



Social Health Insurance Reforms in Kenya: Opportunities and Challenges for Advancing Strategic Health Purchasing

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Introduction

In October 2024, Kenya launched significant reforms in its health financing system by establishing the Social Health Authority (SHA), replacing the long-standing National Hospital Insurance Fund (NHIF) that had been in existence since 1966. Anchored in the Social Health Insurance (SHI) Act of 2023, these reforms are central to the country's efforts to strengthen financial protection, promote equity, and advance progress toward Universal Health Coverage (UHC) through strategic health purchasing (SHP). This policy brief summarizes key features of Kenya's SHI reforms, highlights progress and emerging challenges, and outlines opportunities to optimize purchasing functions and health system performance.

Data Source and Methods

The analysis presented in this brief is based on a review of policy and regulatory documents conducted between September and December 2024, including the Social Health Insurance Act (2023), Social Health Insurance (General) Regulations (2024), SHA benefit package and tariffs, and relevant NHIF policy documents. Feedback from six county sensitization workshops organized by the Social Health Authority were also reviewed. The assessment applied the Strategic Health Purchasing Progress Tracking Framework and the RESYST Framework to examine governance, benefit design, provider payment, accountability arrangements and to assess their alignment with strategic health purchasing principles.

Key SHI Reforms

- ▶ Establishment of the Social Health Authority (SHA) as the principal healthcare purchaser governed by a multi-stakeholder Board.
- ▶ Establishment of three funds: Primary Healthcare Fund (PHCF), Social Health Insurance Fund (SHIF), and Emergency, Chronic, and Critical Illness Fund (ECCIF).
- ▶ Consolidated health benefit package replacing fragmented schemes under NHIF.
- ▶ Introduced mandatory registration and contributions, including premiums for informal sector workers determined by proxy means testing (PMT).
- ▶ Reviewed provider payments and health facility tariffs; global budgets capitation for PHC services, and higher tariffs for various case-based payments, fixed fee for service, and per diem payments.
- ▶ Implementation of a digital membership enrolment and claims management platform, with provision for outsourcing to Third-Party Administrators (TPAs).

Kenya at a Glance

- ▶ Population (2024) : **52 million**
- ▶ Gross Domestic Product (GDP) per capita (2024): **US\$1,890**
- ▶ Current Health Expenditure per capita (2021): **US\$94**
- ▶ Out-of-Pocket Expenditure as % of CHE (2021): **24%**
- ▶ Domestic Government Expenditure as % of CHE (2021): **47%**
- ▶ External Financing % of CHE (2021): **18%**
- ▶ Health Insurance contribution as % of CHE (2021): **9.2%**

Governance and Financial Management Arrangements

The SHA consolidates existing pools (from 80 to 3 main ones) and strengthens the focus health service purchasing functions under a single institution, transitioning from NHIF's fragmented schemes. Its governance structure includes an 11-member board, representing key stakeholders such as the Ministry of Health, National Treasury, county governments, healthcare professionals, technical experts, labour unions, and informal sector workers. The composition of the board reflects an effort to balance technical expertise with broad stakeholder representation, which may ultimately create an inclusive structure that can improve accountability and ensure decisions reflect diverse population needs. However, this diverse representation also introduces the potential for competing interests, requiring strong governance measures to prevent undue influence from dominant groups such as private providers and other political economy factors.

The reforms on governance and management raise concerns around potential fragmentation resulting from the establishment of three separate funds (PHCF, SHIF, ECCIF). Each fund has distinct objectives and financing sources, while promoting cross-subsidization between funds remains unclear. Furthermore, SHA retains revenue collection responsibilities, diverging from prior recommendations in the Health Financing Reforms Expert Panel (HEFREP) Report to assign this role to the Kenya Revenue Authority (KRA). This could limit SHA's focus on purchasing and create inefficiencies in revenue administration.

Similar to many Social Health Insurance Agencies across LMICs, SHA has the difficult role of ensuring financial sustainability while providing adequate population coverage in the implementation of ongoing reforms. The reforms cap administrative costs at 5% of total fund expenditures, ensuring more resources are directed toward service delivery. Additionally, SHIF allows immediate access to benefits without a waiting period, which improves access but raises concerns about adverse selection, as individuals may enrol only when in need of care. Requiring annual premium payments aims to stabilize contributions but may pose affordability challenges, particularly for low-income groups. As a mitigation measure, the proposed premium financing that gives access to informal sector workers at an interest may further increase the costs of SHI for this population segment.

Benefit Package and Provider Contracting

The SHA reforms introduce a single, uniform benefit package that covers a wide range of services, including preventive screenings for common conditions, chronic disease management, mental health, maternal health, assistive devices, and emergency care. This replaces NHIF's multiple fragmented schemes and improves equity by ensuring that all beneficiaries have access to the same set of services regardless of income or employment status. SHA must steer away from introducing schemes to cater for narrow stakeholder groups such as civil servants with enhanced benefits.

The establishment of a Health Benefits and Tariffs Advisory Panel (HBTAP) provides a mechanism for regular, evidence-informed updates to the benefit package and reimbursement rates. This move strengthens the link between services covered and population health needs. It provides an opportunity to institutionalize Health Technology Assessment (HTA) in the revision of the Health Benefit Package (HBP). However, the SHA benefit package still includes provisions limiting access to certain services (e.g., specific chronic care interventions and assistive devices) that is based on availability of resources. Without sustained financial commitment, these limitations may constrain the package's effectiveness in delivering comprehensive care.

SHA contracts both public and private providers through a uniform process, guided by the Kenya Medical Practitioners and Dentists Council (KMPDC) accreditation standards. The separation of roles between SHA as the insurer and KMPDC as the accreditor provides an opportunity to have independent quality monitoring alongside the accreditation of providers. However, the historical rural-urban imbalance in the distribution of providers may persist, as incentives to encourage rural participation are not explicitly outlined.

Provider Payment Mechanisms

Kenya's SHA employs a mixed provider payment system for various health services and levels of the health system. For primary healthcare services, facilities within Primary Care Networks (PCNs) receive funds through global budgets based on population size, with an annual capitation rate of KES 900 per person. Payments are distributed quarterly and adjusted for patient visits and disease burden. This approach incentivizes predictable financing and prioritization of primary care services. However, delays in fund disbursement and the limited financial autonomy of public providers could reduce the responsiveness of facilities to these incentives. In addition, the PCN model implementation must be streamlined to avoid introducing complexities that may lead to delays in funds reaching facilities.

For hospital-based care at secondary and tertiary levels, SHA employs case-based payments for defined treatment packages, such as maternity services and dialysis, alongside per diem payments for general inpatient care. While these payment methods are intended to control costs and improve efficiency, their success depends on appropriate pricing and close monitoring to avoid under-provision of services or unnecessary admissions. In addition, fee-for-service payments are used to reimburse specialized services and emergency care, including diagnostics, emergency services and high-cost interventions. This ensures the availability of key services but carries the risk of overuse if not accompanied by strong claims verification and oversight mechanisms. Overall, these payment reforms represent progress in aligning provider incentives with UHC objectives. However, challenges such as payment delays, administrative complexities and insufficient provider autonomy, particularly in public facilities, may undermine their effectiveness unless addressed.

Gatekeeping for Strategic Purchasing

The SHA explicitly stipulates that the SHIF will only reimburse services referred from primary healthcare (PHC) providers, introducing a gatekeeping mechanism intended to strengthen the role of PHC. Gatekeeping has the potential to improve care coordination, reduce unnecessary utilization of secondary and tertiary services, and enhance efficiency in service delivery. However, effective operationalization will require ensuring that PHC facilities are adequately resourced, that referral systems are functional, and that patients and providers clearly understand the referral pathways. Embedding gatekeeping incentives within capitation contracts, alongside investments in diagnostic capacity and workforce at PHC level, will be critical to making gatekeeping an effective strategy for strategic purchasing.

Performance Monitoring and Accountability

Anchored on a broader government digitization agenda, SHA introduced a centralized digital membership and claims management platform for provider payments, monitoring service delivery, and stakeholder engagement and accountability mechanisms. Claims processing may be outsourced to Third-Party Administrators (TPAs), intended to improve efficiency and detect fraud. While this offers potential benefits, it introduces risks of increased administrative costs and requires regulatory oversight to avoid or limit conflicts of interest.

Stakeholder engagement mechanisms include public education forums, regular provider updates, and the establishment of an independent tribunal to resolve disputes. However, effective implementation of these accountability measures depends on consistent enforcement, transparency in reporting, and ensuring that both providers and beneficiaries can easily access grievance redress systems.

Table 1: Progress and Challenges in Strategic Purchasing

Purchasing Function	Progress Highlights	Key Challenges or Risks
Governance	Unified purchaser (SHA), inclusion of diverse members representing key stakeholders in SHA's board of 12 members	The diverse constitution of the board while important, has potential for competing interests. This requires strong governance measures to prevent undue influence from dominant groups such as private providers.
Financial Management	Broadening the revenues from contributions to include formal, informal and the poor, an administrative cost cap, no waiting period for SHIF benefits	Challenges in the application of the PMT affecting contributions from informal sector workers and late or no contributions from government for the poor; Adverse selection risks because of the removal of waiting period and challenges enforcing mandatory contributions from informal sector workers, raising the sustainability concerns. Risk of fund fragmentation across the PHCF, SHIF, ECCIF; Revenue collection inefficiencies risks among the informal sector.
Benefit Specification	Single standard benefit package, expanded services	Need to ensure the mechanisms for institutionalizing HTA are in place including mapping and engaging institutions to offer costing services and formalizing processes in Benefit package specification; Limitations on some chronic and end-of-life services, subject to availability of funds. Discussions on the reintroduction of civil servants' scheme with enhanced benefit package.
Contracting	Uniform accreditation for public/private providers; gatekeeping mechanisms to strengthen PHC	Failure to explicitly provide solutions to address rural access disparities; limited public health provider autonomy.
Provider Payment	Review of the PPMs and health facility tariffs; Introduction of Global budget capitation for PHC; Increased tariffs for key services	Delays in the flow of funds e.g. PHCF and ECCIF may send the wrong signal to providers, Complexity of implementing PCN arrangements.
Performance Monitoring	Centralized digital claims platform, stakeholder engagement channels	Complex data management through the introduction of TPAs, TPA oversight risks; Data interoperability concerns. Delays in establishing the Dispute Resolution Tribunal hinder adequate stakeholder engagement by limiting the availability of redress mechanisms for issues arising from SHA processes, including means testing outcomes.

Policy Opportunities

- ▶ Clarify fund management structures to prevent fragmentation between PHCF, SHIF, and ECCIF and promote resource pooling.
- ▶ Strengthen implementation of proxy means-testing mechanisms to ensure informal sector contributions are equitable and affordable, with clear enforcement and subsidies for indigent populations.
- ▶ Ensure financial autonomy of public providers by revisiting public financial management constraints to ensure uniform application across all 47 counties, enabling them to respond to SHA payment incentives.
- ▶ Enhance incentives for rural providers, including targeted contracting and support mechanisms to address geographic disparities.
- ▶ Ensure adequate budgetary allocation to finance the PHCF and the ECCIF so as to ensure universal access to the specified services in the benefit package.
- ▶ Strengthen oversight of TPAs and digital claims platforms, ensuring transparency, cost control, and data privacy compliance.
- ▶ Streamline the roll out and operationalization of PCNs as an avenue for global budget capitations to primary healthcare providers.
- ▶ Operationalize stakeholder engagement and grievance systems for timely provider and beneficiary feedback, coupled with transparent reporting of SHA's performance.

Conclusion

Kenya's SHI reforms represent a bold step toward achieving UHC by strengthening strategic health purchasing functions. The reforms introduce new systems in governance, benefit design, provider payment, and accountability. However, addressing fund management, revenue collection inefficiencies, rural access gaps, and ensuring sustainability will be critical to realize the full potential of SHA. Continuous monitoring, stakeholder engagement, and adaptive policy measures are essential to advancing equitable, efficient, and high-quality healthcare for all Kenyans.

For more information, please refer to:

Beryl Maritim et al., "Examining Social Health Insurance Reforms: Implications for Strategic Purchasing of Healthcare in Kenya," 2025 (forthcoming).