



Lessons from the Kenya National Social Health Insurance Reforms and Implementation

Background

Social health insurance (SHI) is a health finance mechanism that seeks to equitably protect people against financial and health burdens through risk pooling, which considers both the health risks of the people and the contributions by individuals, households, enterprises, and the government [1, 2]. SHI is being implemented in many countries as one of their main mechanisms for achieving universal health care (UHC) [1]. SHI typically has three characteristics: compulsory enrolment with members paying a specific premium; only those registered are entitled to benefits; and a legislation outlining the benefits members are entitled to for the premium amount they paid [1].

Kenya is a lower- to middle-income country with an estimated population of 53 million in 2021 [3]. More than two-thirds (69%) of the population reside in rural areas, and the estimated poverty rate is 39% [4, 5]. Kenya adopted a devolved governance system in 2010, which established 47 county governments charged with providing and financing healthcare [6]. Kenya has a mixed health financing system with funding from government (47%), donor funds (18%), out-of-pocket payments (24%) and private (11%) in 2020 [7]. The incidence of catastrophic healthcare expenditure in Kenya was estimated at 7% in 2018, with between 1 and 1.1 million individuals pushed into poverty annually due to out-of-pocket healthcare payments [8].

The Kenya government prioritised universal health coverage (UHC) in its Vision 2030 and chose to transform its national health insurance scheme into a social health insurance scheme to achieve UHC [9]. The move was to ensure that Kenyans have access to the full range of quality health



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services they need, when and where they need them, without financial hardship.

This evidence brief presents a synthesis of published and grey literature describing the reforms leading to the establishment of Kenya's national SHI scheme, current scheme design and factors influencing its design and implementation, to inform ongoing and future SHI reform and implementation processes in Kenya and other similar countries. Whilst Kenya's devolved governance structure necessitates SHI reforms and implementation at the national and county levels, this brief focuses on those steered by the national government. As the brief is based on published and grey literature, it may not be up to date on some issues that are highlighted.

NHIF Reforms

The National Health Insurance Fund or NHIF (previously National Hospital Insurance Fund) was created in 1966 through an act of parliament as a mandatory contributory hospital-based cover for all Kenyans aged over 18 years in formal employment and earning over KShs 1,000 [10]. NHIF has gone through a series of reforms including expansion of

the hospital-based cover in 1972 to incorporate voluntary membership for those working in the informal sector [11–15]. Over the past two decades, NHIF reforms have focused on transforming the hospital-based cover into a national SHI scheme as the main vehicle for achieving UHC [12–19]. Box 1 highlights key NHIF reforms over the past two decades.

Box 1. Key NHIF reforms over the past two decades

- >>> Expansion to cover both inpatient and outpatient services for both the national scheme and specialised services for all the NHIF schemes
- >>> Transfer of the free maternity policy implementation to NHIF, rebranded as 'Linda Mama' (Swahili for take care of the mother) programme, and the addition of antenatal care, post-natal care and delivery-related complications
- >>> Introduction of a health insurance subsidy programme providing 100% subsidy to poor households in both urban and rural areas
- >>> Introduction of a comprehensive medical insurance cover for learners enrolled in all public secondary schools during their four-year study duration
- >>> Increase in the premium contribution rates to cater for the rising cost of healthcare and to enable expansion of its benefits package
- >>> Introduction of new provider payment methods and rates for the new outpatient and specialised benefit packages (capitation for outpatient services and, case-based and fee-for-service payments for the specialised services)
- >>> Increase of the per diem rates for inpatient care
- >>> Decentralisation of the NHIF claims processing to district offices (28 branches across all provinces, in both rural and urban areas) to facilitate a shorter and more effective system that will allow speedy reimbursement of medical claims
- >>> Simplified and computerised NHIF claim procedures and establishment of an electronic data base.

NHIF Governance and Design

NHIF governance

The NHIF is currently governed by the NHIF Act No 9 of 1998 with the core mandate to provide medical insurance cover to all its members and their declared dependants (spouse and children) [10, 19]. The NHIF has 95 fully autonomous branches, satellite offices and a presence in the 47 Huduma Centers across the country that offer comprehensive customer services [10]. The NHIF has a Chief Executive Officer (CEO) and Board of Directors who report to the Ministry of Health (MoH) [10, 19]. To ensure transparency and appropriate utilisation of member contributions, the NHIF is accountable to citizens and the government through the MoH, State Corporations Advisory Committee, National Treasury, Kenya National Audit Office, Inspector General of Corporations, Efficiency Monitoring Unit, and various parliamentary committees [19].



Photo Credit: Allan Gichigi/MCSP

NHIF schemes, eligibility and benefits

The NHIF manages the National Health Scheme (NHS) (also called UHC Supacover) and several other special schemes, which are briefly described in Table 1 [10, 11, 17, 19–22]. More information on the covers can be sourced from the NHIF website [11].

Table 1. NHIF schemes, eligibility and benefits

<p>The National Health Scheme (NHS) or “UHC Supacover”</p> <p>>>> Open to all Kenyans who have attained the age of 18 years; mandatory for those working in the formal sector (both public and private) and voluntary for those working in the informal sector. “UHC Supacover” benefits include Outpatient, inpatient benefits and specialised services obtained from all government facilities (no copayments), faith-based facilities and some small- sized for-profit facilities (possible copayment for surgery, at the discretion of the health facility), private facilities (some out-of-pocket costs or supplemented with other forms of health insurance schemes).</p>
<p>Enhanced Scheme (ES)</p> <p>>>> A special fund for civil servants, police and the Kenya Defence Forces, the Civil Servants and Disciplined Forces Medical Scheme</p>
<p>The Free Maternity Services or ‘Linda Mama’</p> <p>>>> Free pregnancy- related health services open to all pregnant women who are Kenyan citizens. The cover is for one (1) year from the time it is activated at the healthcare facility.</p>
<p>Edu Afya</p> <p>>>> Comprehensive medical insurance cover for all learners enrolled in all public secondary schools during their four-year study duration who are fully registered in the National Education Information System (NEMIS) portal with a valid Unique Personal Identifier (UPI) number generated through the NEMIS database and is registered by NHIF, fully identified by their School Principal.</p>
<p>The Health Insurance Subsidy Program (HISP)</p> <p>>>> Full-premium subsidy programme targeting vulnerable segments of the population including orphans, the elderly, and people living with physical disabilities.</p>
<p>‘Inua Jamii’</p> <p>>>> Free comprehensive health insurance cover targeting one million low-income individuals registered as beneficiaries of the Inua Jamii programme.</p>

NHIF revenue collection

The NHIF is financed through premium contributions to the national scheme from registered members and from general government revenues [13, 15, 19]. Contributions from formal sector individuals are deducted automatically from their salaries and remitted to the NHIF by their employer [13, 15]. Formal sector contributions range from KShs 150 (USD 1.5) for the lowest income bracket (monthly salary of less than KShs 6000 (USD 60)) to KShs 1700 (USD 17) for the highest income bracket (monthly salary of above KShs 100 000 (USD 1000)), while voluntary members pay a monthly flat rate premium of KSh 500 (USD 5), which they submit to district and provincial offices [13, 15, 18].

NHIF risk pooling

The NHIF operates as a single risk pool making it the largest risk pool in the country [15, 19].

NHIF purchasing practice

Accreditation of health care providers: The NHIF contracting process involves four steps: application for accreditation, inspection, gazette and contract signing [19]. Hospitals that apply to be accredited are assessed using criteria that considers the range of services and facilities available including X-rays, intensive care unit, number of health personnel, laboratories, operating theatres, overall area occupied, number of wards and ambulances [15, 18, 19]. The NHIF Board of Directors consider the inspection recommendations, gazettes the hospital, and signs a contract between the NHIF and the hospital that specifies the category of the hospital, the payment mechanisms and rates, and other terms of engagement [19].

Provider payment mechanisms: The NHIF board is mandated to determine provider payment rates based on ownership and the accreditation assessment score, which is calculated as a flat rate per-diem for inpatient services [15, 19]. Hospitals with large bed capacity and which offer a wide range of services receive higher reimbursement rates than smaller hospitals [15]. Currently, the per diem rates for inpatient care range between KShs 1500 and 4000 (USD 15-40) per day for the lowest-level and highest-level hospitals, respectively [17]. The outpatient benefit package is paid for using capitation (KShs 1,200 for public providers and Kshs 1,400 for private providers), and case-based payments and fee-for-service for specific services such as renal dialysis and radiology services, respectively [16, 17, 19, 22].

Quality assurance: The NHIF is mandated by law to inspect contracted health facilities annually and continuously monitor their adherence to its standards of care [19]. The NHIF implements this mandate through a benefits and quality assurance management committee and a department that oversee the quality of services provided by contracted health facilities and act as the link between the consumer and the insurer [19]. The NHIF information system, branch network and organisational structure facilitates monitoring activities [19].

NHS Coverage and Impact

Low but increasing NHS coverage

Health insurance coverage in Kenya is low but has been on an increasing trend and currently stands at 26% as of 2022 with the NHIF being the most common at 23.8% coverage [13, 15, 17, 18, 22, 23].

NHS is falling short on achieving equity

NHIF has so far fallen short of achieving UHC equity aspirations and, crucially, reflects a pro-rich disposition. People who are employed in the formal sector, wealthier, educated (primary, secondary and higher), married, male, older, living in urban areas, and exposed to media (including radio, newspaper and TV) are more likely to be covered by any type of health insurance (including NHS) than their counterparts (employed in informal sector or unemployed, without education, unmarried and previously married, female, younger, living in rural areas and not exposed to media) [13–15, 17, 22]. Among residents of urban slums in Nairobi, their participation in the National Social Security Fund and membership schemes such as savings and credit cooperative organisations (SACCOs) has been found to play a central role in them having a NHIF cover [13].

Factors influencing NHS reforms, implementation and uptake

Ten factors emerge from the evidence as critical in influencing NHS reforms, implementation and uptake including the role of windows of opportunity, insufficient NHIF governance and accountability and quality assurance mechanism, inefficiencies, strategic purchasing gaps, ineffective communication and stakeholder engagement, insufficient evidence informed decision-making, revenue collection challenges and insufficient equity considerations in the NHS scheme design.

Anchoring the NHS reforms on Kenya's Vision 2030:

After a first failed attempt to introduce the Kenya NHS in 2004, those pushing the reforms leveraged Kenya's Vision 2030 development process in 2007, which culminated in the NHS being prioritised as a key pillar [12].

NHIF governance, transparency and efficiency challenges:

The reputation of NHIF has been tarnished over its tenure due to lack of transparency particularly with financial information, inefficiencies attributed to its monopoly in the market and management of multiple fragmented covers, poor governance that does not punish corruption, and poor quality of care in accredited facilities [12, 17, 19, 24, 25]. These issues have nurtured widespread public mistrust of the NHIF relating to its capacity to effectively and efficiently perform revenue collection and purchasing functions for the NHS [12, 15, 24, 26]. There is a strong interest among some stakeholders for the NHIF not to serve as the only pool, rather, there being multiple purchasers to choose from including NHIF [12, 19]. There is also a push for the NHIF to be restructured to improve transparency, its efficiency and its effective regulation and enforcement of the purchaser-provider relationship [12, 24]. Underlying these governance, transparency and efficiency challenges is an unclear accountability mechanism between the NHIF, the MoH and the public, and a weak regulatory and policy environment for strategic purchasing, which have been linked to misuse of resources [12, 19, 25].

Insufficient governance and quality assurance mechanism:

The NHIF's accountability mechanism emphasises financial performance but is silent on the quality of services received by NHIF members and health system efficiency including its responsiveness to complaints from health service users [17, 19]. However, its financial accountability mechanism is also insufficient and has facilitated fraud by both providers and NHIF beneficiaries, which leads to leakage of resources and has worsened over time [17, 22]. Whilst the NHIF has quality assurance mechanisms, they operate inconsistently and infrequently, and have resulted in purchasing of poor quality

of care [17, 19, 22]. For example, the compliance officers do not continuously monitor the standards or quality of services in contracted health facilities, which has been partly attributed to their insufficient technical capacity [17, 19]. The government has employed local representatives including community health workers (CHWs) to conduct targeted outreach and sensitise the public about the NHIF, aimed at restoring public trust, promoting social accountability, and increasing registration into relevant schemes [22, 26]. Furthermore, the NHIF put in place some measures to prevent providers from overcharging including conducting regular physical visits to health facilities, imposing maximum limits on claims payable, training all their staff on how to identify fraud, institutionalising risk and investigation departments, and hiring staff with medical backgrounds in the benefits and quality assurance department [12, 19].

Operational, technical and allocative inefficiencies:

A number of inefficiencies in the NHIF have been identified. The first is the NHIF's high level of expenses for non-claim settling activities (administrative costs) with staff cost contributing 63% of administrative costs in fiscal year 2016–2017 [12, 19]. The NHIF believe that the recent increase in the contribution rates nearly five-fold from those previously charged should translate to a gradual decline in the administration costs [19]. Secondly, the NHIF operates four schemes (civil servants' schemes (CSS), Health Insurance Subsidy Program (HISP), free maternal health programme and national scheme), which has undermined risk sharing and income cross-subsidisation and caused higher risk adjusted costs compared to if all the schemes were consolidated into one pool [2]. NHIF also has overlapping provider payment contracts where, the NHIF pays the same facility an annual capitation fee for outpatient care for the public, and an annual capitation for members of its civil servants' schemes (CSS) [22, 27]. Thirdly, the NHIF's reliance on voluntary membership from the informal sector has cultivated a culture of adverse selection where health care providers encourage and facilitate enrolment of patients who need long-term inpatient care or expensive procedures [22, 28]. The fourth inefficiency is related to the NHIF's accreditation process being biased to hospitals that are predominantly located in urban areas rather than the more cost-effective primary health care services, which compromises allocative efficiency of its resources [22]. Finally, the NHIF fails to make timely payments to providers for the provision of services due to funding flow challenges, which contributes to patients being denied or charged for services [17, 20, 25, 26].

Strategic purchasing not clearly articulated in policy:

The NHIF Act has been criticised for failing to emphasise the need to consider population needs, national priorities, and evidence of cost-effectiveness to inform the benefits package [12, 19]. In addition, Kenya's health sector policies are inconsistent on strategic purchasing requirements. One

study revealed a lack of alignment between the NHIF's benefit package and the Kenya Essential Package for Health (KEPH) [19].

Inadequate understanding of the NHS due to inadequate communication or miscommunication:

Communication emerged as a key challenge in the NHS reform and implementation process. For example, one of the reasons the proposed NHS was initially rejected was the perception that it was too costly to implement, which was attributed to unclear communication and miscommunication about the scheme and its implementation strategy [12, 14]. In addition, the strategies used by the NHIF to transmit information about the schemes (e.g., Edu Afya) and changes to it (e.g., of premium contributions), do not effectively reach target audiences and some key population groups such as the elderly, the uneducated, the unemployed, people living with disabilities (visual or hearing disabilities), the poor, and people in the rural and marginalised areas [17, 22, 25]. This undermines awareness of and access to NHS services and has been partly attributed to limited access to media platforms and the insufficient number of NHIF service points [17, 20, 22].

Minimal private sector engagement and insufficient citizen/community engagement:

Minimal and insufficient engagement of the private sector and communities has nurtured opposition towards the NHS and minimal participation in it. For example, the private sector was not engaged at the design stage of the proposed NHS, which was attributed to their opposition to the reforms, driven by their mistrust of the NHIF and fear about the implications of the changes to their business [12]. However, not engaging the private sector from the beginning worsened their opposition to the scheme. Consequently, their engagement undermines the achievement of the UHC principle on equitable access to healthcare services because they tend to expose NHIF beneficiaries to out-of-pocket costs through balance billing [12].

As it relates to community engagement, some mechanisms for NHIF members or beneficiaries to provide feedback about the NHIF cover such as the NHIF board of directors which comprises labour unions, and a NHIF email and a toll-free number [19]. NHIF also uses its website, newspapers and media pronouncements to communicate its service entitlements but lacks a public forum for reporting their performance to the public [19]. These communication mechanisms have proven ineffective and contributed to mixed awareness of the NHIF scheme, enrolment procedures and benefits, and opposition by labour unions and the public to the revised NHIF benefits package, premium rates and service providers [13, 17–19, 26].

Some studies have documented the preferences of citizens/communities in terms of the design of the NHS and found



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that there is willingness to join the NHIF but the benefit package is viewed as insufficient, unaffordable, not taking into account extended family members and indigents within the community, and more favourable for workers in the formal sector and the wealthy [13, 17–19].

For example, an assessment of the willingness and ability to pay for the NHS benefit package found that informal sector individuals were willing to pay a maximum of KShs 300 (USD 3) NHIF monthly premium, rather than the current KShs 500 (USD 5) [13]. Furthermore, informal sector workers in rural and urban locations have varied preferences about how they would like their healthcare to be financed [24, 25]. One study found more support for a non-contributory mode of financing healthcare among informal workers in urban settings while those in rural areas were more inclined to support a contributing system [24, 25]. Some of these preferences are being addressed to some extent such as the introduction of HISP targeting the segment of the population that are poor [21].

Dissatisfaction with the package of care, provider payment and premium rates:

There were questions and dissatisfaction around the extent to which robust evidence such as actuarial studies were used to inform some aspects such as the HIV and specialised care component of the benefit package and the rationale for the overall provider payment system design and how payment rates are determined [12, 17, 19, 22]. Consequently, providers, particularly from the private sector, were reluctant to be contracted by the NHIF because they perceive the rates for capitation and inpatient reimbursements as low and not sufficient to cover the cost of care [19]. This has been linked to some public providers sending their patients, particularly those with chronic illness, elsewhere to buy their medication [17]. On the other hand, private facilities undertreat, charge co-payments, refer patients to other health facilities, or admit NHIF beneficiaries who would just require outpatient care [17].

Furthermore, the NHIF benefit package has been criticised as not being well informed because it draws largely from customer satisfaction surveys, feedback received from board members and analysis of claims data rather than a formal needs assessment [17, 19]. This has been attributed to a policy gap outlining how the needs assessment for NHIF beneficiaries ought to be done, political interests, and the government lacking technical capacity [19, 26].

NHIF failing to raise sufficient resources to meet service requirements:

The NHIF has not been able to effectively mobilise revenues for healthcare, which has been linked to a number of issues including: a policy gap for regular revision of the premium rate; reliance on voluntary contributions among informal sector workers and their minimal participation; penalties incurred by members for late payment of premiums; and no cover for outpatient services (although the latter may have been addressed with the recent addition of outpatient services to the NHS cover) [22, 25, 26, 29]. The NHIF struggles to retain voluntary members who are mainly informal sector workers due to their unpredictable incomes, lack of organised informal sector groupings or other cost-effective strategies for enforcing mandatory deductions and perceived high premiums they are expected to pay [17, 19, 22, 24, 25]. Informal workers tend to register for NHIF only when they are sick and fail to pay their contributions when they have not made claims that year or when they realise that they do not have access to outpatient benefits (the latter could presumably have been addressed with the expansion of the NHS cover) [19]. However, when informal sector members sign up for NHS during the periods when they are ill, this drives up health risks relative to the monetary value of the financial pool [17, 19, 22, 29].

The application of penalties for members who fail to make their premium payments further exacerbates the high attrition problem [19, 26]. The penalties incurred by members for late payment of premiums have recently been revised to reduce their negative impact but are still regarded as high and continue to deter defaulters from reactivating their NHIF membership [19, 25, 26]. The NHIF has also introduced administrative changes that allow members to make up their missed payments within five days or start over again after a 60-day exclusion period [19]. The government is also striving to increase coverage among the informal sector through conducting outreach activities in both urban and rural areas [15]. Nevertheless, an analysis of the resources the NHIF would have to raise from mandatory and voluntary contributions to support the expanded NHIF benefit package combined with the upward revision of provider reimbursement rates concluded that it was not sustainable [22, 26].

NHIF resource collection, purchasing process and reach compromise equity:

Several issues are compromising NHIF's goal of ensuring equitable access to quality healthcare by all Kenyans. One is that the flat premium rate for informal sector workers does not consider the socioeconomic diversity within the sector i.e., it consists of both wealthy and poor populations [15, 17, 19, 22, 25, 26]. Secondly, the NHIF accreditation process disadvantages marginalised regions and favours private health facilities, which reduces geographical access to NHIF services [17, 19, 22, 26]. NHIF providers are also predominantly hospitals, rather than small outpatient facilities that provide primary health care and from where rural residents typically seek services [22, 26]. The pro-urban and pro-private distribution of facilities contracted by NHIF has been attributed to rural facilities failing to meet NHIF standards, the government health facilities not being keen on applying for accreditation, and the NHIF not doing active follow-ups to register health facilities [17, 20]. In counties where the facility has failed to meet the NHIF accreditation standards and is the only public hospital, this has contributed to NHIF beneficiaries lacking access to some health services [17, 19, 22, 26]. Thirdly, until just over a decade ago, the NHIF was centralised, which contributed to cumbersome and high transaction costs for members and healthcare providers because they had to travel to Nairobi to submit their claims [15]. This has been partly addressed by the NHIF opening branches across the country. However, one study found that this challenge persists for some segments of the population because the NHIF offices are located at district headquarters [18].

Fourthly, the NHIF excludes people who do not contribute, many of whom are likely to be poor [19, 26]. As noted earlier, recently, the NHIF introduced a special scheme targeting the poor, the HISP. However, the HISP has faced inclusion errors where 65% of the beneficiaries were from the richest two quintiles [22, 29]. Fifth, the pro-rich distribution of NHIF health care benefits where civil servants have a more comprehensive cover and wider access to private sector service providers compared to the general public has been linked to their preferential treatment by providers that compromises access to quality services by other service users and contributes to

lower NHIF enrolments among the informal sector [17, 22, 25, 28]. Sixth, the revised benefit entitlements were not accompanied by infrastructure improvements in rural and marginalised areas to support the delivery of outpatient and special benefit packages in terms of medical equipment, medicines and human resources [17, 26]. Finally, the NHIF registration requirements such as the need to present a birth certificate overlook the challenges poor and rural people face in obtaining official documents [25, 26].

Lessons from the Kenya National Social Health Insurance Scheme Reforms and Implementation

This review found that Kenya has made great strides since initiating efforts two decades ago to transform the National Hospital Insurance Fund (NHIF) into a national social health insurance scheme (called National Health Scheme (NHS)) as the main vehicle for achieving universal health coverage (UHC). However, Kenya has faced several challenges that have contributed to the low and inequitable uptake of the Kenya NHS, which has generated the following lessons.

Leverage policy windows of opportunities to push through national social health insurance reforms:

Kenya's experience reinforces the importance of leveraging policy windows of opportunities to achieve big policy shifts as demonstrated by its success in using the Vision 2030 development process to get the national social health insurance scheme (SHI) on the national agenda [30].

Strengthen/establish strong mechanisms for governance, transparency and efficiency for national social health insurance schemes:

Kenya's experience suggests that the NHIF must address the deficiencies in its governance, transparency and efficiency to restore trust in it. The relationship between public mistrust of government and poor government performance is well established [31]. The public mistrust of Kenya's NHIF has resulted in a mix of views among the public on its role in resource collection, risk pooling and purchasing with some groups preferring multiple entities being involved to prevent corruption and create competition that would improve its efficiency. However, Kenya appears to have settled on implementing a single-payer system, which is considered more advantageous compared to a multi-payer system because it simplifies the process of revenue collection, and ensures efficiency, cost control, and subsidy coverage for the poor [1].

Whilst the NHIF is taking steps to improve social accountability by conducting public outreach and sensitising them about the scheme, more needs to be done. One of the issues that NHIF needs to consider when addressing inefficiencies in its operations is consolidating the multiple schemes it is managing. The Philippines has had some success in reducing inefficiencies through merging



Photo by UNOPS/John Rae

various existing community-based healthcare financing schemes into a national SHI [32].

Strengthen stakeholder engagement to inform and communicate the scheme design: Kenya's experience suggests that the NHIF needs to implement more effective stakeholder engagement approaches to inform the NHS scheme design and communicate it to marginalised groups to get their buy-in and improve its uptake. Designing SHI schemes based on consumers' preferences for the health packages and offering a varied choice of health plans has been linked to higher quality and cost-effective services [1]. Also, "willingness-to-pay" for the premiums and acceptable amounts should be assessed and considered before implementing a national SHI scheme [33]

Strengthen evidence generation and use to inform the scheme design: Kenya's experience suggests that the NHIF may need capacity strengthening and technical assistance in generation and use of evidence to inform the NHS scheme design. Several initiatives that have been undertaken in the Kenyan health sector to strengthen the institutional capacity of policymakers' and researchers' evidence-informed decision-making have achieved some success and demonstrated the need for ongoing long-term investments in this area for sustainable impact [34, 35]. This synthesis identified a need for capacity strengthening to conduct actuarial studies and generate evidence to facilitate identification of people eligible for subsidies (e.g., HISP) and make a more robust investment case for health.

Strengthen/ establish the regulatory and policy environment for strategic purchasing for national social health insurance schemes: Kenya's experience suggests that the NHIF must strengthen its regulatory and policy framework for strategic purchasing to facilitate health system efficiency and quality of health services. In Nigeria, the involvement of private healthcare providers in the SHI scheme contributed to increasing the coverage of the underserved population [36]

Strengthen NHIF revenue collection: Kenya's experience suggests that the main way for the NHIF to improve its revenue collection is to mobilise and increase NHS premium contributions from the informal workers. Indeed, other low- and middle- income countries have shown that SHI revenue collection that is dependent on formal sectors is undermined by the presence of large informal sectors. The successful implementation of SHI requires taxation agencies to strengthen their capacity to collect premiums [37].

Strengthen/integrate equity in resource collection, purchasing process and reach: Kenya's experience suggests that the NHIF has to prioritise integrating equity in all aspects of its NHS scheme design and implementation, particularly, resource collection, purchasing process and reach to increase its uptake among marginalised groups. Whilst recent reforms are addressing some of these issues

e.g., the introduction of a subsidies for the poorest segment of the population, some implementation challenges have been noted like flaws in the identification of people eligible for the subsidies. Nevertheless, the creation of special schemes targeting the poor and other vulnerable groups is considered a successful innovative approach [38] Having a one-size-fits-all SHI structure that fails to consider varied income capabilities has been found to promote pro-rich participation; equity could be improved by increasing the premium contribution or decreasing the reimbursement tariff of the high-income group or vice versa for the low-income group [39].

Ongoing reforms:

Ongoing NHIF reforms that are being steered by the government of Kenya via a Social Health Insurance Bill 2023 have prioritised many of the issues raised in this brief. The reforms proposed include: establishment of the Social Health insurance fund (SHIF) and a board to manage it; a mechanism to ensure coverage and access to the SHI; stakeholder and community participation; financing provisions; and transition provisions to move from the NHIF to a SHIF.

Conclusion

The government of Kenya has made some strides towards expanding health care coverage and financial protection among its population, but coverage remains low and inequitable thus falling short of achieving the UHC principles. More work is needed to increase funding and provide sustainable financial risk protection for the achievement of UHC. This requires the government of Kenya putting in place measures to strengthen NHIF governance and accountability, stakeholder engagement, use of evidence to inform reforms and implementation, and reduce the inefficiencies in risk pooling arrangements. The government of Kenya is currently steering additional reforms via a Social Health Insurance Bill 2023, which has prioritised these issues demonstrating their continued commitment to achieving UHC.

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