code Count
Changing contractual terms	Frequent changes in contract terms	3
	Alteration of credit days	2
	Changes in average costs and tariffs	2
Financial pressures	Delayed reimbursements	3
	Cost containment by insurers	2
	Approval and authorization constraints	1
Operational challenges	Contract interpretation disputes	2
	Approval and authorization constraints	1
Partnership	Continuous negotiation	2
	Business review engagements	1

As summarized in Table 4.4, changing contractual terms emerged as one of the main themes in explaining the nature of relationships between healthcare facilities and insurance providers. Participants reported that insurer-provider agreements were characterized by frequent adjustments relating to reimbursement structures, credit periods, and service costs.

In this regard, one participant stated, "*Provider and insurance terms tend to change a lot. For instance, credit days and average costs are altered depending on the agreement at a particular time*." This verbatim suggests that contractual arrangements between insurers and healthcare providers keep changing and subject to continuous revision. Participants stated frequent changes in contract terms created uncertainty in financial planning and operational management in healthcare facilities. The alteration of credit days affected cash flow management, while adjustments in average costs influenced pricing structures and reimbursement expectations.

Data also pointed to financial pressures arising from insurer-provider contractual relationships. Participants explained that delayed reimbursements and strict cost-containment measures by insurers sometime strained the operational capacity of healthcare facilities. One participant noted, *"Sometimes insurers revise payment terms unexpectedly, and this affects how facilities manage suppliers, staffing, and procurement of drugs."* This observation by the participant implies that healthcare providers often experience financial instability when contractual obligations relating to reimbursements are altered or delayed. Participants perceived that insurers' attempts to control healthcare expenditures occasionally shifted financial risks to healthcare facilities, which in turn affected service continuity and operational efficiency.

Participants indicated that disagreements over interpretation of contractual clauses, authorization requirements, and service approvals affected the working relationship between healthcare providers and insurers. In support of this view, one participant observed, *"There are times when the facility and insurer disagree on what services should be covered or the conditions for approvals, which creates tension in the relationship."*

Based on the quote, the participant suggests that contractual ambiguities and differing interpretations of policy provisions led to disputes between insurers and providers. Participants viewed approval and authorization procedures as important operational bottlenecks that occasionally delayed service delivery and strained institutional relationships.

The study further established that continuous negotiation and engagement formed part of the contractual relationship between healthcare facilities and insurers. Participants reported that business review meetings and routine engagements were commonly used to resolve disagreements and review contractual performance. One participant stated, *"The relationship is maintained through constant discussions and business review meetings because both parties have to keep adjusting to operational realities."* This excerpt suggest that insurer-provider contractual relationships are not static but involve ongoing collaboration and renegotiation. Participants perceived that regular engagements helped sustain working relationships, resolve disputes, and align expectations between healthcare facilities and insurers.

sThe findings suggest that insurer–provider contractual relationships are characterized by an inherent tension between cost control and service delivery objectives. While insurers seek to contain healthcare expenditures through contract revisions, authorization requirements, and reimbursement controls, healthcare providers prioritize financial stability and uninterrupted service provision. This explains why changing contractual terms and delayed reimbursements emerged as dominant themes across respondents. The findings further indicate that contractual challenges are not merely administrative issues but have broader implications for healthcare service quality, as financial uncertainty and

approval-related disputes may affect providers' ability to maintain adequate staffing levels, procure essential supplies, and deliver timely services. At the same time, the emphasis on continuous negotiations and business review engagements suggests that both parties recognize their mutual dependence and the need for collaborative mechanisms to sustain service delivery. These findings support the argument that the effectiveness of insurer–provider relationships depends not only on the existence of contractual agreements but also on the stability, clarity, and consistent implementation of contractual provisions.

Overall, the findings indicate that contractual relationships between healthcare providers and insurers are characterized by ever-changing agreements, financial pressures, operational challenges, and continuous negotiations. Whereas participants acknowledged the place of collaboration between insurers and healthcare providers in supporting healthcare service delivery, they also cited concerns relating to changing contract terms, reimbursement uncertainties, approval-related disputes, to mention but a few.

4.4.3 Key Elements Included in Insurer–Provider Agreements

The respondents were asked to identify the key elements commonly included in agreements between healthcare facilities and insurance providers. Since respondents were allowed to provide multiple responses, the findings were analyzed using multiple response qualitative coding to establish the most frequently cited contractual elements. The results are summarized in Table 4.5.

Table 4.5: Key Elements Included in Insurer–Provider Agreements

Element	Code Count
Reimbursement Timelines	6
Payment Rates	5
Service Coverage Scope	5
Service-Level Expectations	4
Dispute Procedures	2

As summarized in Table 4.5, reimbursement timelines was the most frequently cited element in insurer-provider agreements, with six code references. Participants explained that agreements specify the duration within which insurers are expected to reimburse healthcare facilities after claims submission. Respondents perceived reimbursement timelines as crucial because delays in settlement directly affect operational efficiency, cash flow management, and continuity of healthcare services.

Payment rates were also cited with five code references. Participants indicated that contracts usually define the rates payable for specific healthcare services offered to insured clients. The findings suggest that agreed payment rates are important in regulating financial relationships between insurers and healthcare providers while minimizing disputes relating to pricing and reimbursements.

Similarly, service coverage scope recorded five code references. Respondents explained that agreements specify the healthcare services, treatments, medications, and procedures covered under insurance arrangements. Participants perceived service coverage scope as important in guiding healthcare providers on what services could be offered under

insurance cover and reducing disagreements over excluded services.

Service-level expectations also emerged as a key contractual element with four code references. Participants indicated that insurer-provider agreements commonly outline the standards and expectations regarding healthcare service delivery, including response times, quality standards, and operational procedures. These provisions were viewed as important in promoting accountability and maintaining healthcare service quality among contracted facilities.

Dispute procedures recorded two code references, where it was explained that some agreements include mechanisms for resolving disagreements arising between insurers and healthcare providers concerning claims, reimbursements, and interpretation of contractual clauses. Respondents perceived dispute procedures as important in maintaining working relationships and facilitating resolution of conflicts without disrupting healthcare service delivery.

Beyond identifying the contractual elements contained in insurer–provider agreements, the findings reveal the priorities that shape relationships between healthcare providers and insurers. The prominence of reimbursement timelines, payment rates, and service coverage suggests that financial and operational considerations dominate contractual negotiations. This may reflect the need for both parties to balance cost containment with service delivery obligations in an increasingly competitive healthcare environment. The relatively lower emphasis placed on dispute resolution mechanisms is noteworthy, as it may indicate that contracts are designed primarily to regulate routine transactions rather than proactively manage disagreements. However, given the contractual disputes and reimbursement challenges reported in the preceding section, the limited attention accorded to dispute

procedures may contribute to unresolved conflicts and implementation challenges. These findings imply that the effectiveness of insurer–provider agreements depends not only on defining financial obligations and service coverage but also on establishing robust governance and conflict-resolution mechanisms capable of supporting long-term contractual stability and healthcare service quality.

4.4.4 Clarity and Practicality of Contractual Terms

The respondents were asked whether the contractual terms between healthcare facilities and insurance providers were clear and practical to implement. The question sought to establish participants' perceptions regarding the usability and applicability of contractual provisions in day-to-day healthcare operations. Through inductive coding as proposed by Braun and Clarke (2006), a number of themes and codes emerged from the qualitative data. The findings are summarized in Table 4.6.

Table 4.6: Clarity and Practicality of Contractual Terms

Theme	Code	References/Code Count
Clarity of contractual terms	Clearly defined contract terms	1
Practical implementation challenges	Difficulty in implementing cost limits	1
Impact on Treatment Decisions	Alteration of treatment plans	1
Financial constraints	Low coverage ceilings	1

As summarized in Table 4.6, respondents perceived contractual terms to be clear and understandable. However, participants observed that practical implementation of some

contractual provisions were difficult. Notably, financial limitations and coverage ceilings were cited as major barriers affecting implementation of treatment plans and service delivery decisions. One participant explained,

"*Yes, they are clear, but hard to implement. For example, dental has a cost limit of six thousand, which is difficult to achieve. Consequently, it affects treatment planning because a root-canal may end up being replaced with tooth extraction."*

In light of the verbatim, the participant suggests that although insurer-provider agreements provide clear guidelines regarding service coverage and reimbursement limits, some contractual provisions may not resonate with actual healthcare costs and clinical practicalities. Participants perceived low coverage ceilings as limiting providers' ability to offer required and ideal treatment options, which subsequently affected treatment planning and quality of care. The findings further imply that financial restrictions embedded in insurance contracts may compel healthcare providers and patients to opt for affordable treatment alternatives, even when more appropriate clinical interventions are available.

The findings reveal an important distinction between contractual clarity and contractual effectiveness. Although respondents generally considered insurer–provider agreements to be clear and unambiguous, clarity alone did not guarantee practical implementation. The challenges associated with coverage ceilings and cost limitations suggest a disconnect between contractual provisions and the actual cost of healthcare services. This indicates that contractual terms may be administratively clear but operationally restrictive, particularly where reimbursement limits fail to reflect prevailing treatment costs. The findings further imply that financial provisions within insurance contracts

can directly influence clinical decision-making by constraining the range of treatment options available to providers and patients. Consequently, the effectiveness of contractual arrangements should not be assessed solely in terms of clarity and compliance, but also in terms of their capacity to support appropriate clinical care and maintain service quality. These observations reinforce the argument that insurer–provider contracts play a significant role in shaping healthcare accessibility, treatment outcomes, and clients' perceptions of service quality.

4.4.5 Challenges Related to Contract Enforcement

The respondents were asked whether they had experienced challenges related to enforcement of contractual agreements between healthcare facilities and insurance providers. The question sought to establish the extent to which agreed contractual obligations were consistently implemented in insurer-provider relationships in Kenya. The findings are summarized in Table 4.6.

Table 4.6: Challenges Related to Contract Enforcement

Theme	Code	Code Count
Contract Enforcement Challenges	Non-adherence to agreed terms	4
	Failure to enforce contractual timelines	3
	Breach of payment agreements	3
Financial Delays	Extension of credit days	5
	Delayed reimbursements	4
	Cash flow constraints	3
Operational Strain	Disruption of facility operations	3
	Delays in procurement processes	2
	Interference with service delivery	2
Contractual Inconsistencies	Variation in agreed timelines	4
	Unpredictable changes in payment terms	3
	Weak accountability mechanisms	2

As summarized in Table 4.6, challenges relating to contract enforcement were cited in the qualitative findings. Participants reported that insurers did not consistently adhere to agreed contractual obligations regarding reimbursement timelines and credit periods. Respondents perceived non-adherence to contractual timelines as a major source of tension between healthcare facilities and insurance providers. In line with this, a key informant had the following to say, *"Yes. The agreed credit days increase from 5 days to 90 days."*

In the above verbatim, the participant demonstrates how contractual inconsistencies and weak enforcement mechanisms affected healthcare facilities operationally and financially. They perceived extension of credit days beyond agreed timelines as evidence of non-

compliance with contractual obligations by insurers. Such delays were viewed as antecedents of cash flow challenges, disruptions in procurement of drugs and medical supplies, and difficulties in sustaining smooth healthcare service delivery.

The findings further suggest that prolonged reimbursement periods negatively affected trust and predictability within insurer-provider relationships. Participants indicated that healthcare facilities mostly experienced uncertainty when payment timelines changed unexpectedly, which made it difficult to plan operations effectively. Consequently, respondents perceived weak accountability mechanisms and inconsistent enforcement of contractual agreements as key contributors to operational inefficiencies within healthcare facilities.

The findings suggest that the principal challenge is not the absence of contractual agreements but weaknesses in their enforcement and monitoring. The recurrent references to extended credit periods, delayed reimbursements, and unpredictable payment terms indicate a gap between contractual commitments and actual implementation. This finding implies that contractual effectiveness depends as much on compliance mechanisms as on the content of the agreements themselves. Furthermore, the observed cash flow constraints and operational disruptions demonstrate how contract enforcement challenges extend beyond administrative concerns to directly affect healthcare service delivery. Delays in reimbursements may.

4.4.6 Influence of Contract Terms on Healthcare Service Delivery and Facility Operations

The respondents were asked to explain how insurer-provider contract terms influenced availability of services to insured patients, continuity of care, and facility cash flow and

operations. The question sought to establish the practical implications of contractual arrangements on healthcare service delivery and operational sustainability in healthcare facilities in Kenya. Through inductive coding as proposed by Braun and Clarke (2006), the findings are summarized in Table 4.7.

Table 4.7: Influence of Contract Terms on Healthcare Service Delivery and Facility Operations

Area of Inquiry	Theme	Sub-theme / Initial Code	Code Count
Availability of services to insured patients	Resource Constraints	Shortages of medicines and supplies	4
	Service Limitations	Restriction of diagnostic procedures	3
	Financial Pressure on Service Delivery	Delayed remittances affecting service sustainability	3
	Prioritization of Essential Services	Reduction of non-essential service lines	2
	Procurement Challenges	Inability to stock specialized drugs and equipment	3
	Operational Strain	Service availability affected by reimbursement delays	2
Continuity of care	Treatment Interruptions	Delayed approvals affecting treatment continuity	4
	Chronic Care Challenges	Disruptions in chronic illness management	3
	Supplier-Related Disruptions	Pending bills interrupting treatment schedules	2
	Operational Delays	Delays in laboratory tests and specialist referrals	3
	Administrative Barriers	Insurance-related delays postponing treatment reviews	2
	Financially Strained Continuity	Difficulty maintaining uninterrupted patient care	3
Facility cash flow and operations	Reimbursement Delays	Long reimbursement timelines	5
	Financial Pressure	Immediate operational costs despite unpaid claims	4
	Cash Flow Instability	Limited capacity for expansion and quality improvement	3
	Operational Financing Mismatch	Facilities paying suppliers before reimbursement	3
	Operational Disruptions	Procurement and maintenance challenges	3
	Borrowing for Sustainability	Reliance on loans and overdrafts	2
	Human Resource Challenges	Delayed salary disbursement and low staff morale	3

As summarized in Table 4.7, respondents indicated that contract terms influenced availability of services to insured patients, continuity of care, and facility cash flow and

operations. Under availability of services, participants cited shortages of medicines and medical supplies, restriction of diagnostic procedures, and inability to sustain all service lines due to delayed reimbursements and financial constraints. Consistent with this finding, a key informant had the following to say,

> *"When reimbursements delay for several weeks or months, some departments experience shortages of medicines and supplies, which affects the range of services we can offer insured patients."*

The above verbatim suggests that delayed reimbursements negatively affect healthcare facilities' capacity to maintain adequate stock levels and sustain comprehensive healthcare services. Participants perceived reimbursement delays as precursors of operational strain, which subsequently forces healthcare facilities to prioritize essential services while limiting specialized procedures and treatments for insured patients.

Regarding continuity of care, respondents stated that delayed approvals, reimbursement challenges, and supplier-related disruptions interfered with uninterrupted patient treatment for patients with chronic illnesses who require continuous care and follow-up services. In support of this argument, one participant observed, *"Delayed insurance payments interrupt continuity of care because some patients cannot continue treatment when approvals or reimbursements take too long."* From the excerpt, it is the view of the participant that insurer-provider contractual terms directly affect patient treatment continuity by influencing access to medications, laboratory testing, specialist referrals, and scheduled treatment reviews. Participants understood administrative delays and financial strain as major barriers to maintaining uninterrupted healthcare services for insured patients.

Concerning facility cash flow and operations, participants revealed long reimbursement timelines, operational financing mismatches, and financial pressure arising from delayed claims settlement. One participant stated, *"The biggest challenge is that insurers can take anywhere between 30 and 90 days to reimburse claims, yet salaries and operational expenses must be paid immediately."* The informant demonstrates how delayed reimbursements create cash flow in within healthcare facilities. Equally, they interpreted prolonged reimbursement cycles as disrupting procurement processes, equipment maintenance, salary payments, and service expansion initiatives. Some respondents further indicated that facilities occasionally relied on loans or overdrafts to sustain operations while awaiting insurer reimbursements.

The findings demonstrate that insurer–provider contract terms have consequences that extend beyond financial arrangements to directly influence healthcare service availability, continuity of care, and institutional sustainability. A notable pattern emerging from the data is the interconnected nature of reimbursement delays, operational constraints, and patient outcomes. Delayed reimbursements appear to trigger a chain reaction in which cash flow challenges limit procurement of medicines and supplies, disrupt treatment schedules, constrain staffing and operational capacity, and ultimately affect the quality and continuity of care available to insured patients. This suggests that contractual terms function not merely as administrative instruments but as critical determinants of healthcare system performance at the facility level. The findings further imply that the effectiveness of insurer–provider relationships should be evaluated not only in terms of financial compliance but also in terms of their capacity to support uninterrupted service delivery and positive patient outcomes. These observations are consistent with the Donabedian Model,

which emphasizes that structural and process-related factors within healthcare systems directly influence service outcomes and quality of care.

4.4.7 Contractual Disagreements and Patient Service Delivery

The respondents were asked whether contractual disagreements between healthcare facilities and insurance providers had ever affected patient service delivery. The question sought to establish how disputes arising from insurer-provider contractual relationships influenced healthcare access, continuity of services, and patient experiences within healthcare facilities in Kenya. The findings are summarized in Table 4.8.

Table 4.8: Contractual Disagreements and Patient Service Delivery

Theme	Codes	Code Count
Service Disruptions	Suspension of outpatient services	3
	Interruptions in service delivery	2
	Delayed approval of medical services	3
Patient Burden	Patient inconvenience and confusion	3
	Forced out-of-pocket payments	2
	Postponement of treatment	2
Contractual and Financial Disputes	Disagreements over reimbursement rates	3
	Disputes concerning treatment packages	2
	Delayed resolution of contractual issues	1

As summarized in Table 4.8, contractual disagreements between healthcare facilities and insurers were perceived to negatively affect patient service delivery through service disruptions, financial burdens on patients, and operational delays. It was the view of the

informants that disputes relating to reimbursement arrangements and contractual obligations, most of the time, resulted in suspension or interruption of healthcare services, which in turn affected patient access to timely treatment. In support of this view, one participant stated,

> *"There have been instances where an insurer suspended outpatient services without prior notice due to contractual disagreements, and this created confusion and inconvenience for patients who had already booked appointments."*

The above verbatim suggests that contractual disagreements between insurers and healthcare providers can directly disrupt healthcare service delivery and negatively affect patient experiences. Participants perceived sudden suspension of services as creating uncertainty, inconvenience, and dissatisfaction among insured patients who had already planned or scheduled treatment visits. The findings further signify that lack of prior communication during contractual disputes may undermine patient trust and confidence in both insurers and healthcare facilities.

The findings also revealed that disagreements over reimbursement rates, treatment packages, and claim settlements contributed to delays in service approvals and interruptions in patient care. It was the perspective of the informants that some patients were occasionally forced to pay for services out-of-pocket or postpone treatment due to unresolved contractual disputes between insurers and healthcare providers. These experiences were viewed as negatively affecting accessibility, continuity, and reliability of healthcare services for insured patients.

The findings suggest that contractual disagreements have implications that extend beyond

organizational relationships to directly affect patient welfare and healthcare outcomes. A key pattern emerging from the data is that patients often bear the consequences of disputes in which they are not directly involved. Service suspensions, delayed approvals, and out-of-pocket payments indicate that contractual conflicts may transfer operational and financial risks from insurers and healthcare providers to patients. This finding highlights the interconnected nature of insurer–provider relationships and patient experiences, where weaknesses in contractual governance can undermine the core purpose of health insurance, namely, ensuring timely and affordable access to healthcare services. Furthermore, the occurrence of service disruptions and treatment postponements suggests that dispute resolution mechanisms may not be sufficiently effective to protect patients from the adverse effects of contractual disagreements. These findings imply that strengthening communication channels, dispute resolution procedures, and contractual accountability mechanisms is essential not only for improving insurer–provider relations but also for safeguarding continuity, accessibility, and reliability of healthcare services for insured clients.

4.5 Communication and Coordination Mechanisms

4.5.1 Descriptive Statistics

The study sought to analyze the relationship between communication and coordination mechanisms between insurers and healthcare providers and clients' perceptions of healthcare service responsiveness in Kenya. To achieve this objective, respondents were asked to indicate their level of agreement with statements relating to clarity of communication regarding insurance-covered services, responsiveness of insurers to provider queries, coordination between insurers and healthcare facilities, timeliness of

feedback on preauthorization and claims requests, satisfaction with communication processes, and the extent to which coordination improved service responsiveness. Responses were measured on a five-point Likert scale ranging from strongly disagree to strongly agree. The findings are presented in Table 4.5.

Table 4.4: Communication and Coordination Mechanisms

Statement	Strongly Disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly Agree n (%)	Mean	Std dev.
The facility staff communicate clearly about services covered by insurance.	47	52	36	43	14	2.6	1.27
	24.5%	27.1%	18.8%	22.4%	7.3%		
My insurer promptly responds to queries raised by the healthcare provider.	41	50	45	39	17	2.7	1.26
	21.4%	26.0%	23.4%	20.3%	8.9%		
Coordination between the insurer and facility reduces service delays.	22	25	33	65	47	3.5	1.30
	11.5%	13.0%	17.2%	33.9%	24.5%		
The insurer provides timely feedback on preauthorization and claims requests.	25	35	36	59	37	3.3	1.31
	13.0%	18.2%	18.8%	30.7%	19.3%		
I am satisfied with the communication between the insurer, provider, and myself.	19	9	33	70	61	3.8	1.23
	9.9%	4.7%	17.2%	36.5%	31.8%		
Service responsiveness has improved due to better coordination between insurers and providers.	19	9	14	72	78	3.9	1.25
	9.9%	4.7%	7.3%	37.5%	40.6%		
Average						3.3	1.27

The findings revealed that respondents perceived communication by healthcare facility staff regarding services covered under insurance as inadequate (mean = 2.6; S.D. = 1.27). A considerable proportion of respondents strongly disagreed (24.5%) or disagreed (27.1%) that facility staff communicated clearly about insurance-covered services, while only 22.4% agreed and 7.3% strongly agreed. These findings suggest that ineffective

communication regarding insurance benefits and coverage was a challenge among healthcare providers and insurers. Poor communication may negatively affect clients' understanding of available healthcare services and subsequently reduce satisfaction with service responsiveness.

The study established that respondents perceived insurers' responsiveness to healthcare provider queries as relatively low (mean = 2.7; S.D. = 1.26). More than half of the respondents strongly disagreed (21.4%) or disagreed (26.0%) that insurers promptly responded to queries raised by healthcare providers. Only 20.3% agreed and 8.9% strongly agreed with the statement. These findings imply that delayed responses to provider inquiries may hinder effective coordination between insurers and healthcare facilities, consequently affecting the responsiveness and efficiency of healthcare service delivery.

The findings showed that respondents generally believed coordination between insurers and healthcare facilities helped reduce service delays (mean = 3.5; S.D. = 1.30). A majority of respondents agreed (33.9%) or strongly agreed (24.5%) that effective coordination minimized delays in service delivery, compared to 11.5% who strongly disagreed and 13.0% who disagreed. These findings suggest that coordinated interactions between insurers and healthcare providers contributed positively to improved healthcare service responsiveness by facilitating smoother service processes and minimizing administrative bottlenecks.

The study also established that respondents moderately agreed that insurers provided timely feedback regarding preauthorization and claims requests (mean = 3.3; S.D. = 1.31). Specifically, 30.7% of respondents agreed while 19.3% strongly agreed with the statement.

However, a notable proportion of respondents strongly disagreed (13.0%) or disagreed (18.2%) with the statement, indicating mixed experiences regarding the timeliness of insurer feedback. These findings imply that although communication systems relating to preauthorization and claims management had improved, delays and inconsistencies in feedback processes still affected service responsiveness among some clients.

The findings further revealed that respondents were generally satisfied with communication between insurers, healthcare providers, and themselves (mean = 3.8; S.D. = 1.23). The majority of respondents agreed (36.5%) or strongly agreed (31.8%) that communication among the three parties was satisfactory. Only a small proportion strongly disagreed (9.9%) or disagreed (4.7%) with the statement. These findings suggest that despite concerns regarding clarity of insurance information and responsiveness to provider queries, overall communication structures between insurers and healthcare providers were perceived positively by many respondents.

Additionally, the study established that respondents strongly believed healthcare service responsiveness had improved due to better coordination between insurers and healthcare providers (mean = 3.9; S.D. = 1.25). A substantial proportion of respondents agreed (37.5%) or strongly agreed (40.6%) that improved coordination enhanced service responsiveness. Very few respondents strongly disagreed (9.9%) or disagreed (4.7%) with the statement. These findings indicate that effective communication and coordination mechanisms between insurers and providers played a critical role in improving healthcare service responsiveness by reducing delays and enhancing service efficiency.

The findings therefore suggest that respondents differentiated between the quality of

information exchanged during routine interactions and the effectiveness of broader coordination systems. While communication regarding insurance benefits and insurer responses was perceived as inadequate, coordination mechanisms such as digital platforms, preauthorization systems, and provider–insurer linkages were viewed as sufficiently effective in reducing delays and improving service responsiveness. Consequently, the positive ratings for coordination and service responsiveness do not necessarily contradict the lower ratings for communication clarity and responsiveness.

Overall, the findings yielded an aggregate mean score of 3.3 and a standard deviation of 1.27, which signifies moderate perceptions regarding communication and coordination mechanisms between insurers and healthcare providers. The findings imply that while respondents acknowledged improvements in service responsiveness arising from enhanced coordination and communication, challenges relating to clarity of insurance information and delayed responses to provider queries still persisted.

A notable pattern emerging from the findings is the apparent contrast between operational communication challenges and overall perceptions of improved service responsiveness. While respondents expressed dissatisfaction with the clarity of information regarding insurance-covered services and the speed with which insurers responded to provider queries, they simultaneously acknowledged that coordination between insurers and healthcare facilities contributed to reduced service delays and improved responsiveness. This suggests that clients may distinguish between day-to-day communication deficiencies and broader institutional coordination outcomes. The findings imply that effective coordination mechanisms can compensate for certain communication shortcomings by facilitating smoother service delivery processes. However, the relatively low ratings on

communication clarity and insurer responsiveness indicate that information asymmetries remain a significant challenge. Consequently, improvements in service responsiveness may not be fully optimized unless insurers and healthcare providers strengthen information-sharing mechanisms, improve feedback timelines, and enhance transparency regarding insurance benefits and procedures. These findings support the view that communication and coordination are complementary rather than independent determinants of healthcare service responsiveness.

4.5.2 Communication Channels, Authorization Processes, and Service Approval Challenges

The study sought to examine the communication and coordination mechanisms existing between healthcare facilities and insurance providers, with a particular focus on communication channels, efficiency of authorization processes, and challenges encountered during service approval. This objective was anchored on the process component of the Donabedian Model, which puts emphasis on the importance of effective coordination and responsiveness in healthcare service delivery. Respondents were therefore asked to explain the communication systems used between insurers and providers, the efficiency of service authorization procedures, and the common challenges experienced when obtaining approvals for healthcare services. The findings are summarized in Table 4.9.

Table 4.9: Communication Channels, Authorization Processes, and Service Approval Challenges

Area of Inquiry	Theme	Code	Code Count
Communication channels between facilities and insurers	Digital Communication Systems	Digital claims platforms	7
	Electronic Communication	Email/portal systems	6
	Interpersonal Coordination	Liaison officers	6
	Direct Communication Support	Call centers	5
Efficiency of authorization process	Authorization Efficiency	Efficient approvals with private insurers	3
	Delayed Authorizations	Slow approvals under SHA	2
	System Challenges	System downtimes affecting approvals	1
	Operational Delays	Delayed approvals affecting emergency care	2
Challenges in obtaining service approvals	Approval Delays	Long waiting periods for approvals	3
	Claim Rejections	Initial approvals later rejected	2
	Partial Approvals	Limited approval for procedures and medications	2
	Lack of Transparency	Rejections without clear explanations	2

As summarized in Table 4.9, digital claims platforms, email or portal systems, liaison officers, and call centers were cited as the major communication channels used between healthcare facilities and insurers. Respondents indicated that digital communication systems were central to coordinating approvals, claims processing, and service verification processes. Participants further noted that authorization processes were generally efficient among private insurers, where digital systems were integrated into healthcare operations. However, delays, system downtimes, and inconsistent approvals still affected timely healthcare service delivery. Participants also revealed a number of drawbacks relating to service approvals, such as prolonged waiting periods, rejection of previously approved

claims, partial authorization of services, and lack of transparency in approval decisions. One participant explained,

> *"Sometimes the approvals take too long when the treatment is urgent. By the time approval comes through, the patient has already experienced delays in receiving care."*

The above verbatim suggests that delays in authorization processes negatively affect responsiveness of healthcare services in urgent or emergency situations. Respondents perceived prolonged approval timelines and inconsistent authorization decisions as major barriers to efficient healthcare service delivery for insured patients.

The findings reveal that the effectiveness of communication and coordination mechanisms depends not only on the availability of communication channels but also on the efficiency and transparency of the processes they support. Although respondents reported widespread use of digital claims platforms, email systems, liaison officers, and call centers, service approval challenges remained prevalent. This suggests that technological infrastructure alone does not guarantee responsiveness if authorization procedures are slow, inconsistent, or insufficiently transparent. The findings further indicate that authorization processes represent a critical link between communication systems and actual service delivery outcomes. Delays in approvals, claim rejections, and partial authorizations appear to undermine the benefits of otherwise well-established communication networks. Consequently, the results imply that improving healthcare service responsiveness requires not only investment in communication technologies but also reforms aimed at streamlining approval processes, enhancing decision transparency, and reducing administrative bottlenecks. These observations support the process

dimension of the Donabedian Model, which emphasizes that the quality of operational interactions directly influences healthcare service outcomes.

4.5.3 Effects of Communication Delays, Communication Efficiency, and Technological Coordination

The study further sought to establish how communication delays affected healthcare service responsiveness in relation to waiting time for insured patients, patient satisfaction, and staff morale. In addition, respondents were asked whether communication efficiency differed across insurers and whether technology had improved coordination between healthcare providers and insurers. Guided by the process dimension of the Donabedian Model, the study examined how communication responsiveness and technological systems influenced service delivery outcomes. The findings are summarized in Table 4.10.

Table 4.10: Effects of Communication Delays, Communication Efficiency, and Technological Coordination

Area of Inquiry	Theme	Codes	Code Count
Effects of communication delays on waiting time for insured patients	Delayed service Access	Patients waiting for approvals before treatment	3
	Extended waiting periods	Patients staying for hours awaiting insurer feedback	2
Effects of communication delays on patient satisfaction	Patient frustration	Delayed treatment and discharge processes	2
	Reduced patient confidence	Loss of confidence in healthcare services	2
Effects of communication delays on staff morale	Workplace pressure	Patients directing frustrations toward staff	2
	Reduced employee morale	Repeated follow-ups without timely responses	2
Differences in communication efficiency between insurers	Variability in response time	Immediate versus delayed approvals	3
	Technological differences	Efficient digital systems among some insurers	2
	Delayed feedback systems	Communication delays lasting days or weeks	2
Technology and coordination improvement	Digital transformation	Shift from emails to integrated portals	3
	AI-supported systems	Faster approvals and automated feedback	2
	Operational efficiency	Real-time tracking of claims and approvals	2

As summarized in Table 4.10, communication delays between insurers and healthcare providers were perceived to negatively affect waiting time for insured patients, patient satisfaction, and staff morale. Respondents indicated that patients frequently experienced prolonged waiting periods while healthcare facilities waited for authorization or claim

verification from insurers. Delays in communication were also viewed as precursors of frustration among patients and increased pressure on healthcare workers who handled patient complaints arising from approval delays.

The findings further revealed notable differences in communication efficiency between insurers. Participants observed that some insurers processed approvals within minutes due to efficient digital systems, while others took several days or even weeks to respond to healthcare facilities. One participant stated,

> "*Yes, there are major differences between insurers. Some insurers respond to approvals within 5 to 30 minutes, especially those with efficient digital systems, while others can take up to five days before giving feedback."*

Based on the verbatim, it is the view of the participant that communication efficiency largely depended on the technological capabilities and operational systems adopted by insurers. Equally, it was viewed that insurers with integrated digital systems and automated communication platforms as more responsive and efficient in-service coordination.

Technology was quoted as a major factor improving coordination between healthcare facilities and insurers. Participants indicated that there had been a notable shift from traditional email-based communication toward integrated insurer-provider portals supported by artificial intelligence systems. These systems were said to facilitate faster approvals, automatic feedback, and real-time tracking of claims and authorizations, thus enhancing healthcare service responsiveness and coordination efficiency.

The findings suggest that communication efficiency serves as a critical determinant of healthcare service responsiveness, influencing not only operational processes but also

patient and staff experiences. A notable pattern emerging from the data is that communication delays generate cascading effects across the healthcare delivery chain. Delayed approvals increase patient waiting times, contribute to dissatisfaction, and place additional pressure on healthcare workers who must manage patient expectations despite having limited control over insurer response times. The marked differences in communication efficiency across insurers further indicate that organizational capacity and technological sophistication significantly influence service responsiveness. The findings also demonstrate that technology functions as an enabler rather than an end in itself; insurers with integrated digital platforms and automated approval systems appear better positioned to provide timely feedback and facilitate seamless coordination with healthcare providers. Consequently, improvements in healthcare service responsiveness are likely to depend on both technological investment and the redesign of communication workflows to ensure faster decision-making, reduced administrative delays, and enhanced stakeholder experiences. These observations reinforce the Donabedian Model's proposition that effective healthcare processes are fundamental to achieving positive service outcomes and higher levels of client satisfaction.

4.6 Timeliness of Claims Reimbursement and Dispute Resolution

4.6.1 Descriptive Statistics

The study sought to examine the relationship between the timeliness of insurance claims reimbursement and dispute resolution mechanisms and clients' perceptions of healthcare service quality in Kenya. To achieve this objective, respondents were required to indicate their level of agreement with statements relating to prompt processing and approval of claims, delays in accessing healthcare services due to claims issues, fairness and timeliness

of dispute resolution, awareness of claims dispute handling procedures, effects of delayed reimbursements on service quality perceptions, and overall satisfaction with the claims process under their insurance plans. Responses were measured using a five-point Likert scale ranging from strongly disagree to strongly agree. The findings are presented in Table 4.11.

Table 4.11: Descriptive Statistics on Timeliness of Claims Reimbursement and Dispute Resolution

Statement	Strongly Disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly Agree n (%)	Mean	Std dev.
Claims are processed and approved promptly by my insurer.	48	49	37	46	12	2.6	1.27
	25.0%	25.5%	19.3%	24.0%	6.2%		
I rarely experience delays in accessing services due to claim processing issues.	42	48	40	43	19	2.7	1.30
	21.9%	25.0%	20.8%	22.4%	9.9%		
When disputes occur, they are resolved fairly and within a reasonable time.	17	17	48	64	46	3.5	1.20
	8.9%	8.9%	25.0%	33.3%	24.0%		
I am aware of how my insurer and provider handle claim disputes.	27	35	39	53	38	3.2	1.33
	14.1%	18.2%	20.3%	27.6%	19.8%		
Delayed reimbursements or disputes negatively affect my perception of service quality.	21	19	34	59	59	3.6	1.31
	10.9%	9.9%	17.7%	30.7%	30.7%		
Overall, I am satisfied with the claims process under my current insurance plan	18	9	33	65	67	3.8	1.23
	9.4%	4.7%	17.2%	33.9%	34.9%		
Average						3.3	1.27

The findings revealed that respondents generally perceived claims processing and approval by insurers to be slow and inefficient (mean = 2.6; S.D. = 1.27). Half of the respondents strongly disagreed (25.0%) or disagreed (25.5%) that claims were processed and approved promptly by their insurers, while only 24.0% agreed and 6.2% strongly agreed. These findings suggest that delays in claims processing remained a major challenge affecting

clients' experiences with insured healthcare services. Inefficiencies in claims approvals may undermine confidence in insurance systems and negatively affect perceptions of healthcare service quality.

The study established that respondents frequently experienced delays in accessing healthcare services due to claim processing issues (mean = 2.7; S.D. = 1.30). A substantial proportion of respondents strongly disagreed (21.9%) or disagreed (25.0%) that they rarely experienced delays associated with claims processing. Only 22.4% agreed and 9.9% strongly agreed with the statement. These findings imply that delays in reimbursement and claims approval processes negatively affected timely access to healthcare services among insured clients.

The findings further showed that respondents generally perceived dispute resolution mechanisms between insurers and healthcare providers to be relatively fair and timely (mean = 3.5; S.D. = 1.20). The majority of respondents agreed (33.3%) or strongly agreed (24.0%) that disputes were resolved fairly and within a reasonable time whenever they occurred. Only a small proportion strongly disagreed (8.9%) or disagreed (8.9%) with the statement. These findings suggest that although challenges existed in claims reimbursement processes, dispute resolution mechanisms were perceived positively and may have contributed to maintaining confidence in insurer-provider contractual relationships.

The study also established that respondents demonstrated moderate awareness regarding how insurers and healthcare providers handled claim disputes (mean = 3.2; S.D. = 1.33). While 27.6% of respondents agreed and 19.8% strongly agreed that they were aware of

claims dispute handling procedures, a notable proportion strongly disagreed (14.1%) or disagreed (18.2%) with the statement. Additionally, 20.3% remained neutral. These findings imply that although some clients were familiar with dispute resolution procedures, awareness levels remained inconsistent, potentially affecting clients' confidence and experiences during claims disputes.

The findings further revealed that respondents strongly believed delayed reimbursements and disputes negatively affected their perceptions of healthcare service quality (mean = 3.6; S.D. = 1.31). A majority of respondents agreed (30.7%) or strongly agreed (30.7%) that reimbursement delays and disputes adversely influenced their perceptions of healthcare service quality. Only a minority strongly disagreed (10.9%) or disagreed (9.9%) with the statement. These findings suggest that inefficiencies in reimbursement and dispute management processes significantly shaped clients' evaluations of healthcare quality under insurance arrangements.

The study established that respondents were generally satisfied with the overall claims process under their current insurance plans (mean = 3.8; S.D. = 1.23). A substantial proportion of respondents agreed (33.9%) or strongly agreed (34.9%) with the statement, compared to relatively few who strongly disagreed (9.4%) or disagreed (4.7%). These findings imply that despite concerns regarding delays in claims processing, respondents still perceived the overall claims management systems under their insurance plans positively.

Overall, the findings yielded an aggregate mean score of 3.3 and a standard deviation of 1.27, which indicates moderate perceptions regarding the timeliness of claims

reimbursement and dispute resolution mechanisms. The findings suggest that while dispute resolution processes and overall claims management systems were perceived relatively positively, delays in claims approvals and reimbursement processes continued to negatively affect healthcare access and perceptions of healthcare service quality.

A notable pattern emerging from the findings is the coexistence of dissatisfaction with claims processing speed and relatively positive perceptions of dispute resolution and overall claims management. This apparent contradiction suggests that clients may differentiate between routine operational inefficiencies and the mechanisms available for resolving problems when they arise. While delays in claims approvals and reimbursements were perceived as barriers to timely healthcare access, respondents appeared to derive confidence from the existence of dispute resolution processes that were generally viewed as fair and timely. Nevertheless, the findings indicate that reimbursement delays have a more immediate and visible impact on service experiences than dispute resolution outcomes, as they directly affect access to care and perceptions of service quality. The moderate levels of awareness regarding dispute handling procedures further suggest that the effectiveness of these mechanisms may not be fully realized due to information gaps among insured clients. Consequently, improving healthcare service quality may require not only faster claims processing and reimbursement systems but also enhanced client education and transparency regarding dispute resolution procedures. These findings reinforce the importance of administrative efficiency as a key determinant of perceived healthcare quality within insurance-mediated healthcare systems.

4.6.2 Thematic Analysis of Claims Reimbursement and Dispute Resolution

Following the analysis of quantitative findings, the study further explored qualitative

responses relating to claims reimbursement and dispute resolution to assess how reimbursement processes, claims disputes, and administrative inefficiencies influence healthcare service quality in private health facilities. The open-ended questions sought to generate in-depth insights regarding reimbursement turnaround times, operational effects of delayed payments, service denial linked to pending claims, causes of claims rejection, dispute resolution mechanisms, and the implications of claims processing inefficiencies on service reliability, patient trust, and overall healthcare quality. To analyze these responses, the study adopted thematic analysis, where recurring ideas and patterns were coded into themes and sub-themes. Table 4.12 presents the thematic summary generated from the analysis.

Table 4.12: Thematic Summary of Claims Reimbursement and Dispute Resolution

Area of Inquiry	Theme	Sub-theme / Initial Code	Code Count
Typical Turnaround Time for Reimbursement	Delayed reimbursement cycles	Reimbursements take between 60-90 days with average of 75 days	3
Effect of Reimbursement Delays on Operations	Financial and operational strain	Delayed reimbursements affect restocking of drugs and supplies	2
	Cash flow constraints	Inability to meet salaries, rent, utilities, and operational expenses	3
	Service disruptions	Reduced patient handling capacity and interruptions in service delivery	2
Delay or Denial of Services Due to Pending Claims	Service limitation and denial	Facilities limit services or require cash payments	2
	Patient referral and turn aways	Patients referred elsewhere due to unpaid claims	1
Causes of Claim Rejection or Disputes	Documentation errors	Missing documents and incomplete claim forms	2
	Clinical and coding inconsistencies	Diagnosis mismatch, coding errors, and inaccurate records	3
	Authorization and policy exclusions	Lack of preauthorization and non-covered treatments	2
Dispute Resolution Mechanisms	Negotiation and business reviews	Business review meetings and reconciliation processes	2
	Alternative dispute resolution	Mediation and negotiations preferred to preserve relationships	1
	Escalation and claim audits	Legal escalation, audits, and direct engagement with case managers	2
Effect on Reliability of Services	Uncertainty in service delivery	Delayed approvals disrupt treatment consistency	2
	Interruptions in specialized care	Delays affect admission and specialized treatment services	1
Effect on Patient Trust	Reduced confidence in insurance	Patients lose trust due to repeated delays and claim rejections	2
	Frustration and dissatisfaction	Patients perceive insurance cover as unreliable	1
Effect on Overall Service Quality	Decline in quality of care	Delays affect availability of drugs, supplies, and equipment	2
	Increased staff pressure	Healthcare workers experience strain and slower service delivery	1

As summarized in Table 4.12, the analysis of claims reimbursement and dispute resolution

yielded a number of themes and codes relating to delays in reimbursement, operational constraints, service disruptions, claims rejection, dispute resolution practices, and the effects of inefficiencies on healthcare service delivery. Respondents indicated that reimbursement processes were characterized by prolonged turnaround periods, where many facilities had waiting time between 60 and 90 days before claims are settled by insurers. This prolonged waiting period was perceived as disruptive to healthcare financing and continuity of services. One respondent stated*, "Takes an average of 75 days."* Another respondent added, "*Others span to 90 days with a median of 75 days."* The observation by the participant signifies that reimbursement delays are a common challenge in insured healthcare provision and have notable implications for healthcare facility sustainability.

Participants further explained that delayed reimbursements create operational and financial constraints within healthcare facilities. Respondents reported difficulties in restocking drugs and medical supplies, meeting operational expenses, such as rent and salaries, and maintaining smooth service delivery. In some cases, suppliers reportedly withheld supplies because facilities had accumulated unpaid balances resulting from insurer delays. One participant explained,

> *"Reimbursement delays affect our ability to restock essential drugs and medical supplies because suppliers demand payment before delivering new stock."*

Another respondent observed,

> *"When insurers delay reimbursements, the facility struggles to meet operational expenses such as rent, utilities, and staff salaries, which disrupts service delivery."*

From above quotes, it can be inferred that reimbursement inefficiencies lead to financial

instability within healthcare facilities, which subsequently undermines continuity and reliability of healthcare services. Review of responses further showed that pending claims occasionally force healthcare facilities to limit or deny services to insured patients. Participants noted that some facilities resort to restricting treatment options, requesting cash payments, or referring patients elsewhere when insurers fail to settle outstanding claims. Such practices were viewed as necessary coping mechanisms to sustain operations despite financial strain. One respondent narrated,

> *"Yes, there are situations where pending claims force facilities to limit services to only low-cost treatments or ask patients to pay cash because the insurer has not settled previous bills."*

Similarly, another participant explained,

> *"I have personally seen patients turned away or referred elsewhere when outstanding claims remain unpaid for too long."*

From the verbatims, participants viewed reimbursement delays affect healthcare facilities financially as well as compromise equitable access to insured healthcare services. The study equally explored the common causes of claim rejection and disputes between insurers and healthcare providers. Participants identified incomplete documentation, coding inconsistencies, clinical mismatches, lack of preauthorization, and policy exclusions as the major causes of disputes and claim denials. Respondents explained that administrative inaccuracies and discrepancies between diagnoses and prescribed treatments frequently trigger insurer queries and rejections. In support of this argument, one participant stated,

> *"One of the most common causes of claim rejection is incomplete*

documentation, especially when claim forms are not properly filled or supporting documents are missing."

Another respondent observed,

"Clinical rejections occur frequently when the diagnosis provided does not match the prescribed tests, procedures, or drugs."

Reflecting on the quotes, it is possible that both administrative and clinical documentation challenges translate into delays and disputes in claims reimbursement processes. With regard to dispute resolution mechanisms, participants revealed that disputes were resolved through business review meetings, negotiations, mediation, audits, and direct engagements between healthcare providers and insurers. In some situations, which involve prolonged disputes or large financial claims, legal mechanisms are reportedly used. One respondent explained,

"Most disputes are first addressed through business review meetings between the insurer and the healthcare facility, where both parties reconcile claims and discuss areas of disagreement."

Another participant added,

"Some insurers prefer alternative dispute resolution mechanisms such as negotiations and mediation because they are faster and help maintain working relationships between providers and insurers."

Based on these observations, dispute resolution appears to rely heavily on collaborative and administrative approaches, which is aimed at preserving long-term relationships between insurers and healthcare facilities. Participants also revealed the effects of claims processing inefficiencies on the reliability of healthcare services. Notably, delayed

approvals and prolonged reimbursement periods create uncertainty in treatment access for specialized care and admission services. According to respondents, patients are often unsure whether insurers will approve treatments on time, which affects continuity of care. One participant explained,

> *"Patients are not always sure whether they will receive treatment on time or whether the insurer will approve the services."*

Another respondent noted,

> *"It is common in our facility to experience interruptions in service delivery when claims take too long to process."*

From his evidence, it is possible to argue that reimbursement inefficiencies undermine the predictability and reliability of healthcare delivery systems. In relation to patient trust, respondents revealed that repeated reimbursement delays and unexpected claim rejections negatively affect patients' confidence in both insurers and healthcare providers. Participants explained that patients become frustrated when approvals are delayed or when insurance coverage appears unreliable. One informant had the following to say,

> *"I have seen many patients lose trust in both the insurer and the facility when they are repeatedly told to wait for approvals or when claims are rejected unexpectedly."*

Another informant stated,

> *"Delayed claims processing creates frustration among patients, and some end up feeling that their insurance cover is not dependable."*

Respondents explained that reimbursement inefficiencies negatively affect the overall quality of healthcare services. Participants noted that delayed payments affect the

availability of drugs, supplies, and equipment, while also increasing pressure on healthcare workers due to slowed service delivery and financial strain. One informant stated the following,

> *"It is common in our facility for service quality to decline whenever reimbursement delays affect the availability of drugs, supplies, and other essential resources."*

Another respondent added,

> *"I have observed that claims processing inefficiencies increase pressure on healthcare workers and slow down service delivery, which eventually affects the overall quality of care offered to patients."*

From these findings, it can be inferred that claims reimbursement inefficiencies have broader implications for healthcare quality, staff performance, and patient experiences within insured healthcare systems.

A notable pattern emerging from the findings is that claims reimbursement inefficiencies create a cascading effect that extends beyond financial management to influence healthcare service reliability, patient trust, and overall service quality. While reimbursement delays initially manifest as administrative and financial challenges, the evidence suggests that their consequences progressively affect operational capacity, treatment continuity, and patient experiences. The findings indicate that healthcare facilities often respond to delayed payments through service limitations, referrals, or requests for cash payments, thereby transferring part of the financial burden to patients. Furthermore, the prevalence of documentation errors, coding inconsistencies, and authorization-related disputes suggests that many reimbursement challenges originate from systemic weaknesses in claims

management rather than isolated incidents. The reliance on negotiation, mediation, and business review meetings further demonstrates that collaborative dispute resolution has become a necessary mechanism for sustaining insurer–provider relationships in the face of persistent reimbursement challenges. Ultimately, the findings imply that improving healthcare service quality requires not only faster reimbursement cycles but also stronger claims management systems, clearer documentation standards, and more efficient coordination between insurers and healthcare providers. These observations support the study's argument that reimbursement and dispute resolution processes are critical determinants of perceived healthcare service quality.

4.7 Quality of Healthcare

4.7.1 Descriptive Statistics on the Quality of Healthcare

The study sought to examine respondents' perceptions regarding the quality of healthcare services received under their insurance covers in Kenya. The dependent variable, quality of healthcare services, was assessed using statements relating to whether healthcare services met respondents' expectations, willingness to recommend their insurer and healthcare provider to others, and overall satisfaction with healthcare services received under insurance coverage. Respondents were required to indicate their level of agreement using a five-point Likert scale ranging from strongly disagree to strongly agree. The findings are presented in Table 4.13.

Table 4.13: Quality of Healthcare

Statement	Strongly Disagree n (%)	Disagree n (%)	Neutral n (%)	Agree n (%)	Strongly Agree n (%)	Mean	Std dev.
The services provided under my insurance cover meet my expectations.	34	36	60	42	20	2.9	1.2
	17.7%	18.8%	31.2%	21.9%	10.4%		
I would recommend my insurer and provider to others based on my experience.	35	37	62	42	16	2.8	1.20
	18.2%	19.3%	32.3%	21.9%	8.3%		
Overall, I am satisfied with the quality of healthcare services I receive under insurance.	26	21	61	55	29	3.2	1.23
	13.5%	10.9%	31.8%	28.6%	15.1%		
Average						3.0	1.22

The findings revealed that respondents expressed moderate dissatisfaction regarding whether healthcare services provided under their insurance covers met their expectations (mean = 2.9; S.D. = 1.20). A considerable proportion of respondents strongly disagreed (17.7%) or disagreed (18.8%) with the statement, while 31.2% remained neutral. Only 21.9% agreed and 10.4% strongly agreed that the services received under insurance met their expectations. These findings suggest that although some respondents were satisfied with the healthcare services received, a substantial proportion perceived gaps between expected and actual service delivery under insurance arrangements.

Similarly, the study established that respondents were relatively hesitant to recommend their insurer and healthcare provider to others based on their experiences (mean = 2.8; S.D. = 1.20). More than one-third of the respondents strongly disagreed (18.2%) or disagreed (19.3%) with the statement, while 32.3% remained neutral. Only 21.9% agreed and 8.3%

strongly agreed that they would recommend their insurer and healthcare provider to others. These findings imply that respondents held mixed perceptions regarding the quality and reliability of healthcare services provided under insurance coverage. The relatively low mean score further suggests that some respondents may have encountered service delivery challenges that reduced their willingness to endorse their insurers and healthcare providers.

The findings further revealed that respondents expressed moderate satisfaction with the overall quality of healthcare services received under insurance coverage (mean = 3.2; S.D. = 1.23). A majority of respondents agreed (28.6%) or strongly agreed (15.1%) that they were satisfied with the quality of healthcare services received, compared to 13.5% who strongly disagreed and 10.9% who disagreed. Additionally, 31.8% of respondents remained neutral. These findings suggest that although respondents generally perceived the quality of healthcare services positively, concerns regarding service consistency, responsiveness, and fulfillment of expectations still existed among a significant proportion of insured clients. Overall, the findings yielded an aggregate mean score of 3.0 and a standard deviation of 1.22, indicating moderate perceptions regarding the quality of healthcare services received under insurance coverage.

The findings reveal an important distinction between client satisfaction and perceived healthcare quality. Although respondents reported moderate satisfaction with the healthcare services received, the lower scores relating to expectation fulfilment and willingness to recommend insurers and providers suggest that satisfaction does not necessarily translate into strong confidence in the healthcare system. This pattern may indicate that insured clients evaluate healthcare quality using broader criteria that extend beyond immediate service encounters to include responsiveness, reliability,

communication, claims processing efficiency, and continuity of care. The large proportion of neutral responses across all indicators further suggests variability in service experiences, implying that the quality of healthcare received may differ across insurers and healthcare facilities. Consequently, the moderate overall rating of healthcare quality appears to reflect a balance between positive experiences with healthcare services and persistent concerns regarding administrative inefficiencies and service consistency. These findings support the Gaps Model of Service Quality, which posits that healthcare quality is ultimately determined by the extent to which actual service experiences meet or exceed client expectations.

4.7.2 Client Perceptions of Service Quality

The study sought to examine client perceptions of service quality among insured patients, particularly in relation to insurer–provider dynamics and their influence on healthcare experiences. Specifically, the study explored the major complaints raised by insured patients, perceived differences in treatment between insured and cash-paying patients, and how insurer-provider relationships affect the SERVQUAL dimensions of reliability, responsiveness, assurance, empathy, and tangibles. In addition, the study examined strategies healthcare facilities employ to maintain service quality despite reimbursement and insurer-related challenges. Thematic analysis generated several themes and codes, as summarized in Table 4.14.

Table 4.14: Client Perceptions of Service Quality

Area of Inquiry	Theme	Code	Code Count
Complaints Raised by Insured Patients	Financial burden	High out-of-pocket payments despite insurance cover	2
	High cost of services	Expensive drugs and services not fully covered	2
	Limited insurance coverage	Exclusion of drugs, laboratory tests, and specialized procedures	1
Perceived Differences Between Insured and Cash-Paying Patients	Differential treatment	Insured patients stay longer in hospitals	1
	Unequal financial charges	Insured patients charged more and prescribed expensive medication	1
Reliability of Services	System failures	Portal downtime and verification failures	1
	Inconsistent service delivery	Conflicting communication between hospitals and insurers	1
Responsiveness of Services	Delayed Authorization	Long waiting time for pre-authorization approvals	2
	Administrative Delays	Delayed discharge processes linked to insurer approvals	1
Assurance (Trust/Confidence)	Reduced Patient Trust	Doubts about doctors' treatment decisions due to insurer limits	1
	Confidence in Preferred Providers	Trust associated with insurer-provider relationships	1
Empathy (Personalized Attention)	Reduced personalized care	Doctors rushing consultations due to reimbursement pressure	1
	Patients viewed as claims	Patients perceived as financial risks rather than individuals	1
Tangibles (Facilities & Equipment)	Deteriorating infrastructure	Poor maintenance of facilities and equipment	1
	Resource availability differences	Better insurer payments linked to improved infrastructure	1
Strategies for Maintaining service quality	Administrative compliance	Proper documentation practices	1
	Financial follow-up	Following up insurer payments	1
	Operational standards	Adherence to SOPs	1

The study sought to establish the major complaints raised by insured patients regarding healthcare service delivery. Findings revealed that insured patients frequently expressed dissatisfaction with the financial burden associated with healthcare despite possessing

insurance coverage. Participants indicated that patients often complained about making additional out-of-pocket payments for drugs, consultations, laboratory tests, and specialized procedures that they expected would be fully covered by their insurance providers. Concerns were also raised regarding limited coverage and exclusion of certain services from insurance packages. This result was triangulated by an informant who had the following to say,

> *"From my experience, most insured patients complain that they are still required to pay large amounts of money out-of-pocket despite having insurance cover. They complain about being charged highly for services or medications that they expected would be fully covered by their insurance plans."*

The study further explored whether insured patients perceive differences in treatment compared to cash-paying patients. Responses indicated that insured patients feel disadvantaged due to longer waiting times, prolonged hospitalization processes, and differential treatment associated with insurance verification and reimbursement procedures. Some respondents explained that insured patients are occasionally prescribed alternative medications or subjected to more administrative scrutiny compared to cash-paying patients. One participant noted, "*Yes. They are charged more money as well as stay longer in the hospitals."*

Regarding reliability of services, respondents explained that insurer-provider arrangements affect consistency in healthcare delivery. Participants revealed challenges, such as insurer portal failures, delays in verification of coverage, and conflicting communication between insurers and healthcare facilities. Such inefficiencies are thought to create uncertainty regarding treatment access and continuity of care. One respondent explained, *"You go*

there today, they say the 'portal is down' so they can't verify your cover. You go tomorrow; it's a different story. Sometimes the hospital tells you a certain service is covered, then the insurer rejects it mid-treatment."

The study also examined how insurer-provider dynamics affect responsiveness and the speed of healthcare service delivery. Findings revealed that insured patients frequently experience delays linked to prolonged authorization procedures, insurer approvals, and communication breakdowns between healthcare providers and insurers. Participants explained that such delays affect admissions, treatment initiation, and discharge processes. One respondent narrated,

> "*I sat at that reception for three hours. The hospital said they sent the pre-auth, the insurer said they hadn't seen it. The discharge process is a nightmare. The doctor says I'm free to go at 10:00 AM, but I'm still in the ward at 4:00 PM waiting for the insurer to 'release' the final bill."*

In relation to assurance and trust, respondents revealed that insurer influence on treatment decisions reduces patients' confidence in healthcare providers. Participants explained that patients sometimes question whether clinical decisions are based on medical necessity or insurance policy limitations. One respondent stated,

> *"I start doubting the doctor when he tells me I need a cheaper drug because my insurance won't approve the better one. You feel safer going to a provider that has a long-standing 'preferred' relationship with the insurer."*

The study explored how insurer-provider dynamics affect empathy and personalized attention during healthcare delivery. Responses indicated that low reimbursement rates and

financial pressure from insurers force healthcare workers to manage high patient volumes within limited consultation periods. Consequently, patients may feel rushed through treatment processes and perceive reduced individualized attention from healthcare providers. One participant explained,

> *"The doctor is so stressed about the 'per-capita' payment from the insurer that he spends exactly five minutes with me. They stop looking at you as a human and start looking at you as a potential rejected claim."*

With regard to tangibles such as facilities and equipment, participants explained that insurer reimbursement practices directly influence the quality and maintenance of healthcare infrastructure. Facilities experiencing delayed or inadequate reimbursements struggle to maintain equipment, repair infrastructure, and provide comfortable healthcare environments. An informant had the following to say,

> *"The ones that aren't have broken chairs, the AC doesn't work, and they tell you the scan machine is under repair. Because this insurer pays well, this clinic has the latest tech."*

From the quote, it is possible that financial relationships between insurers and healthcare providers have direct implications on the quality of physical healthcare environments and availability of modern medical equipment. The study examined strategies healthcare facilities employ to maintain service quality despite insurer-related challenges. Participants explained that healthcare facilities rely on proper documentation practices, active follow-up on payments, and adherence to standard operating procedures (SOPs) to minimize disruptions associated with delayed reimbursements and insurance disputes. An informant stated the following, *"Ensure that there is proper documentation. Following up on*

payments," while another added, "*Adhere to the SOPs."*

The findings reveal that client perceptions of healthcare quality are shaped by more than clinical outcomes alone; they are significantly influenced by insurer–provider administrative and financial relationships. A recurring pattern across the SERVQUAL dimensions is that many of the concerns raised by patients, including delayed approvals, limited coverage, inconsistent service delivery, reduced trust, and perceived differential treatment, originate from insurer-related processes rather than direct clinical shortcomings. This suggests that patients evaluate healthcare quality holistically, often attributing administrative inefficiencies to the overall quality of care received. The findings further indicate that financial pressures arising from reimbursement constraints may affect provider behaviour, consultation time, infrastructure maintenance, and resource availability, thereby influencing perceptions of empathy, responsiveness, and tangibles. Moreover, the perception that insured patients receive different treatment from cash-paying patients highlights the potential for insurer–provider arrangements to create inequities in service experiences. Consequently, maintaining healthcare quality requires not only clinical excellence but also efficient claims management, transparent communication, reliable authorization processes, and sustainable reimbursement systems. These findings support both the SERVQUAL framework and the Donabedian Model by demonstrating how organizational processes and financial arrangements ultimately shape patients' perceptions of healthcare quality.

4.8 Multiple Linear Regression

The researcher conducted a multiple linear regression analysis to determine the combined and individual influence of insurer-provider contractual arrangements, communication and coordination mechanisms, and timeliness of claims reimbursement and dispute resolution on quality of healthcare. The analysis was conducted using SPSS version 31 in order to establish the predictive relationship between the independent variables and the dependent

variable. The findings are presented in Tables 4.15, 4.16, and 4.17.

Table 4.15: Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.759[a]	.577	.570	.80752

Predictors: (Constant), Insurer-Provider Contractual Arrangements, Communication and Coordination Mechanisms, Timeliness of Claims Reimbursement and Dispute Resolution.

Under the model summary, the coefficient of determination (R^2) was used to explain the extent to which variations in the dependent variable could be explained by changes in the independent variables. The findings indicated that insurer-provider contractual arrangements, communication and coordination mechanisms, and timeliness of claims reimbursement and dispute resolution jointly explained 57.7% of the variation in quality of healthcare as represented by the R Square value of 0.577. This implies that the three predictor variables significantly contributed to healthcare quality outcomes within healthcare facilities. The remaining 42.3% of the variation in quality of healthcare may be explained by other factors not included in the current study. Additionally, the adjusted R Square value of 0.570 suggests that the regression model was reliable in explaining the relationship between the study variables.

Table 4.16: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	166.901	3	55.634	85.315	.000[b]
	Residual	122.594	188	.652		
	Total	289.495	191			

a. Dependent Variable: Quality of healthcare.

b. Predictors: (Constant), Insurer-Provider Contractual Arrangements, Communication and Coordination Mechanisms, Timeliness of Claims Reimbursement and Dispute Resolution.

The ANOVA findings presented in Table 4.16 show that the overall regression model was statistically significant in predicting the relationship between the independent variables and quality of healthcare. The calculated F value was 85.315 with a significance level of 0.000, which is less than the threshold value of 0.05. This indicates that the regression model was appropriate and that the predictor variables jointly had a statistically significant influence on quality of healthcare. The results therefore imply that insurer-provider contractual arrangements, communication and coordination mechanisms, and timeliness of claims reimbursement and dispute resolution significantly predict variations in healthcare quality. Had the significance value been greater than 0.05, it would imply that the independent variables do not significantly explain variations in the dependent variable.

Table 4.17: Coefficients of Multiple Linear Regression

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	.928	.210		4.419	.000
	Insurer-Provider Contractual Arrangements.	.442	.049	.472	8.994	.000
	Communication and Coordination Mechanisms.	.543	.055	.578	9.870	.000
	Timeliness of Claims Reimbursement and Dispute Resolution.	.160	.063	.157	2.535	.012

a. Dependent Variable: Quality of healthcare.

From the regression findings, the multiple linear regression equation was expressed as:

$$Y = 0.928 + 0.442X_1 + 0.543X_2 + 0.160X_3$$

Where:

Y= Quality of healthcare

X_1= Insurer-Provider Contractual Arrangements

X_2= Communication and Coordination Mechanisms

X_3= Timeliness of Claims Reimbursement and Dispute Resolution

The regression equation shows that holding all other factors constant at zero, quality of healthcare would be 0.928. The findings further revealed that a unit increase in insurer-provider contractual arrangements would result in a 0.442 increase in quality of healthcare. Similarly, a unit increase in communication and coordination mechanisms would lead to a 0.543 increase in quality of healthcare, while a unit increase in timeliness of claims reimbursement and dispute resolution would lead to a 0.160 increase in quality of healthcare.

The significance values further indicated that all the independent variables had a statistically significant influence on quality of healthcare since their p-values were less than 0.05. Among the predictor variables, communication and coordination mechanisms had the strongest influence on quality of healthcare as indicated by the highest beta coefficient (β = .578), followed by insurer-provider contractual arrangements (β = .472), and timeliness of claims reimbursement and dispute resolution (β = .157). This implies that effective communication and coordination between insurers and healthcare providers play the most critical role in improving healthcare quality compared to the other variables examined in the study.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter entails of discussion of the findings in relation to the study objectives, conclusion, policy recommendations of the study, and study limitations.

5.2 Discussion

5.2.1 Insurer-Provider Contractual Arrangements

The findings revealed that insurer–provider contractual arrangements significantly influence perceived availability and reliability of healthcare services among insured patients in Kenya. While this finding generally supports existing literature suggesting that contractual governance enhances service accessibility, continuity of care, and operational efficiency (Zhao et al., 2024), the results also reveal complexities that are not fully captured by existing theoretical assumptions. Both the Donabedian and Gaps Models implicitly assume that effective organizational structures and processes will translate into improved service outcomes. However, the present findings suggest that the existence of contractual arrangements alone does not guarantee improved healthcare experiences. Rather, the effectiveness of such arrangements depends on how contractual provisions are implemented and enforced within specific institutional contexts.

Although respondents generally reported adequate access to healthcare services and broad acceptance of insurance cover by healthcare facilities, qualitative evidence simultaneously revealed persistent challenges related to delayed claims approvals, reimbursement bottlenecks, and inconsistent enforcement of contractual obligations. This apparent contradiction suggests that healthcare access and service reliability are not necessarily

experienced uniformly by all insured patients. While formal contractual relationships may facilitate access at the point of care, administrative inefficiencies within those same arrangements may undermine continuity of treatment and service responsiveness. This finding challenges the simplistic assumption that stronger contractual structures automatically produce better healthcare outcomes and instead points to the importance of examining the quality of contractual implementation.

The findings further revealed that contractual disagreements, changing reimbursement terms, and prolonged credit periods negatively affected healthcare facility operations, resulting in shortages of medicines and supplies, cash-flow constraints, and occasional interruptions in service delivery. These findings are consistent with studies by Donneli (2026) and Chen et al. (2026), which associate reimbursement delays with operational inefficiencies and reduced service quality. However, unlike these studies, the present findings demonstrate that healthcare facilities often continue providing services despite financial pressures, suggesting a level of institutional adaptation not sufficiently addressed in existing literature. This indicates that the relationship between contractual challenges and healthcare quality may be more dynamic than previously assumed.

The study also established that reimbursement timelines, payment rates, service-level expectations, and coverage provisions constituted the most influential contractual elements affecting healthcare service delivery. Although respondents generally perceived contractual terms as clear, they simultaneously reported difficulties in implementing some provisions, particularly where reimbursement ceilings did not correspond with actual treatment costs. This finding raises important questions regarding the applicability of theoretical models developed in highly regulated insurance environments to the Kenyan

healthcare context. Whereas the Donabedian Model emphasizes the importance of organizational structures in shaping service outcomes, the findings suggest that structural adequacy alone may be insufficient where financial realities and healthcare costs are poorly aligned with contractual provisions.

Overall, the findings contribute to theory by demonstrating that insurer–provider contractual arrangements influence healthcare quality through a complex interaction between contractual design, implementation capacity, and contextual realities. The study therefore extends existing theoretical perspectives by showing that in emerging health insurance markets such as Kenya, the effectiveness of contractual arrangements depends not only on their existence or clarity but also on their practical enforceability, financial viability, and adaptability to healthcare delivery conditions.

5.2.2 Communication and Coordination Mechanisms, Timeliness of Claims

The findings indicated that communication and coordination mechanisms between insurers and healthcare providers significantly influence healthcare service responsiveness. Consistent with existing literature, respondents identified digital claims platforms, integrated insurer–provider portals, liaison officers, email systems, and call centers as the primary channels facilitating coordination and information exchange. These findings support arguments by Peltokorpi et al. (2020) and Gilavand and Maraghi (2019) that effective communication systems enhance operational efficiency, reduce administrative delays, and facilitate continuity of care. However, the findings also reveal that the relationship between communication systems and service responsiveness is more complex than existing theories often assume.

A notable contradiction emerged from the study. While respondents rated communication

clarity and insurer responsiveness relatively low in the quantitative findings, they simultaneously acknowledged that coordination mechanisms had improved healthcare service responsiveness. This suggests that communication quality and coordination effectiveness are not necessarily synonymous. In the Kenyan context, healthcare facilities may continue to achieve acceptable levels of coordination despite weaknesses in information flow and responsiveness. This finding challenges the assumption within the Donabedian Process Model that improvements in communication processes automatically translate into uniformly positive service experiences. Instead, the findings suggest that certain process deficiencies may be compensated for by institutional adaptations such as liaison officers, follow-up mechanisms, and informal coordination practices.

The findings further revealed that digital technologies, including AI-supported portals and integrated claims management systems, improved authorization processes, enhanced claims tracking, and facilitated real-time feedback between insurers and healthcare providers. While this finding aligns with studies by Rabiei and Almasi (2026) and Morris (2025), the evidence also demonstrates that technological adoption alone does not eliminate communication challenges. Despite the existence of digital systems, respondents continued to report authorization delays, inconsistent feedback, and prolonged waiting periods. This suggests that technological infrastructure may be a necessary but insufficient condition for improving healthcare responsiveness. Organizational practices, insurer responsiveness, and institutional capacity appear equally important in determining whether digital systems translate into meaningful service improvements.

The study also established substantial variation in communication efficiency across insurers, with some processing approvals within minutes while others required several days

or weeks. This finding is particularly important because it highlights a limitation in existing theoretical models, which often treat healthcare processes as relatively uniform across organizations. The results suggest that insurer-specific operational capacities significantly influence healthcare responsiveness and patient experiences. Consequently, service quality may depend not only on the existence of communication mechanisms but also on the ability of individual insurers to utilize those mechanisms effectively.

Furthermore, communication delays were found to negatively affect patient waiting times, staff morale, and patient satisfaction. While this finding supports previous studies (Zhao et al., 2024; Su et al., 2024), the present study extends existing knowledge by demonstrating how communication inefficiencies create cascading effects throughout the healthcare delivery chain. Delays originating within insurer administrative systems ultimately influence provider operations, healthcare worker experiences, and patient perceptions of service quality. This finding suggests that communication should not be viewed merely as an administrative process but as a critical determinant of healthcare quality outcomes.

Overall, the findings contribute to theory by demonstrating that communication and coordination mechanisms influence healthcare responsiveness through a combination of technological, organizational, and institutional factors. Rather than fully validating existing theoretical assumptions, the study suggests that in emerging health insurance markets such as Kenya, effective coordination can sometimes coexist with perceived communication weaknesses. This highlights the need for a more context-sensitive understanding of how healthcare communication processes operate in resource-constrained and administratively complex healthcare systems.

5.2.3 Reimbursement and Dispute Resolution

The findings demonstrated that the timeliness of claims reimbursement and the effectiveness of dispute resolution mechanisms significantly influence perceived healthcare service quality in Kenya. While this finding generally supports existing literature linking reimbursement efficiency to service quality outcomes (Sriwidodo et al., 2025), the results suggest a more complex relationship than that assumed in many healthcare quality frameworks. Existing theories often imply a relatively direct relationship between administrative efficiency and service quality. However, the present findings indicate that reimbursement delays affect healthcare quality indirectly through their impact on facility finances, procurement systems, treatment continuity, and patient experiences.

Respondents reported that delayed reimbursements negatively affected procurement of medicines, payment of suppliers, operational cash flow, and continuity of healthcare services. Consistent with Shen et al. (2024), prolonged reimbursement periods created financial strain within healthcare facilities, forcing some providers to rely on overdrafts, loans, or prioritization of essential services while awaiting insurer payments. However, the findings also revealed that healthcare facilities frequently developed coping mechanisms to sustain service delivery despite reimbursement challenges. This suggests that the relationship between reimbursement delays and healthcare quality is not always linear. Rather than immediately causing service failure, reimbursement delays may gradually erode service quality through accumulated financial pressure and operational constraints.

A particularly important finding was that delayed reimbursements disrupted treatment schedules, delayed laboratory investigations, and limited access to specialized services. These outcomes suggest that administrative processes traditionally viewed as non-clinical

may have direct implications for clinical care. This finding challenges conventional distinctions between clinical and administrative determinants of healthcare quality. While healthcare quality is often associated with diagnosis, treatment, and patient outcomes, the results indicate that insurer administrative processes can substantially influence the patient experience and continuity of care. Consequently, the findings extend existing theoretical perspectives by demonstrating that non-clinical financial processes are integral components of healthcare quality rather than merely supporting functions.

The study further established that disputes frequently arose from incomplete claims documentation, claim rejections, reimbursement disagreements, authorization challenges, and exclusions within insurance coverage. Although such disputes are often viewed as routine administrative occurrences, the findings suggest that their consequences extend beyond organizational relationships to affect patient trust and perceptions of service quality. This observation partly supports the SERVQUAL framework, particularly the dimensions of reliability, responsiveness, and assurance. However, the findings also reveal limitations within SERVQUAL when applied to insurance-mediated healthcare systems. While the framework emphasizes service encounters between providers and patients, it does not adequately account for the influence of insurer administrative decisions on patient experiences. The present findings therefore suggest that healthcare quality in insurance-based systems is shaped by a broader network of institutional relationships than those traditionally captured within service quality models.

Respondents indicated that business review meetings, negotiations, alternative dispute resolution mechanisms, and legal processes were commonly used to address disagreements between insurers and healthcare providers. Although many disputes were resolved through

continuous engagement, unresolved disputes were found to undermine service reliability, patient confidence, and continuity of care. Nevertheless, the findings also revealed an unexpected pattern: despite widespread concerns regarding reimbursement delays, respondents generally perceived dispute resolution mechanisms as relatively fair and effective. This suggests that stakeholders may differentiate between dissatisfaction with reimbursement processes and confidence in mechanisms for resolving disputes. Such findings highlight the importance of distinguishing between operational inefficiencies and institutional trust when assessing healthcare service quality.

Overall, the findings contribute to theory by demonstrating that reimbursement and dispute resolution processes influence healthcare quality through multiple interconnected pathways involving financial sustainability, operational efficiency, patient trust, and continuity of care. Rather than simply validating existing theories, the study extends them by showing that in Kenya's private health insurance sector, administrative and financial processes are not peripheral to healthcare quality but constitute critical determinants of how quality is experienced and evaluated by patients and providers alike.

5.3 Conclusion

This study concludes that insurer–provider contractual relationships are significant determinants of perceived healthcare service quality among insured patients in Kenya. Empirically, the study established that the terms and enforcement of insurer–provider contracts, communication and coordination mechanisms, and the timeliness of claims reimbursement and dispute resolution processes all have statistically significant relationships with healthcare service quality outcomes. The findings demonstrate that contractual and administrative processes influence service availability, reliability,

responsiveness, continuity of care, and overall patient satisfaction. The study further revealed that reimbursement delays, communication inefficiencies, and contractual inconsistencies create operational and financial challenges that ultimately affect patient experiences and perceptions of healthcare quality.

Theoretically, the study contributes to the Donabedian Model, SERVQUAL Framework, and Gaps Model of Service Quality by demonstrating that healthcare quality within insurance-mediated systems is shaped not only by clinical interactions but also by insurer–provider administrative and financial processes. The findings suggest that some assumptions underlying these theories may not fully capture the complexities of emerging health insurance markets such as Kenya, where effective coordination can coexist with communication weaknesses and where administrative inefficiencies can significantly influence perceptions of healthcare quality. The study therefore extends existing theoretical perspectives by highlighting the importance of contractual governance, reimbursement systems, and institutional relationships in shaping healthcare quality outcomes.

From a practical and policy perspective, the findings underscore the need for stronger contractual enforcement mechanisms, improved communication and coordination systems, more efficient claims reimbursement processes, and transparent dispute resolution frameworks. Strengthening these areas would enhance operational efficiency, improve continuity of care, increase patient confidence in health insurance arrangements, and contribute to the broader goal of achieving high-quality and patient-centered healthcare services in Kenya.

5.4 Recommendations

The following policy recommendations were established upon evaluation of the study findings:

The study recommends that private insurers and healthcare providers strengthen enforcement of contractual obligations, including reimbursement timelines, service standards, and payment agreements, to improve healthcare reliability and availability. The Insurance Regulatory Authority and Ministry of Health should enforce clear reimbursement and compliance regulations. Healthcare facilities should also engage qualified legal consultants during contract negotiation and implementation to ensure contractual clarity, fairness, legal compliance, and protection of institutional and patient interests.

The study found that communication and coordination mechanisms between insurers and healthcare providers had a strong and statistically significant relationship with clients' perceptions of healthcare service responsiveness. Towards this end, the study recommends that insurers and healthcare providers strengthen the adoption of integrated digital communication systems, including AI-supported insurer–provider portals that facilitate real-time approvals, claims verification, and feedback mechanisms. Healthcare facilities and insurers should also establish dedicated liaison structures and standardized communication protocols to minimize delays in authorization, coordination, and claims processing.

The study established that the timeliness of insurance claims reimbursement and the effectiveness of dispute resolution mechanisms had a positive and statistically significant relationship with clients' perceptions of healthcare service quality in Kenya. Consequently, the study recommends that insurers and healthcare providers adopt efficient reimbursement

systems and strengthen alternative dispute resolution mechanisms to address claim disputes promptly and minimize interruptions in healthcare service delivery. Insurers should further enhance transparency in claims approval and rejection processes by providing timely explanations, clear communication, and regular feedback to healthcare providers.

5.5 Study Limitations

Despite the measures taken to ensure methodological rigor, several limitations may have influenced the findings of this study. First, the study relied substantially on self-reported data from insured clients, healthcare providers, and insurance representatives. Consequently, some responses may have been affected by recall bias, subjective interpretation of experiences, or social desirability bias, particularly when discussing sensitive issues such as reimbursement delays, contractual disputes, and service quality.

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APPENDICES

APPENDIX I: QUESTIONNAIRE

STRUCTURED QUESTIONNAIRE FOR INSURED CLIENTS

Research Title: *Insurer–Provider Contractual Relationships and Perceived Healthcare Service Quality in Kenya*

Study Sites: Accredited Private Health Facilities in Nairobi and Kakamega Counties

Target Respondents: Insured clients seeking outpatient services under active medical insurance cover

Sample Size: 300 clients (20 facilities × 15 clients per facility)

Section A: Background Information (Demographics)

(Tick or fill the appropriate option)

1. Gender: ☐ Male ☐ Female ☐ Prefer not to say
2. Age: _____years
3. County: ☐ Nairobi ☐ Kakamega
4. Facility type: ☐ Inpatient ☐ Outpatient ☐ Both
5. Type of health insurance: ☐ Employer-based ☐ Individual/private plan ☐

   Other (specify) __
6. Duration of insurance cover: ☐ <1 year ☐ 1–3 years ☐ 4–6 years ☐ >6 years
7. Frequency of healthcare visits under insurance: ☐ Once ☐ 2–3 times ☐ 4–6 times ☐ >6 times annually

Section B: Service Availability and Reliability (Objective 1)

To measure clients' perceptions of service access, reliability, and the effects of insurer–provider contractual arrangements.

Using a 5-point Likert scale:

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Statement

B1. I can easily access healthcare services when needed under my insurance plan.

B2. The facility always accepts my insurance cover without unnecessary restrictions.

B3. There are sufficient healthcare providers (doctors, nurses, specialists) available when I visit.

B4. My insurer and provider adhere to agreed contractual service standards (e.g., authorization timelines, payment agreements).

B5. Delays in claim approvals affect my access to healthcare services.

B6. I am confident that the insurance–provider relationship ensures consistent service quality.

Numerical Data Output:

i. Mean perception scores for *availability* and *reliability*.

ii. Binary variables for *contract enforcement effects* (e.g., "contract issues experienced: yes/no").

Section C: Communication, Coordination, and Responsiveness (Objective 2)

To measure clients' perceptions of how insurer–provider communication and coordination influence service responsiveness.

Likert Scale (1–5):

Statement

C1. The facility staff communicate clearly about services covered by insurance.

C2. My insurer promptly responds to queries raised by the healthcare provider.

C3. Coordination between the insurer and facility reduces service delays.

C4. The insurer provides timely feedback on preauthorization and claims requests.

C5. I am satisfied with the communication between the insurer,provider, and myself.

Statement

C6. Service responsiveness has improved due to better coordination between insurers and providers.

Measurable Indicators:

i. Mean scores for *communication quality* and *coordination.*

ii. Derived variable for *responsiveness* index = average (C1–C6).

Section D: Claims Processing, Delays, and Dispute Resolution (Objective 3)

To measure clients' perceptions of timeliness, transparency, and dispute management in claims reimbursement and their effect on service quality.

Likert Scale (1–5):

Statement

D1. Claims are processed and approved promptly by my insurer.

D2. I rarely experience delays in accessing services due to claim processing issues.

D3. When disputes occur, they are resolved fairly and within a reasonable time.

D4. I am aware of how my insurer and provider handle claim disputes.

Statement

D5. Delayed reimbursements or disputes negatively affect my perception of service quality.

D6. Overall, I am satisfied with the claims process under my current insurance plan.

Statistical Data Output:

i. Quantitative indicators of *timeliness* and *dispute frequency*.

ii. Dependent variable: *perceived service quality*, derived from D1–D6 composite mean.

Section E: Overall Satisfaction with Healthcare Service Quality

To capture overall client satisfaction as the ultimate dependent variable across all objectives.

Likert Scale (1–5):

Statement

E1. The services provided under my insurance cover meet my expectations.

E2. I would recommend my insurer and provider to others based on my experience.

Statement

E3. Overall, I am satisfied with the quality of healthcare services I receive under insurance.

Derived Outcome:

i. Composite satisfaction index used as the dependent variable for regression analysis.

Section F: Open-Ended Questions (for Contextual Insights)

(Optional qualitative supplement to enrich interpretation of quantitative data)

1. What do you consider the main challenges in accessing healthcare services under your insurance cover?
2. How would you describe the communication and coordination between your insurer and healthcare provider?
3. In your opinion, what improvements are needed to enhance service quality for insured clients?

KEY INFORMANT INTERVIEW GUIDE

Target Respondents: Senior Representatives of Private Medical Insurance Providers *(e.g., Medical Directors, Claims Managers, Provider Relations Managers, Regional Managers)*

SECTION A: Background Information

1. What is your current role in this organization?
2. How long have you been involved in managing insurer–provider relationships?
3. Where does your company operate from?
4. Approximately how many accredited providers does your organization work with?

SECTION B: Insurer–Provider Contractual Arrangements

(Objective 1 – Terms and Enforcement)

5. How would you describe the structure of your standard contracts with healthcare providers?
6. What key elements are typically included in your contracts?

i. Scope of services

ii. Reimbursement rates

iii. Payment timelines

iv. Performance standards

v. Dispute resolution clauses

7. How are contractual performance standards monitored and enforced?
8. What challenges do you experience in enforcing contractual obligations with providers?

9. In your view, how do contractual terms influence:

i. Availability of services to insured clients?

ii. Reliability and consistency of service delivery?

10. Have you experienced instances where weak contract enforcement affected client access or satisfaction? Please elaborate.

SECTION C: Communication and Coordination Mechanisms

(Objective 2 – Responsiveness)

11. What communication channels exist between your company and healthcare providers?

i. Digital claims systems

ii. Email/portal systems

iii. Dedicated liaison officers

iv. Call centers

12. How are service authorizations handled (e.g., pre-authorization systems)?

13. What systems are in place to ensure timely feedback between insurers and providers?

14. What coordination challenges commonly arise between insurers and providers?

15. In your view, how do communication gaps affect:

i. Service responsiveness?

ii. Waiting times for insured clients?

iii. Client satisfaction?

16. Have technological systems improved coordination? If yes, how?

SECTION D: Claims Reimbursement and Dispute Resolution

(Objective 3 – Timeliness & Quality Perception)

17. What is the average turnaround time for claims reimbursement?

18. What factors contribute to delays in claims settlement?

19. How frequently do disputes arise between your organization and providers?

20. What formal mechanisms are in place for dispute resolution?

i. Arbitration

ii. Internal review panels

iii. External mediation

21. In your experience, how do reimbursement delays affect:

i. Provider willingness to serve insured clients?

ii. Service quality delivered to insured clients?

22. Do you believe claims processing efficiency influences clients' perceptions of reliability and assurance? How?

SECTION E: Client-Centered Service Quality

23. From your perspective, what are the main determinants of client satisfaction under private health insurance?

24. Have you received complaints related to:

i. Service denial?

ii. Delayed approvals?

iii. Hidden exclusions?

iv. Unexpected co-payments?

25. How does your organization collect and respond to client feedback?

26. In your view, what reforms are necessary to improve insurer–provider relationships in Kenya?

SECTION F: Regulatory and System-Level Issues

27. How does the regulatory environment (e.g., IRA oversight) influence insurer–provider contracts?

28. Do you believe current regulatory frameworks adequately address reimbursement delays and disputes?

29. What policy adjustments would strengthen accountability and service quality?

SECTION G: Closing Reflection

30. In your opinion, what single change would most improve healthcare service quality for insured clients in Kenya?

31. Is there anything else you would like to add regarding insurer–provider dynamics and service delivery?

SEMI-STRUCTURED INTERVIEW GUIDE

Target Respondents:

Facility Administrators / Hospital Managers / Insurance Liaison Officers

Study Sites: Nairobi & Kakamega Counties

SECTION A: Background Information

1. What is your current role in this facility?
2. How long have you worked in this position?
3. How many insurance companies is your facility accredited with?
4. Approximately what proportion of your patients are insured clients?

SECTION B: Insurer–Provider Contractual Arrangements

(Objective 1 – Terms & Enforcement | Donabedian: Structure)

5. How would you describe the contractual relationship between your facility and insurance providers?
6. What key elements are typically included in your agreements?
   i. Service coverage scope
   ii. Payment rates
   iii. Reimbursement timelines
   iv. Service-level expectations
   v. Dispute procedures
7. Are the contractual terms clear and practical to implement? Why or why not?
8. Have you experienced challenges related to contract enforcement?
9. How do contract terms influence:
   i. Availability of services to insured patients?

ii. Continuity of care?

iii. Facility cash flow and operations?

10. Have there been instances where contractual disagreements affected patient service delivery? Please explain.

SECTION C: Communication and Coordination Mechanisms

(Objective 2 – Responsiveness | Donabedian: Process)

11. What communication channels exist between your facility and insurers?

i. Digital claims platforms

ii. Email/portal systems

iii. Liaison officers

iv. Call centers

v. How efficient is the authorization process for services?

12. What challenges do you face in obtaining service approvals?

13. How do communication delays affect:

i. Waiting time for insured patients?

ii. Patient satisfaction?

iii. Staff morale?

14. Are there differences in communication efficiency between insurers?

15. Has technology improved coordination? If yes, how?

SECTION D: Claims Reimbursement and Dispute Resolution

(Objective 3 – Timeliness & Quality Perception)

16. What is the typical turnaround time for reimbursement from insurers?

17. How do reimbursement delays affect your facility's operations?
18. Have you ever had to delay or deny services due to pending claims?
19. What are the most common causes of claim rejection or disputes?
20. How are disputes typically resolved?
21. Do reimbursement challenges influence how staff treat insured patients? (Probe gently.)
22. In your opinion, how do claims processing inefficiencies affect:

i. Reliability of services?
ii. Patient trust?
iii. Overall service quality?

SECTION E: Client Perceptions of Service Quality

(SERVQUAL Dimensions – Outcome Level)

23. From your experience, what do insured patients complain about most?
24. Do insured patients perceive differences in treatment compared to cash-paying patients?
25. In your view, how do insurer–provider dynamics affect:

i. Reliability (consistent service delivery)?
ii. Responsiveness (speed of service)?
iii. Assurance (trust/confidence)?
iv. Empathy (personalized attention)?
v. Tangibles (facilities & equipment)?

26. What strategies does your facility use to maintain service quality despite insurer challenges?

SECTION F: Regulatory and System-Level Issues

27. How does the regulatory environment (e.g., Insurance Regulatory Authority requirements) influence your relationships with insurers?
28. Do you think current regulations adequately protect providers and patients?
29. What reforms would improve insurer–provider collaboration in Kenya?

SECTION G: Closing Reflection

30. In your view, what is the biggest barrier to delivering high-quality care to insured patients?
31. If you could change one thing in insurer–provider relationships, what would it be?
32. Is there anything else yaou woul like to add?

APPEDIX II: APPROVAL LETTER

Strathmore UNIVERSITY

11th March 2026

Dr Muhadia Scarlet,
scarlet.muhadia@strathmore.edu

Dear Dr Muhadia,

RE: Insurer–Provider Contractual Relationships and Perceived Healthcare Service Quality in Kenya

This is to inform you that SU-ISERC has reviewed and **approved** your above **SU-masters** research proposal. Your application reference number is **SU-ISERC3399/26.** The approval period is from **11th March 2026 to 10th March 2027.**

This approval is subject to compliance with the following requirements:

i. Only approved documents including (informed consents, study instruments, and MTA) will be used
ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by SU-ISERC.
iii. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to SU-ISERC within 72 hours of notification
iv. Any changes, anticipated or otherwise, that may increase the risks or affect the safety or welfare of study participants and others or affect the integrity of the research must be reported to SU-ISERC within 72 hours
v. Clearance for the export of biological specimens must be obtained from relevant institutions.
vi. Submission of a request for renewal of approval at least 60 days prior to the expiry of the approval period. Attach a comprehensive progress report to support the renewal.
vii. Submission of an executive summary report within 90 days of completion of the study to SU-ISERC.

Before commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology, and Innovation (NACOSTI) https://research-portal.nacosti.go.ke/ and obtain other clearances needed.

Yours sincerely,

Mr Ambrose Rachier,
Chairperson; SU-ISERC

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APPEDIX III: WORK PLAN

PROPOSED STUDY: INSURER–PROVIDER CONTRACTUAL RELATIONSHIPS AND PERCEIVED HEALTHCARE SERVICE QUALITY IN KENYA

Student Name : Scarlet Muhadia
Institutional affiliation: Strathmore Business School (SBS)

THESIS WORKPLAN

PHASE	TIMELINE	KEY ACTIVITIES	OUTPUTS/DELIVERABLES
Pre-Field Preparation	1–14 March 2026	Supervisor clearance; ethics approval; finalize tools; recruit assistants; pilot testing	Approved tools; ethics clearance; pilot report
Data Collection	15 March – 10 April 2026	Questionnaires; insurer KIIs; facility interviews; document review	Raw datasets; recordings; field notes
Data Cleaning & Transcription	11–24 April 2026	Data cleaning; transcription; coding; reliability checks	Clean dataset; coded transcripts
Data Analysis	25 April – 8 May 2026	Statistical analysis; thematic coding; triangulation	Statistical outputs; themes matrix
Results Writing	9–22 May 2026	Write Chapters 4 & 5; integrate tables and figures	Draft results chapters
Full Thesis Drafting	23–30 May 2026	Edit Chapters 1–3; conclusions; references; appendices	Complete thesis draft
Supervisor Review & Submission	31 May – 5 June 2026	Corrections; formatting; plagiarism check; submission	Thesis submitted (5 June 2026)
Oral Defence Preparation	6–20 June 2026	Defence slides; mock defence; refinement	Defence presentation ready
Post-Defence Corrections	21–26 June 2026	Address examiner comments; final formatting	Corrected thesis submitted
Graduation Preparation	July – August 2026	Clearance; binding; graduation registration	Graduation readiness
Graduation	12–14 August 2026	Degree award	Official graduation

APPENDI X IV: RESEARCH PERMIT

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **875335**

Date of Issue: **08/April/2026**

RESEARCH LICENSE

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