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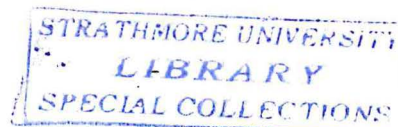
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**AN ASSESSMENT OF THE PURCHASING ARRANGEMENTS OF AN EMPLOYER
IN-HOUSE MANAGED SCHEME: A CASE STUDY OF AAR HEALTHCARE**

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MBA/HCM 096321/17



Submitted in partial fulfilment for the requirement for the award of degree of Master's in
Business Administration in Healthcare Management (MBA-HCM)

Strathmore Business School, Nairobi, Kenya

MAY 2019

DECLARATION

I declare that this MBA 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 does not contain material previously published or written by any person except where due reference is made in the thesis itself.

Mwaura N. Lilian

Sign:

Date: May 2019

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ABSTRACT

Kenya has made a commitment to achieve Universal Health Coverage (UHC) by 2022. The country is undertaking health financing reforms that will set it on the path to achieving this goal. While health financing reforms have typically focused on the resource generation and pooling function of the health system, there is increasing recognition of the importance of the purchasing function of the health financing system. Purchasing refers to the transfer of pooled funds to healthcare providers in exchange for healthcare services provided to citizens. Purchasing could either be passive, which means merely paying bills, or strategic, which means structured to enhance the health system goals of equity, efficiency, and quality. Healthcare purchasing in Kenya is carried out by 5 main entities namely 1) the national hospital insurance fund (NHIF), 2) the county health systems 3) private health insurance 4) community-based health insurance schemes, and 5) employer in-house medical schemes. Previous studies done in Kenya has assessed the purchasing arrangements of the first 4. There is however not study that has examined the purchasing arrangements of employer in-house medical schemes. To fill this knowledge gap, this proposed study examined the purchasing arrangements of employer in-house schemes in Kenya. Specifically, the study used a qualitative case study approach to examine the extent to which the purchasing arrangements of the AAR in-house medical scheme are strategic. This study employed the conceptual framework developed by the Resilient and Responsive Health Systems (RESYST) consortium to examine the purchasing actions of the AAR medical scheme across the three purchasing relationships, namely purchaser-government, purchasing-providers, and purchasing-citizens. Data was collected through a combination of in-depth interviews and document reviews. Respondents for the in-depth interviews were selected purposively to get individuals with in-depth knowledge of scheme. Relevant documents that contain information on the scheme were also obtained and analysed. Qualitative data was audio recorded, transcribed, imported to NVIVO software, and analysed using a thematic approach. It was evidenced, by the findings put forward in this section that the purchasing mechanism in AAR Healthcare is passive as characterized by arbitrary fun allocation to the in-house scheme and nominal sourcing of providers. There was no evidence of strategic purchasing with regard to the acquisition or distribution of financing in the service provision process. The process was however deemed effective by all users. With regard to the second objective, it was evident that AAR Healthcare did not feature a specific purchasing entity as the purchasing functions were distributed between the HR, Procurement and Finance department. This therefore rendered the relationship between the purchaser and the other entities – citizens (employees), government and providers – as fragmented and uncharacterized; the system was essentially run as in-house health benefit scheme with the exception of contracted services given that the organization provided health services, such services were mainly sought in-house as opposed to through contracts with other providers. The main recommendation forthcoming from this study is that AAR Healthcare should consider a switch to strategic purchasing in effecting its healthcare provision function to employees. In achieving these, it will be necessary to first and foremost institute a designated purchaser for the fund; one that would be charged with orchestrating all functions involved with other actors in the purchasing function. Findings from this study can also be used to prescribe possible purchasing arrangements for employer managed schemes.

LIST OF ABBREVIATIONS

UHC Universal Health Coverage

SP Strategic Purchasing

WHO World Health Organisation

RESYST Resilient and Responsive Health Systems

LMICS Low and Middle-Income Countries

PHI Private Health Insurance

MOH Ministry of Health

CBHI Community-based Health Insurance

IRA Insurance Regulatory Authority

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DEDICATION

To God almighty for his mercies and blessings.

To my dear parents, Mary Wanjiku and John Mwaura, who planted a seed in me long before I could understand its meaning and nurtured it into faith; hard work, integrity, perseverance, excellence and many more values. You have constantly inspired me and showered me with love.

To my dearest brothers Silvester and Gordon Mwaura.

To my dear sisters Perpetual Mwaura and Angie Mwaura for walking with me every step of the way and encouraging me on this journey with great belief.

I dedicate this document to my family and colleagues for their immense support throughout the journey

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

Universal Health Coverage (UHC) as envisioned by the World Health Organization (WHO) involves ensuring equity in access to and quality of health services, and protection from financial hardship (WHO, 2015). UHC requires reforms to the health system to configure it in a way that it meets these goals. The WHO health systems framework categorises the pillars of the health system as governance, healthcare financing, service delivery, human resources for health, medical products and technologies, and health information systems (WHO, 2000). The function of health financing has received great attention since the publication of the World Health Report 2010. This report emphasises the need for greater attention to health financing on the road to UHC.

Lagomarsino, Garabrant, Adyas, Muga, and Otoo (2012) study nine developing countries in Asia and Africa identified health financing reforms as a key part of reforms towards achievement of UHC. Similarly, in an assessment of healthcare financing in Africa observe that significant strides in financing policy have been made across the continent with 46 countries implementing healthcare financing reforms aimed at ensuring effective purchasing of healthcare services. Cotlear and Rosemberg (2018). Health financing comprises three functions, revenue collection, pooling and purchasing (Kutzin, 2001). The three functions serve to achieve UHC intermediate objectives and goals.

Revenue collection is the process by which health systems receive financial resources from households and organizations. Pooling describes the accumulation and management of the collected resources in such a manner as to ensure that the costs involved in provision of healthcare are borne by all the members of the pool i.e. effective cross-subsidisation. Finally, the purchasing aspect of healthcare financing, that this study focuses on, is defined as the process by which pooled funds are transferred to providers for the delivery of health services to a defined population (Kutzin, 2001). Honda (2014) defines the term as entailing the critical link between resources mobilised for universal coverage and the effective delivery of quality services. Figueras, Raobinson and Jakubowski (2005) further break down the concept into three main functions – identifying the sets of interventions required for purchasing, choosing providers of the services, and deciding on the purchasing approach.

Munge et al., (2015) define the purchaser as any entity that is involved in the linkage between financing of healthcare and the eventual provision of healthcare services to a targeted population. This entity can therefore involve such organizations as governments, national health insurance agencies, private health institutions and in-house employer managed schemes. Drawing on principal agent theory, Picazo, Ulep, Pantig, & Ho (2015) define the purchaser as the principal charged with the mandate of buying services on behalf of the agent – the recipient of the services. Figueras et al., (2005) put forward that the concept of purchasing involves identification of what item or service is purchased, from whom it is purchased, how it is purchased, and for how much it is purchased.

The Joint Learning Network for Universal Health Coverage approaches purchasing from a similar conceptual approach as Figueras et al., i.e. purchasing involves identification of what item or service is purchased, from whom it is purchased, how it is purchased, and for how much it is purchased. However, the JLN's approach is focussed on providing tools for purchasers to attain these aims. These tools include provider payment assessment guides, costing manuals and health benefits policy frameworks and country assessments (Cashin, Ankhbayar, & Phuong, 2015).

An alternative approach to the same is captured in the Resilient and Responsive Healthcare System Research Consortium's (RESYST) approach which conceptualizes strategic purchasing as arrangements made up of these actions performed within three sets of principal-agent relationships. The principal-agent relationships approach draws on Agency theory in which the principal is the party who is in need of a particular outcome that can only be delivered through an agent whose actions the principal has limited information. As a result, the principal has to employ a number of strategies (incentives) to ensure that the agent's actions are to the benefit of the principal. Based on this framework, the purchaser forms the central point of focus in the purchasing arrangement with relationships between this actor and three others: government, provider and citizen.

Purchasing arrangement in Kenya is done through four main mechanisms: government (both national and county), the National Hospital Insurance Fund, private insurers and community-based health insurance fund and this have been assessed using the RESYST framework. This framework of strategic purchasing is of particular relevance given its use in previous studies done in Kenya. These studies have focused on the National Health Insurance Fund (NHIF), Private Health Insurance (PHI), and Community-based Health Insurance (CBHI) contexts of purchasing (Mbau et al., 2018; Munge, Mulupi, Barasa, & Chuma, 2019). In summary, they identified that the purchasing arrangements of these organisations were passive. The details of these studies can be found in the literature review of this (Chapter 2). However, these studies, and others from other settings, have omitted a key purchaser: employer in-house medical schemes. This proposal therefore seeks to assess the purchasing arrangements in the employer managed schemes in Kenya by focusing on the three main relationships involved in the RESYST framework; as will be subsequently discussed.

1.1.1 Types of purchasing arrangements

Purchasing arrangement can either be passive or strategic (WHO, 2010).

Passive purchasing involves the use of predetermined budgets in offsetting or acquiring health services (Munge et al., 2015).

Strategic purchasing arrangement involves a continuous search of best ways to achieve UHC goals of equity, effectiveness, efficiency, quality and responsiveness (Munge, Mulupi, & Chuma, 2015; WHO, 2018). The concept therefore differs from procurement which is the efficient management of the supply of equipment and materials in a variety of settings including in healthcare provision (Ahmadi, Pishvae, & Torabi, 2018). In the UK context, Woodin (2016) provides a different term “commissioning” highlighting that the concept, as used in healthcare provision, involves a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role. Specifically applied to purchasing, the commissioning concept involves planning, designing and implementation of efficacious purchasing approaches.

Strategic purchasing arrangement involves the relationships and actions between three peripheral – healthcare providers, government, citizen – and one principle stakeholder, the purchaser (Picazo et al., 2015; Mbau et al., 2018)

In the Government -purchaser relationship, the government provides policy and regulatory frameworks for purchasing practices (Mbau et al., 2018). The government therefore is primarily responsible for the creation of an environment within which strategic purchasing can be conducted and to ensure that the overall process involved in the sourcing of funds and provision of services is sound and effective. According to the RESYT framework, the government serves four primary functions – ensuring clear purchasing frameworks, fill service delivery infrastructure gaps, ensuring adequate resource mobilization and ensuring accountability.

In the Purchaser-provider relationship, in the strategic purchasing arrangement, the role of the provider involves the rendering of the medical services as required by the agreement between themselves and the purchaser who is acting as an agent on behalf of the population or scheme beneficiaries. The RESYST framework requires the purchaser to, among other things, select and contract providers based on their ability offer services; incentivise quality service delivery and establish provider payment mechanisms (PPMs).

In the Citizen-purchaser relationship, the citizen is the party to whom services are rendered and is a principal to the purchaser (Lagomarsino et al., 2012). The RESYST framework requires the purchaser to carry out a health needs assessment of the population and use this to design the package of benefits that it offers to the population. The purchaser must also inform citizens of their entitlements along with mechanism to handle feedback and complaints.

The purchasing arrangements can be divided into different models based on the contractual agreements between the purchaser and the provider (contract or integrated), as well the ownership of the purchaser (private or public). The public contract models involves a purchaser-provider split contract from a social insurer, as is the case in Germany, where insurance services are issued under public contract (Klasa, Greer, & van Ginneken, 2018). An example of the private contract model is from the Netherlands where private insurance contracting pools from both public and private providers (Figueras et al., 2005). The integrated model does not involve a purchaser provider split. For example, a country's ministry of health could purchase services from a public health care provider it owns, under a public integrated model and a health management organisation could purchase services from a private hospital it owns under a private integrated model (Munge et al., 2015)

1.1.2 The RESYST Framework and strategic purchasing arrangement

As aforementioned, the RESYST framework conceptualizes strategic purchasing arrangement as entailing the relationship between three peripheral – healthcare providers, government, citizen – and one principle stakeholder, the purchaser (Picazo et al., 2015; Mbau et al., 2018). It is this conceptualization of strategic purchasing that forms the basis of assessment of strategic purchasing in this study. The RESYST framework has been used extensively by different researchers in different contexts. Examples are presented below.

Awosusi, Folaranmi and Yates (2015) in a study of Strategic purchasing through the RESYST framework in Nigeria indicate that although there had been intermittent progress towards achieving Strategic purchasing, the situation remains wanting as the purchasing approach remains passive and is characterised by minimal budgetary allocations (at the government level) and increasing out-of-pocket payments. Using the same framework (RESYST), in an assessment of strategic purchasing in Brazil, Russia, China, India and South Africa, (Marten et al., 2014) highlight that particularly in South Africa, the move to equitable financial service provision remains a major challenge with the problem, in part, attributed to the lack of strategic purchasing in facilitating healthcare financing through such avenues as private voluntary schemes.

1.1.3 AAR Employer in-house scheme.

Employer in-house schemes are health schemes where the employer offers health benefits as incentives to their employees and their dependants by way of a self-insured in-house medical scheme (The Ministry of Foreign Affairs and the Netherlands Enterprise Agency (2016)). Employer in-house schemes are described as enterprise financing schemes in the Kenya National Health Accounts 2015/16. Though they contributed only 3% of total current health expenditure of KES 326B in FY 2015/16, they are a significant source of financing in absolute terms (KES 10B) when compared to social health insurance schemes (KES 15B) and voluntary health insurance schemes (KES 35B).

Mwai (2016) observes that private financing (within which employer managed schemes are housed) account for 36% of healthcare expenditure in the country. Maina, Akumu, & Muchiri (2016) in a publication on Kenya Country Health Accounts further highlight that there are 480 employer managed schemes in Kenya with the majority (378) located in Nairobi County. There is limited evidence on the purchasing arrangements of employer in-house schemes. This proposal

focuses on AAR Kenya as the chosen organization depicting the employer-managed scheme model based on anecdotal evidence. Choice of the organization was purposive as AAR offers an in-house employer-managed scheme with all aspects of the program provided by the organization. All principle actors in the RESYST framework, for this organization, with the exception of the regulators (IRA and MOH), are thus housed within AAR.

AAR Healthcare is one of the largest private healthcare providers for outpatient services in East Africa with a network of 21 clinics across the country served by 300 employees. The organization seeks to provide healthcare solutions that are quality and affordable as a function of the organization's mission. The company serves close to 300,000 clients (AAR Kenya, 2019). AAR Healthcare also provides an employer in-house medical scheme which caters to the health needs of employees (the "citizens") in the event of illness for outpatient services only. The service can be accessed only at any AAR clinic (the "providers"). The purchaser is the fund manager within AAR healthcare who works with the AAR Healthcare management. The government role in the purchasing relationship is performed by the Insurance Regulatory Authority and the Ministry of Health.

1.2 Statement of the problem

Past studies conducted to assess purchasing arrangements in Kenya have demonstrated deviations from strategic purchasing practices. These examinations have covered the NHIF, county departments of health, private health insurance and community-based health insurance (Mbau et al., 2018). In the studies conducted on the purchasing arrangements in Kenya, NHIF is generally lacking in structure and enforcement (Mbau et al., 2018). For instance, the NHIF benefit package was not informed by a formal needs assessment. Also, no established channel of communication existed between the public to the NHIF.

There was inadequate evidence of reporting to the government from NHIF and particularly so with regard to purchasing arrangements. These findings are also reported in a working paper by the same authors which included data on private health and community-based health insurance schemes. These schemes were also found to have gaps in purchasing arrangements which included low capacity to ensure quality assurance and use of inefficient provider payment mechanisms. Studies from other settings (Picazo et al., 2015; Honda, 2014), have omitted a key type of purchaser i.e. employer in-house medical schemes. These schemes play a significant role

in the health system and as such their examination is critical to improving the quality, efficiency, equity and effectiveness of the health system.

This is of significance in Kenya where there is an accelerated attempt to attain UHC by 2022 (Barasa, Nguhiu, & McIntyre, 2018). This proposal therefore seeks to fill this gap in the literature with direct implications for health and social policy. This study therefore seeks to examine the purchasing arrangements in employer in-house medical schemes against the proposed ideals of strategic purchasing as put forward in the RESYST framework. Using a case study approach, it seeks to establish the actual purchasing arrangements of the AAR Healthcare employer in-house medical scheme; and assess these against the strategic purchasing arrangements described in the RESYST framework.

The aim, under this framework, involves assessment of the relationships between the four actors involved – government, citizen, purchaser, and provider with the aim of indicating how the actions by these relationships identified, affect the quality, efficiency, equity and responsiveness of health service provision. The current purchasing arrangements in Kenya done by different purchaser agents (NHIF, CBHI, Ministry of health, PHI and employee schemes) are still passive (Mbau et al., 2018). However, these examinations have not focussed on employer managed in-house medical schemes: a key feature of the Kenyan health system.

1.3 Objectives

1.3.1 General Objectives

To examine the purchasing arrangements of employer in-house medical scheme in Kenya using a case study approach.

1.3.2 Specific objectives

- i) To determine the purchasing arrangements of the AAR Healthcare employer in-house medical scheme.
- ii) To assess the government -purchaser relationships and actions of the AAR Healthcare employer in-house medical scheme for evidence of strategic purchasing.
- iii) To assess purchaser-provider relationships and actions of the AAR Healthcare employer in-house medical scheme for evidence of strategic purchasing
- iv) To assess the citizen-purchaser relationships and actions of the AAR Healthcare employer in-house medical scheme for evidence of strategic purchasing

1.4 Research questions

- i) What are purchasing arrangements of the AAR Healthcare employer in-house medical scheme?
- ii) Are the government -purchaser relationships and actions of the AAR Healthcare employer in-house medical scheme strategic?
- iii) Are the purchaser-provider relationships and actions of the AAR Healthcare employer in-house medical scheme strategic?
- iv) Are the citizen-purchaser relationships and actions of the AAR Healthcare employer in-house medical scheme strategic?

1.5 Scope of study

This project was for a case study of the AAR Healthcare employer in-house medical scheme in Kenya. AAR Healthcare is one of the leading private healthcare providers in East Africa, with close to 300 employees and a network of 21 clinics located in different parts of Kenya. The study was conducted in Nairobi over the months of April to May 2019 using qualitative research methods including document reviews, semi-structured key informant interviews.

1.6 Justification

This study sought to examine the purchasing arrangement in an employer in-house health scheme and intends to provide information that is of use to a variety of health system actors. First, the findings filled a gap in the literature concerning a purchasing arrangement that has not been examined for strategic purchasing practice. Second, the data was useful to the employer-managed organizations delivering value to employees in terms of maximising the equity, effectiveness and quality of health services they receive. Third, the study contributed to policy dialogues by highlighting the importance of strategic purchasing to the overall UHC agenda given the role of these forms of insurance in offering complementary or supplementary insurance. The study therefore had significance at different levels. By need assessment, the employees will also understand their entitlements. Other beneficiaries to the study would be other healthcare providers with an employment health benefit and academic institutions.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The purpose of this chapter is to provide a discussion of the theoretical and empirical literature put forward with regard to strategic purchasing. The chapter identifies the gap in the literature with regards to employer in-house medical schemes.

2.2 Theoretical Review

The purpose of the review of theoretical literature is to describe the theoretical foundations of the approaches to assessing purchasing arrangements described in empirical literature. To this end, two theories were considered – the principal agent theory and the designer-buyer-supplier interface theory.

2.2.1 The principal agent theory

The principal agent theory emanated in the 1970s, from observations put forward in the economics and institutional theory disciplines and put forward, independently, by Stephen Ross and Barry Mitnick (Mitnick, 1975). The essence of the theory is that often parties involved in transactions have differing priorities and objectives thereby resulting in inefficiencies in the conducting of mutually dependent projects (Soguel & Chatagny, 2007).

2.2.2 The RESYST framework theory

The RESYST framework applies the theory to purchasing arrangements. It identifies three sets of relationships in which one party (the principal) has conflicting goals and objectives with the other (the agent). By assessing the actions being conducted in these relationships. The three relationships, in order of principal-agent, are government-purchaser, purchaser-provider and citizen-purchaser. It is possible to assess these actions and to classify the purchasing arrangements as passive or strategic.

2.2.3 Designer-buyer-supplier interface theory

Whereas the principal-agent approach categorizes actors as principal or agent, the designer-buyer-supplier interface conceptualizes the interactions based on the role that each play in the overall health systems (Dowlatshahi, and Contreras, 1999). The role of government is seen as involving – in collaboration with other stakeholders – deigning of the environment within which health services are offered. Citizens serve the role of buyers while medical practitioners serve the

role of suppliers (Dowlatshahi, 2000). While this theory explains the actors, it does not specify the actions that should be performed by each actor or within each relationship.

2.3 Empirical Review

The purpose of this section is to review the empirical literature on purchasing arrangements. It is organised starting with an overview of purchasing arrangements followed by a reference to the three principal-agent relationships alluded to in the theoretical literature (Section 2.2)

Klasa, et al., (2018) investigated the implementation of strategic purchasing in 10 European Union nations made up of 7 nations and 3 units in decentralized nations: England in the UK, Veneto in Italy and Catalonia in Spain. The conceptual framework was designed by reviewing various strategic purchasing definitions in literature, including by WHO and RESYST and included the following actions: addressing population needs; empowering the public; strengthening government stewardship; developing purchaser and provider groups; and cost-effective contracting. The paper showed difficulty in attaining all aspects of strategic purchasing in all 10 countries. It recommended a need for improved information management to increase provider accountability; and greater choice for patients with regard to which provider to go to. This, however, had the potential to limit the power of the purchaser to steer the patient to lower-cost or higher-quality providers.

These findings mirror those of Figueras *et al.*, (2005). Their study of purchasing actions in European health systems highlight that purchasers ought to set structures to ensure the providers offer quality services. These actions include supplying an essential drug list or an itemized list of services; selection of providers based on their ability to offer the services required; and the use of contracts delineating the range of offered services, timing and amount of payment etc. Purchasers must also study the market to always provide the best healthcare at the lowest cost. Purchasers should also choose convenient payment methods that encourage providers to maintain service quality, and constantly monitor service quality.

In Iran, there were gaps in purchasing arrangements with regards to determining what to buy Dehnavieh, Sirizi, Mehrolhassani and Kalantari (2016). This is due to inadequate information systems and a lack of criteria for to evaluate services. These can be mitigated by establishing a framework to use to evaluate services in healthcare. A second shortcoming was who to buy from i.e. determining from which entities to purchase. Providers were often not ranked according to

relationship. There was also evidence that financial resources i.e. budgets were not well aligned with the needs of the population.

The Health Policy Research Group (2016) discussed the strategic purchasing practices of private insurance companies in Kenya. The publication highlights that from a provider perspective PHIs perform better than the government with regard to purchasing function. The Association of Kenyan Insurers had a contracting document by which they abide to contract providers. However, premiums only recently began being determined by actuarial analysis, which is hindered by inadequate expertise. In addition, uptake of new forms of provider payment e.g. capitation was low among providers. Little oversight was offered by the MoH and the Insurance Regulatory Authority on strategic purchasing.

2.3.1 Government – purchaser relationship

Figueras et al., (2005) highlight the observation that the role of government may differ based on the purchasing model. For example, the authors highlight that in a public contract model, as in Germany the role of the government is pervasive throughout the purchasing process. This is because due diligence on the part of the government has to be ensured both in the identification of the appropriate service renderers and the ensuring of sufficiency in the financing aspect. The authors further highlight the functioning of the model in the Netherlands where private insurance contracts pool from both public and private providers under private contracts (Figueras et al., 2005). As with the first instance the role of the government with relation to the provider involves that of ensuring compliance among the private insurer so as to prevent foul-play on the part of the provider and sufficiency of funding by the citizen. In the second model – no purchase-provider split – the role of the purchaser and the provider is carried out by a single entity.

In an assessment of the purchasing function in China, Yip and Hanson (2009) highlight that the process is generally passive in that no strategic approaches are involved in the purchasing of healthcare. The authors highlight that the role of the Ministries of Health and Labour and Social Security in acting for or independently of citizen's interests is not established; this therefore would hinder strategic purchasing.

Honda et al. (2016) highlight the role of the government-purchaser relationship in a study conducted in the Philippines. The study highlights the low expenditure of the national expenditure program (PhilHealth) and the minimal benefits provided to the subscribers. Given

the goals of UHC, the authors opine that it is the governments mandated role to ensure sufficient expenditure on the part of the provider and that this can be effected through both the establishment of policies and enforcement of existing policies. The eventual effect of such an approach would therefore involve sufficient expenditure and an increase in benefits to citizens such that comprehensive medical cover would be more readily available without damaging economic implications.

In a study of the purchaser-government relationship in Nigeria, Etiaba et al., (2018) highlight that in the case of the national healthcare program and the rendering of healthcare services through HMOs, the government had unsatisfactorily achieved the regulation goals involved in ensuring adequate regulation of HMOs and healthcare providers, provision of accreditation, and regulation of payment methods. In general, the authors postulate that the government lacks sufficient political will to undertake its regulatory function in the industry. The eventual effect of this shortfall, as depicted by the author, is an inefficient health provision system that hinders citizens from accessing necessary healthcare as depicted in the UHC goals.

In the local context, Munge et al. (2015) assess the role of government-purchaser relationship as pertains to the NHIF, PHI and CBHIs as one involving ensuring adequacy of funding for operations. They identified gaps in the availability of resources and propose increases in financing for health.

2.3.2 Purchaser – provider relationship

In the bid to achieve UHC in Nigeria, the government put in place healthcare schemes aimed at addressing the medical needs of federal and formal private sector employees (Etiaba et al., 2018). The approach taken in this effort has been the setting up of the Formal Sector Social Health Insurance Programme (FSSHIP) an insurance program that operates in two levels - National Health Insurance Scheme (NHIS) and health maintenance organisations (HMOs). In assessing the purchaser-provider relationship in the program, it is observed that there is a lack of established governance arrangements that promote strategic purchasing. This lack of established protocols stems from a lack of capacity among both public purchasers and regulators. The current purchasing arrangement with respect to providers is therefore generally passive with existing stipulations put in place to regulate the purchasing framework remaining unenforced.

The stewardship role to be played by NHIS over the FSSHIP is also curtailed by the lack of capacity and insufficient allocation of resources.

The purchaser-provider relationship can be enhanced through multiple avenues aimed at ensuring efficiency throughout the interactions involved. Among the actions highlighted in the RESYST framework with regard to the purchaser-provider relationship are the need for secure information on services rendered and the development, management and use of information systems (Munge et al., 2019). An effort to this end as implemented in German has been the introduction of an electronic health card to ensure proper patient identification, ensure easy provision of information to the provider and to minimize system abuse through accurate and accountable use of information (Klasa et al., 2018). In further assessing the dynamics of the provider-purchaser relationship, Klasa et al., 2018) highlight that allowing for patient choice in the selection of providers can result in inefficiencies in service provision and particularly so in the event of clear preference for specific providers in a healthcare scheme; this situation is apparent in England thereby necessitating a shift in the purchaser-provider agreements in such a manner as to limit chances of overutilization of specific providers as the expense of others. The authors provided an example of such an amendment with regard to service provision by citing Switzerland and Netherlands where insurance plans limit choice by requiring cost sharing for patients visiting non-contracted providers as a result of preference for such providers.

A comparison of purchasing in Thailand's Universal Coverage Scheme (UCS) and the Civil Servant Medical Benefit Scheme (CSMBS) indicate that the former showed less evidence of strategic purchasing than the latter with the consequence of this difference being 4-times higher expenditure by the CSMBS (Patcharanarumol et al., 2018). With particular regard to the purchaser-provider relationship, the authors posit that there is need for the purchaser to ensure effective mechanisms are in place to determine and mirror the citizen's needs and that the service rendering process ensures accountability on the part of the provider. The authors further observe that the mode of payment between the two schemes is such that the fee-for-service approach in effect for the CSMBS results in the issuance of excessive medication thereby increasing patient cost; this contrasts with the multiple reimbursement rate system which mitigates against unnecessary treatment and over-prescription. With regard to provider preference as exercised by citizens, it was apparent that the lack of restrictions in CSMBS resulted in higher expenses as

compared to UCS which exercised gatekeeping restrictions by stipulating service providers to whom citizens have access.

In Kenya, Munge et al. (2015) and Mbau et al. (2018) observe that although there are no legal frameworks stipulating considerations of strategic purchasing, some basic requirements, e.g. registration, are in place. The nature of the relationship between the provider and the purchaser, other than in this aspect, are generally left to the discretion of the agreeing parties. The eventual situation, therefore, is an ad-hoc stipulation of contractual arrangements between purchasers and provider particularly for integrated models e.g. the county department of health. This is further undermined by the power of providers over purchasers especially among high-cost hospitals that are preferred by citizens.

2.3.3 Citizen – purchaser relationship

The implications of the relationship between these two parties is depicted by two studies conducted in two contexts – Tangcharoensathien *et al* (2018) in Thailand and Dao and Mulligan (2016) in Columbia. In the Thai study, the authors highlight that efforts towards provision of universal healthcare in the country have been ongoing pre-UHC goals tracing back to as early as the 1970s. The essence of the approach has been the allocation of adequate resources to the healthcare sector aimed at minimization of out of pocket payments hence advancement towards realization of UHC goals. This mechanism is also founded on regular needs assessments including through national congresses and dedicated priority setting mechanisms e.g. Health Intervention and Technology Assessment Program (HITAP).

In contrast, in the Colombian context, Dao and Mulligan (2016) highlight that tension exists between the two parties in that the purchaser views the citizen as a possible negative influence on the effectiveness of the system given that the latter is considered to willingly engage in risky behaviour on account of securing insurance plans. The resulting situation, therefore, is the move towards minimal expense in the addressing of payments that the purchaser deems avoidable. Unlike in the forgoing example, therefore, the purchaser is motivated more by the prospect of minimizing loss than by the will to increase coverage for the citizen.

In a study conducted in Australia Marston, Cowling and Bielefeld (2016) report a tension between the taxpayer perception of the taxation system – which is in part used to facilitate healthcare – and taxpayer behaviour. The authors report that despite high levels of compliance,

citizens do not generally perceive expenditure allocations as being tailored to their needs. Cases of tax non-compliance, for instance, through way of over reported deductions, were reported with the citizens motivated to avoid taxation on account of disgruntlement. The implication of this finding, therefore, is that a lack of alignment between purchaser and citizen needs may result in reduced willingness, on the part of the citizen, to issue payments necessary for the rendering of services.

An analysis of the purchaser-citizen relationship in Kenya as applies to Micro Health Insurance (MHIs) was conducted by Munge et al (2019) who observe that the regulatory framework in place within the country served as a hindrance to efficient service delivery. The lack of guiding policies and enforcement, for instance, resulted in MHIs sourcing providers that were relatively small and thus at the behest of the MHI. This dynamic resulted in less-than-optimal-quality with regard to service rendering in general and a lack of efficient feedback channels from beneficiaries to providers. Furthermore, the authors report that coverage was determined based on the amounts paid by the individual thereby rendering the services inaccessible to low-income households.

2.4 Research gap

The theoretical literature demonstrates the value of an approach to purchasing arrangements that captures the relationships between the various actors. This is captured in the principal agent theory as described in the RESYST framework. The empirical evidence shows a gap in the assessment of the purchasing arrangements of employer in-house medical schemes. The available evidence suggests that there are gaps in the purchaser-government relationship in that there are no clear regulatory frameworks and policies that govern purchasing arrangements. This might extend to employer in-house medical schemes.

In the context of the proposed project, the providers of services are the in-house clinics that AAR employees are required to frequent for out-patient services. The literature suggests that there would need to be clear requirements by the purchaser, in this case the fund manager, to ensure that the nature of the relationship between the two parties guarantees quality and efficient services. This requires examination in the proposed project given the absence of evidence. In the context of the ongoing study, the purchaser is the fund manager of the employer in-house medical scheme and the citizen as the employee. The literature proposes that the relationship

between the two parties involves assessment of service needs preferences and values for the setting of entitlements and benefits; information issuance to the employees; ensuring access by employees; establishment of a feedback and complaints mechanism; and reporting on resource use and performance.

It is therefore evident that limited studies have been conducted on employer in-house medical schemes in Kenya and other settings. The literature demonstrates the relevance of the RESYST framework for assessing purchasing arrangements. This framework has been used in Kenya to assess purchasing in the National Health Insurance Fund (NHIF), Private Health Insurance (PHI), and Community-based Health Insurance (CBHI) contexts of purchasing (Mbau et al., 2018); Health Policy Research Group, 2016; Munge et al., 2019). This study therefore seeks to fill the gap of evaluation of the purchasing arrangements of employer in-house medical schemes in Kenya in light of strategic purchasing.

2.5 An analytical framework

This project proposes to assess the purchasing arrangements of employer in-house medical schemes in Kenya in light of strategic purchasing as encapsulated in the RESYST framework. The RESYST framework will therefore be used as an analytical framework in that the assessment of strategic purchasing fit or misfit will be done through the lens of the framework (Figure 1).

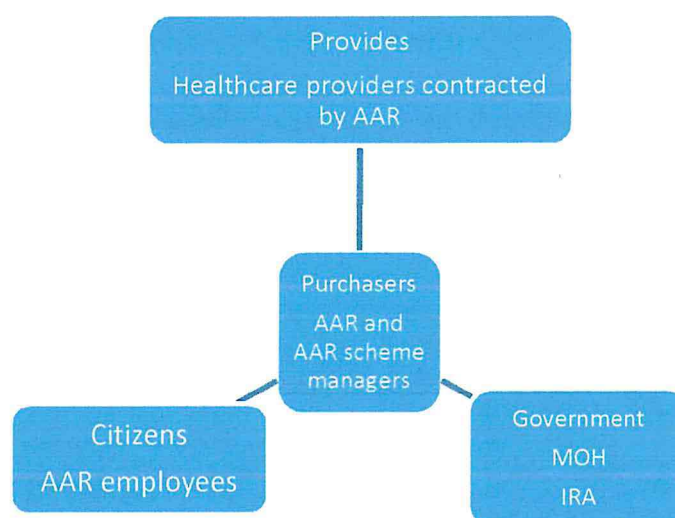


Figure 2.1 RESYST framework

The assessment is of the purchasing arrangements within three distinct relationships (purchaser-provider, citizen-purchaser and government-purchaser). These purchasing arrangements will be assessed against the ideal arrangements described in the RESYST framework (Table 1). This means that, for example the purchaser government relationship will be assessed with the understanding that the relationship involves establishment of clear frameworks; the purchaser-provider relationship involves selection of providers and provider payment mechanisms and finally, purchaser-citizen relationship involves need assessment and citizen entitlement (Mbau et al., 2018); Health Policy Research Group, 2016; Munge et al., 2019).

Table 2.1 RESYST framework

Key strategic purchasing actions by the government in relation to purchasers
• Establish clear frameworks
• Fill service delivery infrastructure gaps
• Mobilize adequate resources to meet service delivery
• Ensure accountability of purchaser(s)
Key strategic purchasing actions by the purchasers in relation to the citizens
• Assess the service needs, preferences and values of the citizens and use these to design service benefits/entitlements
• Inform the population of their entitlements and obligations
• Ensure citizens can access their entitlements

<ul style="list-style-type: none"> • Establish effective complaints and feedback mechanisms
<ul style="list-style-type: none"> • Publicly report on the use of resources and other measures of performance
STRATEGIC PURCHASING
Key strategic purchasing actions by the purchasers in relation to providers
<ul style="list-style-type: none"> • Select providers considering the range and quality of services and their location
<ul style="list-style-type: none"> • Establish contracts/ service agreements
<ul style="list-style-type: none"> • Develop formularies (Of generic drugs, surgical and medical supplies) and standard treatment guidelines
<ul style="list-style-type: none"> • Design, implement and modify provider payment methods to encourage efficiency and service quality
<ul style="list-style-type: none"> • Establish provider payment rates
<ul style="list-style-type: none"> • Secure information on services provided
<ul style="list-style-type: none"> • Monitor provider performance and act on poor performance
<ul style="list-style-type: none"> • Audit provider claims
<ul style="list-style-type: none"> • Protect against fraud and corruption
<ul style="list-style-type: none"> • Pay providers regularly
<ul style="list-style-type: none"> • Allocate resources equitably across areas
<ul style="list-style-type: none"> • Implement Other strategies to promote equitable access to services
<ul style="list-style-type: none"> • Establish and monitor user payment policies
<ul style="list-style-type: none"> • Develop, manage and use information systems

Source: (Mbau et al., 2018)

CHAPTER THREE: METHODOLOGY

3.1 Introduction

The chapter describes research design, study population, data collection tools, data collection and data analysis. The purpose of the chapter, therefore, was to provide an elucidation of the manner in which the research objectives were addressed.

3.2 Research Design

The study utilized a qualitative case study approach with an employer-managed in-house scheme in AAR Kenya as the unit of analysis. The case study approach allows for holistic study of an entity with the intention of explaining reasons behind relationship and observations presenting from the entity (Kothari, 2004). This approach was chosen as the researcher focused solely on AAR due the organization's in-house employer-managed scheme.

3.3 Population and Sampling

Purposive sampling was used to select AAR Healthcare as the case that shall be evaluated in the study. Purposive sampling was selected as the sampling method because it is suitable when one wishes to select respondents that are particularly informative (Lewis Adrian Thornhill & Thornhill, 2012). Francis, Johnston, Robertson, Glidewell, Entwistle, Eccles, and Grimshaw (2010) observed that a minimum of 20 respondents is deemed sufficient in conducting a qualitative study through the use of interviews. The researcher therefore sought 20 respondents from AAR out of which 4 were AAR scheme managers, 12 employees and 4 healthcare providers. Two government representative bodies were considered – the Ministry of Health and the Insurance Regulatory Authority (IRA). Two respondents from each were sought from these organizations. The total number of respondents from the study was thus be 24.

3.4 Data Collection method

Data collection was through three approaches: document reviews, interviews with key informants using semi-structured interview guides. The document review phase involved assessment of both contract stipulation and in-house-insurance specific codes of regulation; these are provided to each employee and are available through the company's intranet. This document spoke to the policy design aspects of the in-house insurance program. Interviews with key informants were conducted using a semi-structured interview guide (annex 2). The interview

prompt was adjusted to fit the interviewed parties. As these interviews included both the governing faction (AAR managers) and employees charged with in-house-insurance management (purchasers). These interviews was to assess the perspectives of the employees on the various relationships as conceptualized in the framework. The final approach involved interviews with the employees serviced by the in-house insurance program.

3.5 Data analysis

Interview data from audio were transcribed to generate scripts; the scripts was then standardized to ensure that all data was captured in English. All scripts were transcribed verbatim to ensure accurate capturing of all information. The quality checked scripts were then input into Nvivo for analysis via a thematic framework analysis approach with codes developed based on the analytical framework and on emergent themes from the data. The development of the coding framework was iterative, and the codes were reviewed and agreed on with the supervisor, as the analysis proceeds.

3.6 Research Quality

Research quality involves assurance of validity and reliability of approaches to and thus results of a study (Neuedorf, 2002). Gilson (2012) highlights that reliability involves ensuring careful study design, tool development, data collection and appropriate statistical analysis. This study was conducted through the use of the RESYST framework – a tried and tested framework – as the main analytical and conceptual framework thus ensuring reliability of the findings. Data was also collected through interviews hence allowing for clarification of questions directed to the respondents; this served to ensure reliability of responses. Construct validity – an assessment for objectivity in assessing a parameter (Gilson, 2012) – was ensured through consultation with the supervisor on the appropriateness of the chosen questions directed to the respondents. The structure of the questions was such that the elements in the questions are relevant, focussed and accurate.

3.7 Ethical Issues

According to Shamoo and Resnick (2003), adherence to ethical standards serves the purpose of promotive knowledge and truth hence lending credence to the authority of findings emanating from a study. The nature of the ongoing study was such that it involves interactions with different parties with the intention of collecting information that may have bearing on the interest of the respondents given that all assessments were conducted in-house at AAR facilities. The researcher therefore understood the need for privacy and confidentiality in the study. To this end, all respondents were informed of their right to decline to answer any of the questions put forward and all collected data were kept confidential and used only for the purpose of the ongoing study. Furthermore, approval was sought from Strathmore University Ethics Committee, and the National Commission for Science and Technology (NACOSTI).

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF RESULTS

4.1 Introduction

The purpose of this chapter is to provide evidence of the addressing of the research objectives through an analysis of the data collected for the study and presentation of findings. This chapter is therefore subdivided into three main sections – descriptive statistics, objectives of the study and summary of findings; these sub-sections are subsequently discussed.

4.2 The Purchasing arrangement in AAR healthcare

AAR Healthcare emerged as an offshoot of the mother company AAR in 2017 as the latter sought to diversify its portfolio through the inclusion of a health provision business unit. The company is however run independently of AAR insurance and therefore offers healthcare services as an independent outpatient system with 21 outlets. As part of the benefits availed to employees, the organization provides 336 individuals with inhouse covers inclusive of dependents with the total tally of scheme subscribership being 750 individuals. The services provided under the cover include general consolation, laboratory and dental services and minor procedures, maternity and physiotherapy services. The entity does not provide optical services. Each individual is availed a smart card that allows for the seeking of services predominantly from AAR healthcare providers (95%) and a minority panel of contracted external facilities (5%). A total of 20 individuals were queried for the study with 10 constituting employees (benefit recipients), three HR representatives, five service providers, and the finance, and procurement heads.

The researcher sought to assess the general purchasing arrangement at AAR and in doing so, to categorize it as passive or strategic based on multiple determinants; these are subsequently discussed. As reported by two HR representatives and the procurement head, the fund allocation process for the scheme was done on the basis of a budgetary allocation agreed upon the board of managers. The company having emerged from AAR in 2017 doubled its allocation on the grounds of previously noted exceeding on the set cap. The budget allocation process was however mainly informed solely by the consensus on previous performance and in the event that

minimal overages were reported, the allocation was deemed sufficient. This therefore presented as evidence of passive purchasing.

The main purchasing functions as depicted in the RESYST framework were performed by the HR, Procurement and Finance departments (3 respondents). This therefore indicated a split in the purchaser function in that the purchaser was not specialized to the purchasing function and was instead constituted as a subset of function held within different departments. The centralized team of seven HR managers was charged with the role of overseeing the machinations of the scheme with a clear stipulation of preferred inhouse treatment. The basis of arriving at inhouse service providers was done by virtue of the cost implications involved given that inhouse service providers, being salaried, would not require extra payment for serving staff. The negotiation of payment with providers – given that 95% of them were inhouse – was therefore passive. Additionally, all external service providers with agreements with the company were inherited from the mother company's panel. However three respondents indicated that plans were underway to establish MOUs with external providers deemed of high quality by the quality assurance manager and the board of managers. In summation, the purchasing arrangement within the organization showed no evidence of strategic purchasing.

4.3 Purchasing relationships

The second objective of the study assessed the purchasing actions within AAR Healthcare. In doing so, the researcher sought to assess three main relationships – purchaser-citizen, purchaser-provider, and purchaser-government. Each of the relationships is subsequently discussed.

4.3.1 Purchaser-citizen relationship

The purchaser-citizen relationship, as encapsulated within the organization, involved the HR department as the main purchaser with the procurement and finance managers/directors performing some of the traditional purchasing functions. The indicated in the world cloud (figure 4.1) the managers and directors of the three departments were the hub of the relationship between the purchasing function and employees within the organization. The HR department was responsible for orchestrating the service rendering process specific to in-house service provision. This process involved monitoring of the expenditure rates of each of the individuals, orchestrating payment with panel service providers and informing employees of their benefits within the scheme. The sourcing of funds was channelled through the organization hence citizens

Table 4.1 Key strategic actions Purchaser-Citizens relationship

Key strategic purchasing actions by the purchasers in relation to the citizens	AAR Status Quo
<ul style="list-style-type: none"> Assess the service needs, preferences and values of the citizens and use these to design service benefits/ entitlements 	<ul style="list-style-type: none"> The process is informed by a budgetary allocation decided upon by the board of managers
<ul style="list-style-type: none"> Inform the population of their entitlements and obligations 	<ul style="list-style-type: none"> Benefits from the scheme are communicated through the orientation process
<ul style="list-style-type: none"> Ensure citizens can access their entitlements 	<ul style="list-style-type: none"> Service provision governed by the smart card system
<ul style="list-style-type: none"> Establish effective complaints and feedback mechanisms 	<ul style="list-style-type: none"> Feedback mechanism is similar to that employed by other service seekers that frequent facilities
<ul style="list-style-type: none"> Publicly report on the use of resources and other measures of performance 	<ul style="list-style-type: none"> No public reporting to employees is practiced.

4.3.2 Purchaser-Provider relationship

- Of the total number of service providers 95% are in-house with the minority involving contractual agreements inherited from the mother company AAR and offering specialist services that are not available through AAR Healthcare. The purchaser-provider relationship is therefore not governed by contractual agreements except in the event of interaction with panel providers that were vetted by the mother company. There however are plans in effect to arrive at new service providers through MOU; these are deliberated upon predominantly by the quality assurance head in consultation with the board of managers among whom are the HR, Finance and Procurement department heads.

The general purchaser-provider relationship was therefore typical of what would be expected of a departmentalized organization whereby HR served the function of addressing queries pertaining to treatment but did not exercise a direct contractual role with the service providers. The service providers were often not knowledgeable of the distinction between in-house-scheme members and non-members and therefore proceeded to treat, as reported by two healthcare providers, all patients as they would any other. Off-system referrals were therefore issued but these were mainly in the event of non-panel specialists.

The monitoring role exercised by the purchaser over the provider was handled as an in-house quality assessment process whereby the task was handled by the AAR Healthcare's quality

Table 4.2 Key strategic purchasing actions purchaser-provider relationship

Key strategic purchasing actions by the purchasers in relation to providers	AAR Status Quo
<ul style="list-style-type: none"> Select providers considering the range and quality of services and their location 	<ul style="list-style-type: none"> The current providers were inherited from AAR insurance but plans are underway to generate MOU with new providers
<ul style="list-style-type: none"> Establish contracts/ service agreements 	<ul style="list-style-type: none"> A function of the board to be effected by procurement department
<ul style="list-style-type: none"> Develop formularies (Of generic drugs, surgical and medical supplies) and standard treatment guidelines 	<ul style="list-style-type: none"> N/A
<ul style="list-style-type: none"> Design, implement and modify provider payment methods to encourage efficiency and service quality 	<ul style="list-style-type: none"> Payment methods in place or in-panel providers where HR pass on invoiced to finance for actioning
<ul style="list-style-type: none"> Establish provider payment rates 	<ul style="list-style-type: none"> N/A
<ul style="list-style-type: none"> Secure information on services provided 	<ul style="list-style-type: none"> Privacy in inhouse facilities enforced through limiting access to medical data to practitioners.HR however still have access to centralized database
<ul style="list-style-type: none"> Monitor provider performance and act on poor performance 	<ul style="list-style-type: none"> Inhouse quality assessments on service provision run annually by head of quality assurance.
<ul style="list-style-type: none"> Audit provider claims 	<ul style="list-style-type: none"> N/A
<ul style="list-style-type: none"> Protect against fraud and corruption 	<ul style="list-style-type: none"> N/A
<ul style="list-style-type: none"> Pay providers regularly 	<ul style="list-style-type: none"> Providers paid through smart card system for external providers; internal providers are salaried.
<ul style="list-style-type: none"> Allocate resources equitably across areas 	<ul style="list-style-type: none">
<ul style="list-style-type: none"> Implement Other strategies to promote equitable access to services 	<ul style="list-style-type: none"> N/A
<ul style="list-style-type: none"> Establish and monitor user payment policies 	<ul style="list-style-type: none"> Assessment of limits on payment are done by HR department
<ul style="list-style-type: none"> Develop, manage and use information systems 	<ul style="list-style-type: none"> Single information system accessed differently by different users

4.3.3 Purchaser-Government relationship

There was no direct relationship between the government (IRA and MoH) and AAR Healthcare as a unit. None of the entities performing the purchasing action – HR, Procurement, and Finance interacted with the entities directly. As reported by a regulator, interactions between the entities was only as may be inferred through interactions with AAR Insurance. The stipulations in the Section 75 of the Insurance Act was referenced as the primary mode of governance of the insurance agency with stipulations put forward with regard to policy documents and contract terms, pricing aspects, and claims procedures. Given that no direct relationships were reported between the organization and the governing body, it was inferred that AAR Healthcare, as an independent body, operated unregulated except for internal measures put in place by the management. Table 4.3 provides a summary of the actions in AAR Healthcare vis-à-vis those stipulated in the purchaser-government relationship as encapsulated in the RESYST framework.

Table 4.3 Key strategic purchasing actions purchaser-government relationship

Key strategic purchasing actions by the government in relation to purchasers	AAR Status Quo
<ul style="list-style-type: none"> • Establish clear frameworks 	<ul style="list-style-type: none"> • No direct interaction with governing agencies as AAR Healthcare; governance function performed by inhouse protocol with board of managers at the helm. • Frameworks are dependent on HR rules and regulations as pertains to the benefits outlined in the orientation process and crated by the organization.
<ul style="list-style-type: none"> • Fill service delivery infrastructure gaps 	<ul style="list-style-type: none"> • N/A as no direct interactions with government regulators are in place
<ul style="list-style-type: none"> • Mobilize adequate resources to meet service delivery 	<ul style="list-style-type: none"> • N/A as no direct interactions with government regulators are in place
<ul style="list-style-type: none"> • Ensure accountability of purchaser(s) 	<ul style="list-style-type: none"> • N/A as no direct interactions with government regulators are in place

4.4 Summary of findings

With regard to the first question, it was evidenced, by the findings put forward in this section that the purchasing mechanism in AAR Healthcare is passive as characterized by arbitrary fun allocation to the in-house scheme and nominal sourcing of providers. There was no evidence of strategic purchasing with regard to the acquisition or distribution of financing in the service provision process. The process was however deemed effective by all users.

With regard to the second objective, it was evident that AAR Healthcare did not feature a specific purchasing entity as the purchasing functions were distributed between the HR, Procurement and Finance department. This therefore rendered the relationship between the purchaser and the other entities – citizens (employees), government and providers – as fragmented and uncharacterized; the system was essentially run as in-house health benefit scheme with the exception being that given that the organization provided health services, such services were mainly sought in-house as opposed to through contracts with other providers.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

The purpose of this chapter is to highlight the research findings in light of extent literature put forward in addressing the purchasing function of healthcare provision. This chapter is structured into five main sections, discussion, conclusion, and recommendations, limitations of the study and areas for further research.

5.2 The purchasing arrangements of AAR Healthcare employer in-house medical scheme

Figueras et al., (2005) put forward that the concept of purchasing involves identification of what item or service is purchased, from whom it is purchased, how it is purchased, and for how much it is purchased. In light of this definition of purchasing, the researcher identified the purchased services as entailing the – general consolation, laboratory and dental services and minor procedures, maternity and physiotherapy services. The AAR Healthcare employer inhouse medical scheme does not provide optical services or inpatient services. The services are mainly purchased from the inhouse service providers (95%) with 5% of the services sourced from outside service providers of which all were inherited from the sister company – AAR insurance.

With regard to the manner of purchasing, it was evident that the purchasing begins with a budgetary allocation of finances to the in-house medical scheme. Each of the beneficiaries (totalling 750 inclusive of dependents) is allowed a maximum cap of KES 100,000. The service payment process is effected through the use of a smart system whereby each beneficiary is issued a smart card that contains the employees/dependents details and expenditure information. Management of the spending function is predominantly handled by the HR department. Whereas payments are effected directly from the fund to each of the 21 clinics as necessary through the smart system, payments to on-panel providers must be ratified by the HR department after which they are actioned by the finance department.

The amount of purchasing involved in the service provision process was attached to the remuneration mechanism of the organization in that practitioners and sourcing of medical resources was not scheme-specific. The resources associated with the service rendering processes

were bundled together with those required for the provision of services to other insurance and out-of-pocket service seekers from the public domain.

Strategic purchasing arrangement involves a continuous search of best ways to achieve UHC goals of equity, effectiveness, efficiency, quality and responsiveness (Munge, Mulupi, & Chuma, 2015; WHO, 2018) Passive purchasing involves the use of predetermined budgets in offsetting or acquiring health services (Munge et al., 2015). Woodin (2016) in an investigation of the purchasing function in the UK highlights the term “commissioning” which entails a proactive strategic role in planning, designing and implementing the range of services required, rather than a more passive purchasing role.

The allocation of KES 100,000 as the stipulated cap per individual was done with consideration of the competitiveness of the benefit scheme as compared to other players in the healthcare space. As depicted in the findings, the cap was an improvement from the previous KES 50,000 offered before the entity – AAR Healthcare – emerged as an independent subsidiary in 2017. There however were not mechanisms in place to statistically or strategically justify the allocation as indicated by the purchasers. Nevertheless, the allocation was generally deemed satisfactory in addressing the needs of the scheme members. The sourcing of funds was dependent on a budgetary allocation and no proactive approaches were in place to assess the sufficiency of the financing except for the monitoring of incidences of burst caps. The identification of service providers was also done through the inheritance of a panel of providers from the mother company’s list. It was therefore apparent that the purchasing mechanism was passive in nature. This finding is in keeping with studies on the National Health Insurance Fund (NHIF), Private Health Insurance (PHI), and Community-based Health Insurance (CBHI) contexts of purchasing (Mbau et al., 2018; Munge, Mulupi, Barasa, & Chuma, 2019) both of which provide evidence of the passive purchasing practices in the Kenyan context.

5.3 Assessment of the Purchasing relationships and actions of the AAR Healthcare employer in-house medical scheme for evidence of strategic purchasing

The current study was structured in accordance with the Resilient and Responsive Health Systems (RESYST) consortium in examining the purchasing actions of the AAR medical scheme across the three purchasing relationships, namely purchaser-government, purchasing-providers, and purchasing-citizens (Health Policy Research Group, 2016). Each of the purchasing

relationships is characterized by a set of actions that constitute the rubric used in assessing for evidence of strategic purchasing in the purchasing function. The entails of the purchasing mechanism at AAR in light of the actions encapsulated in each of the relationships are subsequently discussed.

5.3.1 Government-Purchaser relationship

The actions stipulated in this relationship include - Establishing clear frameworks, filling service delivery infrastructure gaps, mobilizing adequate resources to meet service delivery and ensuring accountability of purchaser(s) entitlement (Mbau et al., 2018; Health Policy Research Group, 2016; Munge et al., 2019). All stated functions were managed internally by the board of managers which constituted among others, the HR representative, the finance department head, the quality assessment head, and the procurement department head. There were no direct interactions between either the Ministry of Health or the Insurance Regulatory Authority. There was therefore no evidence of strategic purchasing with regard to this relationship.

5.3.2 Purchaser-citizen relationship

The actions indicated in this relationship include – Assessment of the service needs, preferences and values of the citizens and use these to design service benefits/ entitlements, informing the population of their entitlements and obligations, ensure citizens can access their entitlements, establishing effective complaints and feedback mechanisms, and publicly reporting on the use of resources and other measures of performance (Mbau et al., 2018; Health Policy Research Group, 2016; Munge et al., 2019).

The assessment of needs and the use of resulting information in structuring benefits/entitlement plans was done after the fact in that yearly assessments on over-expenditure vis-à-vis expenditure caps were assessed. Over-the-cap expenditure were used to inform possible revisions of the overall expenditure cap whereas inclusion of other providers in the panels and consideration of out-network referrals was informed by feedback from scheme members. Employees were informed of their entitlements and obligations through the orientation process and through direct contact with the HR department. Assurance of service provision was orchestrated by the HR department as effected through the smart card system and as actioned by the finance department when on-panel but off-network provider were involved. With regard to the feedback mechanism, there were no specific channels pertaining to the scheme as employees

were required to utilize the standard channel utilized by the public in issuing feedback on rendered services. Finally, there were no mechanisms in place to service scheme members with reports detailing the performance of the scheme. In general, the purchasing relationship was not strategic and therefore passive.

5.3.3 Purchaser-provider relationship

The actions stipulated in this relationship included – selection of providers, establishment of actions, development of formularies, efficiency-based development of payment methods, establishing provider rates, securing information, monitoring of performance, auditing, fraud protection, regular payment, equitable resource allocation, establishment of user payment policies, and use of information systems (Mbau et al., 2018; Health Policy Research Group, 2016; Munge et al., 2019). This relationship the most evidence of strategic purchasing (with regard to actions) given the in-house management of the service rendering process. As depicted in section 4.3.2.2 the service rendering process was typical of a departmentalized system where all functions were handled inhouse through interactions with the HR department and the 21 clinics as pertains to staff healthcare. In the event that on-panel outside-network services were involved, the process was generally effected by the HR department with payments made by the finance department. It was surmised that the relationship, though showing some evidence of strategic purchasing – e.g. in the use of an information system and protection against fraud and privacy infringements – could not be deemed strategic given the self-managed nature of the actions.

The general observation, therefore, in assessing this objective was that as was the case with studies focused on the National Health Insurance Fund (NHIF), Private Health Insurance (PHI), and Community-based Health Insurance (CBHI) contexts of purchasing (Mbau et al., 2018; Munge, Mulupi, Barasa, & Chuma, 2019), the purchasing function did not show evidence of strategic purchasing and was therefore deemed passive.

5.4 Conclusion

As put forward in the forgoing discussion, the general arrangement of AAR Healthcare's employer scheme was structured as an in-house benefit scheme with evidence of passive purchasing practices. The purchasing arrangement carried out within the organizations were mainly decentralized being predominantly orchestrated by the HR department in association with

the finance, procurement and quality assessment departments. In assessing the purchasing actions vis-a-vis the stipulations put forward by the RESYST framework detailing the prescribed encapsulated in the outlined relationships, it was evident that arrangement within the organization did not meet the requirements of strategic purchasing; the purchasing arrangement was therefore deemed passive.

Given that the findings are in keeping with those put forward in assessment of the purchasing arrangement in NHIF, PHI and CBHI (Mbau et al., 2018; Munge, Mulupi, Barasa, & Chuma, 2019), it may be surmised that the general purchasing arrangement in health insurance schemes in Kenya is mainly passive showing little evidence of strategic purchasing. It is therefore necessary that restructuring of the purchasing arrangement be reconsidered so as to achieve effective allocation of financial resources in the bid to achieve UHC goals.

5.5 Recommendations

The main recommendation forthcoming from this study is that AAR Healthcare should consider a switch to strategic purchasing in effecting its healthcare provision arrangement to employees. In achieving these, it will be necessary to first and foremost institute a designated purchaser for the fund; one that would be charged with orchestrating all functions involved with other entities in the purchasing function. Findings from this study can also be used to prescribe possible purchasing arrangements for employer managed schemes

5.6 Limitations of the study

The main limitations in this study were methodological; in particular, the study focused on a single employer managed scheme – AAR Healthcare, hence the findings though of prescriptive value, cannot be generalized to similar schemes. Additionally, the researcher, due to privacy stipulations of the company, was unable to access documents detailing the nature of interaction between AAR Healthcare and other service providers that did not fall under the AAR umbrella. It was therefore not possible to conduct an in-depth analysis of this link.

5.7 Areas for further study

It is necessary that similar studies be conducted to assess the purchasing arrangement in other employer managed schemes. Additionally, further studies should be conducted to assess the reasons behind preference of passive purchasing arrangement; although the practice may be due

to a lack of information of the merits of strategic purchasing, it may also be the case that the shift to the approach is not warranted given the high satisfaction rates, as was the case in the current study, reported by users of the schemes.

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APPENDICES

ANNEX 1: CONSENT FORM

PARTICIPANT INFORMATION AND CONSENT FROM

STUDY TITLE: AN ASSESSMENT OF THE PURCHASING ARRANGEMENTS OF AN EMPLOYER IN-HOUSE MANAGED SCHEME: A CASE STUDY OF AAR HEALTHCARE

SECTION 1: INFORMATION SHEET– INVESTIGATORS

Investigator: Dr Mwaura Njeri Lilian

Institutional affiliation: Strathmore Business School (SBS)

Investigator: Dr Edwine W Barasa

Institutional affiliation: Strathmore Business School (SBS)

SECTION 2: INFORMATION SHEET–THE STUDY

2.1: Why is this study being carried out?

This study is being carried out to assess the role of inhouse-employees insurance programs in the bid to achieve Universal Health Coverage. Specifically, the study takes on a case study approach in assessing inhouse-insurance in AAR Kenya. The researcher applies the RESYST framework in assessing the purchasing function within the organization.

2.2: Do I have to take part?

No. Taking part in this study is entirely optional and the decision rests only with you. If you decide to take part, you will be interviewed to get information on the AAR inhouse insurance program. If you are not able to answer all the questions successfully the first time, you may be asked to sit through another informational session after which you may be asked to answer the questions a second time. You are free to decline to take part in the study from this study at any time without giving any reasons.

2.3: Who is eligible to take part in this study?

- AAR managers
- AAR inhouse-insurance program managers
- AAR staff

2.4: Who is not eligible to take part in this study?

- Staff that subscribe to the inhouse insurance program
- AAR managers
- AAR inhouse-insurance mangers

2.5: What will taking part in this study involve for me?

You will be approached and requested to take part in the study. If you are satisfied that you fully understand the goals behind this study, you will be asked to sign the informed consent form (this form) and then taken through an interview.

2.6: Are there any risks or dangers in taking part in this study?

There are no risks in taking part in this study. All the information you provide will be treated as confidential and will not be used in any way without your express permission.

2.7: Are there any benefits of taking part in this study?

The information will be used provide theoretical understanding of the machinations of an in-house insurance program and thus will serve to provide a rubric for assessment of the purchasing function for other employers in light of UHC targerers

2.8: What will happen to me if I refuse to take part in this study?

Participation in this study is entirely voluntary. Even if you decide to take part at first but later change your mind, you are free to withdraw at any time without explanation.

2.9: Who will have access to my information during this research?

All research records will be stored in securely locked cabinets. That information may be transcribed into our database but this will be sufficiently encrypted and password protected. Only the people who are closely concerned with this study will have access to your information. All your information will be kept confidential.

2.10: Who can I contact in case I have further questions?

You can contact me, Mwaura Njeri Lilian, at SBS, 0724536040 or lilianmwaura24@gmail.com or my supervisor Strathmore faculty EBarasa@kemri-wellcome.org

I, _____, have had the study explained to me. I have understood all that I have read and have had explained to me and had my questions answered satisfactorily. I understand that I can change my mind at any stage.

Please tick the boxes that apply to you;

Participation in the research study

I AGREE to take part in this research

I DO NOT AGREE to take part in this research

Storage of information on the completed questionnaire

I AGREE to have my completed interview stored for future data analysis

I DO NOT AGREE to have my interview stored for future data analysis

Participant's

Signature:

Date: ____ / ____ / ____

DD / MM / YEAR

Participant's

Name:

Time: ____ / ____

(Please print name)

HR / MN

I, _____ (Name of person taking consent) certify that I have followed the SOP for this study and have explained the study information to the study participant named above, and that she has understood the nature and the purpose of the study and consents to the participation in the study. She has been given opportunity to ask questions which have been answered satisfactorily.

Investigator's

Signature:

Date: ____ / ____ / ____

DD / MM / YEAR

Investigator's

Name:

Time: ____ / ____

(Please print name)

HR / MN

ANNEX 2: EMPLOYEES INTERVIEW PROMPT

Benefit of competence of the system

1. Have you ever benefitted from your inhouse scheme services? If so, how did you benefit?
2. The AAR inhouse insurance scheme is responsible for transferring funds to health care service providers to ensure that people get the services they need and that the services are of acceptable quality.
Do you have any specific thoughts on how the scheme is performing their role?
If you do, could you share those thoughts with me?

Complaints and feedback management

3. Is there any means by which scheme members can express their views on health care service provision, particularly relating to the types of health care providers that you can use and the services that you can receive (through health facilities / via the schemes)? If you can, by what means do you do so? Who is involved? How does the system work? How well has this system been working? Why do you think so?
4. What mechanisms exist to integrate scheme members' views, values and preferences into the selection of the types of providers and types of health care services that you access? Who is involved? How do the mechanisms work? How well have these mechanisms been working? Why do you think so?

Adjustability of the program

5. Can AAR employees choose health care providers? How well have these mechanisms been working? Why do you think so?

Feedback channel

6. What mechanisms exist to allow you to express your disappointment with health care service providers and/or AAR inhouse insurance program? If they do exist, what are those mechanisms? Who is involved? How do the mechanisms work?

Accountability

7. To what extent and by what mechanism is the inhouse AAR insurance scheme accountable to scheme members? How do the mechanisms work? How well have these mechanisms been working? Why do you think so?

Employee involvement

8. Do any mechanisms exist for scheme members to see how the inhouse AAR insurance scheme is performing? If they do exist, what are those mechanisms? Who is involved? How do the mechanisms work? How well have these mechanisms been working? Why do you think so?

Thank you for taking time to participate in this study.

ANNEX 3: GOVERNMENT (IRA and MOH) INTERVIEW PROMPT

- Nature of organisation: vision, mission, mandate, decision-making power
 - Establishment details: year of establishment; background to the establishment; history of organisational changes (where applicable)
 - Organisational structure: organogram; number of staff (including gender breakdown and qualification distribution)
 - Management / leadership: term served by senior management (both contracted and actual); selection process for senior management; senior management turnover
 - Decision-making process within the organisation
1. Could you comment on the role of employee inhouse schemes in the broader health financing system in Kenya?
 2. Could you comment on how well (or not well) employee inhouse schemes are aligned with the policy goals and direction of the MOH? What is the MOH role in ensuring this alignment? How is the MOH ensuring this?
 3. What regulatory frameworks exist to ensure that inhouse medical schemes are regulated to properly perform their functions?
 4. Are there regulations to guide the development and content of benefit packages that should be offered by the employer inhouse schemes? Could you discuss these regulations?
 5. Are there regulations to guide the pricing and financial management of employer inhouse schemes?
 6. What mechanisms exist to hold inhouse medical schemes directly accountable to the regulators? What mechanisms exist to hold inhouse employer-managed schemes directly accountable to the employees? How well do these accountability mechanisms work? Why do you think so?
 7. How does MOH or IRA monitor inhouse employer-managed scheme on purchasing performance? Are there formal monitoring and evaluation mechanisms? How well do the

monitoring and evaluation mechanisms work? Have the results of any monitoring or evaluation been incorporated into policy decisions?

ANNEX 4: PURCHASER (AAR INHOUSE SCHEME MANAGER AND OTHER RELEVANT MANAGERS) INTERVIEW PROMPT

Checklist for purchaser profile information:

- Nature of organisation including: vision, mission, mandate, decision-making power
- Size of organisation including: amount of funding; funding sources; number of beneficiaries / members
- Establishment details: year of establishment; background to establishment; history of organisational changes
- Organisational structure including: organogram; number of staff (including gender breakdown and qualification distribution)
- Management / leadership: term served by senior management (both contracted and actual); selection process for senior management; senior management turnover
- Financial management (i.e. how funds are managed within the organisation)
- Auditing mechanisms
- Decision-making process within the organisation

A. Citizen/beneficiary – purchaser relationships

1. How do you communicate with the employees subscribed to the scheme? What is the purpose of the communication and how often is it undertaken?
2. What mechanisms exist to assess the health needs of employees using the collection and analysis of demographic, epidemiological and other related data? If such mechanisms exist, please elaborate on the mechanisms? (For example: Who is involved in the data collection? How do the mechanisms work? How well do the mechanisms function? Why do you think so?)

3. What mechanisms exist to allow people employees to express their views, values and preferences on purchasing priorities (i.e. on who provides health care services and what service benefits are provided)? If such mechanisms exist, please elaborate on the mechanisms. (For example: Who is involved in the mechanism? How do the mechanisms work? How well have the mechanisms been functioning and why do you think this?)
4. What mechanisms exist to integrate the needs and preferences of employees of your private health insurance into decisions on the service benefits to be delivered? If they do exist, please elaborate on the mechanisms. (For example: Who is involved in the mechanisms? How do the mechanisms work? How well have the mechanisms been functioning and why do you think so?)
5. What mechanisms exist to hold AAR inhouse health insurance scheme directly accountable (i.e. direct route of accountability) to the members? If such mechanisms do exist, please elaborate on the mechanisms. (For example: Who is involved in the mechanisms? How do the mechanisms work? How well do the mechanisms function and why do you think so?)

B. Purchaser – provider relationships

6. From what types of providers do you purchase health care services for the inhouse health insurance members? How do you communicate with those health care providers, in what way, how often and for what purposes?
7. Please describe the mechanism by which providers are selected? Can you (as a purchaser) choose the providers with whom you contract to deliver specific services? If you can, how do you select providers? How well does the system function? What makes you think so?

8. Please describe the arrangements that you have established with health providers in terms of:

Registration/licensing and accreditation

Payment mechanisms and levels

Types of services to be delivered, and how service specification is decided

Monitoring and evaluation of health care quality (Please describe how you monitor and evaluate the quality of health care services supplied by providers. How do you manage the quality of the health care that they provide?)

Monitoring and evaluation of the cost of the health services supplied by providers (Please describe how you monitor and evaluate the cost of supplying health services. How do you ensure the efficient use of resources by providers?)

Information / reports that providers are required to submit about their services to inhouse health insurance schemes (Please describe the information/reports that providers are required to submit on the services they supply to inhouse health insurance schemes?)

Please describe the process through which you developed the above arrangements with providers? Who was involved in the process of developing the arrangements and by what process were decisions made? How long did it take to reach agreement with the providers on the arrangements? How well do the above-mentioned arrangements work and why do you think this?

9. Please describe how financial resources flow between the inhouse health insurance scheme (purchaser), providers and any other actors involved in the transfer of financial resources from the purchaser to providers when purchasing health services on behalf of the population in your province/your medical scheme members.

C. Government – purchaser relationships

10. Do you fall under any regulation from the IRA or MOH? What regulations are this and how do they operate?

11. How do you communicate with AAR management (i.e. about the transfer of resources to health care providers in exchange for the purchase of health services on behalf of the employees)? For what purposes do you communicate and how often? How well do the communication mechanisms work? Why do you think so?
12. What regulatory frameworks, in terms of service benefits, regulation of prices and purchaser's budgets, exist for AAR to ensure that purchasers and providers comply with stated policy objectives? What consequences exist for non-compliance? What enforcement mechanisms exist and how do the mechanisms work? How well do you think the mechanisms work? Why do you think so?
13. What mechanisms exist to ensure that company-wide employee priorities are reflected in purchasing decisions? (i.e. What is purchased and for whom (service benefits)? From whom are services purchased (who are the providers)? How are providers paid and at what price are services purchased (provider payment mechanisms)?) How do the mechanisms work? How well do the mechanisms function? Why do you think so?
14. How does AAR monitor private health insurance schemes in terms of their purchasing performance? Who is involved in the monitoring? What information is collected and how often is it collected?

Thank you for taking time to participate in this study

ANNEX 5: PROVIDERS' INTERVIEW PROMPT

1. What provider payment mechanisms are employed by the AAR scheme managers to allow you provide sufficient services to its members (employees). How are resources channelled from the purchaser to the provider?

2. Do you have any influence/power on decision making for the number and type of service interventions to be purchased. Does the purchasing power of AAR pose as a threat or an opportunity for you.

3. Do you face any level of competition by other providers in the market space? How do you overcome these challenges? What type of market structure exists within AAR clinics?

4. Do you have a contractual arrangement with the purchaser? What licencing and accreditation requirements present in your agreement with the purchaser?

5. Do you have stipulations regarding payment levels and type of service delivered? Do you have to provide evidence of the most cost-effective approach to treatment?

6. How does the purchaser monitor the quality of care provided? Is this process effective? How does the process affect you?

7. Does AAR as a purchaser consider the ownership structure of the provider organizations? Does AAR assess the degree of autonomy of the provider? Are you required, by AAR, to be accountable to AAR employees with regard to the service rendering process (e.g. providing reasons for particular treatment approaches when requested?)

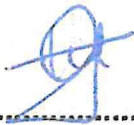
Thank you for taking time to participate in this study.

**THIS IS TO CERTIFY THAT:
DR. LILIAN NJERI MWAURA
of STRATHMORE BUSINESS SCHOOL,
77528-100 nairobi, has been permitted
to conduct research in *Nairobi County***

**Permit No : NACOSTI/P/19/92473/30872
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**on the topic: *AN ASSESSMENT OF
PURCHASING ARRANGEMENT IN AN
INHOUSE EMPLOYER MANAGED SCHEME***

**for the period ending:
4th June,2020**



.....
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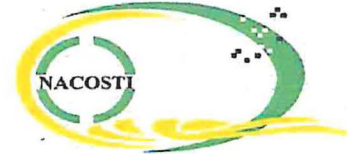
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Fax: +254-20-318245, 318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref. No. **NACOSTI/P/19/92473/30872**

Date: **4th June, 2019.**

Dr. Lilian Njeri Mwaura
Strathmore Business School
P.O. Box 59857 - 00200
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*An assessment of purchasing arrangement in an in-house employer managed scheme.*" I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for the period ending **4th June, 2020.**

You are advised to report to the **County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit a **copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:
The County Commissioner
Nairobi County.

The County Director of Education
Nairobi County.

Tuesday, 02 April 2019

**The Chief Executive Officer,
AAR Healthcare Kenya.**

Dear Sir/Madam,

RE: INTRODUCTION - LILIAN MWAURA

This is to introduce **Ms. Lilian Mwaura**, admission number **MBA HCM/96321/2017** who is an MBA in Healthcare Management (MBA HCM) student at Strathmore University Business School (SBS). As part of our SBS MBA HCM Master's Program, Lilian is expected to do applied research and to undertake a project. This is in partial fulfilment of the requirements of the Master of Business Administration. She would like to request for appropriate data from your organization to help her finalize her research.

Lilian is undertaking a research project on '**An analysis of strategic purchasing in a recommendable employer in house health scheme using a framework that analyses the relationship between the purchaser, provider, employee relationship**'. The information obtained from your organization shall be treated confidentially and shall be used for academic purposes only.

Our MBA seeks to establish links with industry, and one of these ways is by directing our research to areas that would be of direct usefulness to industry. We would be glad to share our findings with you after the research, and we trust that you will find them of great interest, if not of practical value to your organization.

We very much appreciate your support and we shall be willing to provide any further information required.

Yours Faithfully,



**Veronica Muniu,
Manager – Programs.**



23rd May 2019

LILIAN NJERI MWAURA
P.O BOX 77529-00611,
NAIROBI.
lilianmwaura24@gmail.com

Dear Dr. Njeri,

REF Protocol ID: SU-IERC0462/19

AN ASSESSMENT OF THE PURCHASING ARRANGEMENT IN EMPLOYER MANAGED HEALTH SCHEME .A CASE STUDY APPROACH OF AAR HEALTHCARE.

We acknowledge receipt of your application documents to the Strathmore University Institutional Ethics Review Committee (SU-IERC) which includes:

1. Study Protocol submitted 2nd April 2019
2. Cover letter listing all submitted documents 2nd April 2019
3. Proposal declaration page signed by supervisors 2nd April 2019

The committee has reviewed your application, and your study "*An assessment of the purchasing arrangement in employer managed health scheme. A case study approach of AAR healthcare.*" has been granted approval.

This approval is valid for one year beginning **23rd May 2019** until **23rd May 2020**

In case the study extends beyond one year, you are required to seek an extension of the Ethics approval prior to its expiry. You are required to submit any proposed changes to this proposal to SU-IERC for review and approval prior to implementation of any change.

SU-IERC should be notified when your study is complete.

Thank you

Sincerely,

for: Prof. Florence Oloo
Secretary

Strathmore University Institutional Ethics Review Committee

