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Transformation of Kenya's Health Financing: A Journey towards Equity and Access

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The attainment of health equity and access requires robust health financing mechanisms, including diverse health revenue collection strategies, reducing catastrophic health spending through proper risk pooling, and prioritising health service purchasing. Over the last few decades, health leaders have seen a rise in global health expenditure from US $3.5 trillion to US $8.0 trillion in 2016 [1]. Low- and middle-income countries (LMICs) account for a disproportionate share of disease burden, and a large disparity exists between LMICs and high-income countries (HICs) [2].

Similar to many African countries, health financing in Kenya has undergone significant transformations over many decades, shifting from a predominantly government-funded system in the early post-independent era to a more diversified and structured financing model in the 21st century. These changes have been driven by the need to enhance healthcare access, improve financial protection, and attain health-related sustainable development goals (SDG), especially universal health coverage (UHC). This article explores the historical evolution, key reforms, and their impact on health financing in Kenya, highlighting challenges and exploring future prospects in achieving health equity.

Early Post-independence Era

In post-independence Kenya (1963-1989), the government primarily financed the healthcare system through general taxation. The existing user fees were abolished, and the state provided free medical services in public hospitals, ensuring access for the majority of the population. In 1966, the government introduced a mandatory National Hospital Insurance Fund (NHIF) to provide coverage of basic healthcare services to all formal sector government employees. Economic challenges in the 1980s necessitated the implementation of Structural Adjustment Programs (SAPs) by the World Bank and the International Monetary Fund (IMF), leading to a decline in government healthcare expenditure. These programs required liberalisation of the economy in developing countries, with catastrophic impacts on health financing in Kenya.

Introduction of User Fees

One of the most significant policy shifts occurred in 1989. With the aim of improving revenue generation, the government re-introduced user fees under the cost-sharing policy. This action had adverse effects, including reduced access to healthcare services, especially among vulnerable population's (e.g. children, women), unaffordability of healthcare services especially in rural communities, and increased morbidity and mortality rates among affected communities. This policy exacerbated existing disparities in healthcare access, further highlighting the need for a more equitable and sustainable healthcare financing system in the country.

Second National Health Sector Strategic Plan (2005–2010)

The Second National Health Sector Strategic Plan (NHSSP-II) (2005–2010) was developed in 2005, with the aim of enhancing efficiency in healthcare service delivery. The plan adopted a sector-wide approach in devising strategies meant to effectively operationalize the *Kenya Health Policy Framework (1994)* [3]. The major priorities of this plan were primary healthcare, improvements in health infrastructure, human resource development, and mechanisms for financial risk protection [4].

The need for *NHSSP-II* was informed by deteriorating health indicators, including rising infant and child mortality rates, significant decline in the utilisation of public healthcare services (e.g. new consultations per person as 0.6 in 1990 and 0.4 in 1996), reduced doctor-to-population ratio, and stagnation of public sector contributions to healthcare (e.g. per capita health expenditure dropping from US $12 in 1990 to US $6 in 2002) [4]. Furthermore, poverty levels increased from 47% in 1999 to 56% in 2002, exacerbating barriers to healthcare access.

NHSSP-II: Achievements and Challenges

The implementation of NHSSP-II marked significant progress in

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strengthening Kenya's healthcare system, particularly in health financing and service delivery. Some of the key achievements included increased investments in healthcare infrastructure, expanded access to medical services and enhanced efficiency and reach of the NHIF. In addition, the introduction of a community health strategy played a pivotal role in strengthening primary healthcare at the grassroots level.

Despite these advancements, high out-of-pocket expenditures continued to burden many households contributing about 26.1% of total health expenditure, and thus limiting access to essential healthcare services [5]. Health insurance coverage remained inadequate, particularly among informal sector workers, with about 19% of the population having insurance coverage, leaving a significant portion of the population without financial protection [5]. Furthermore, the heavy reliance on donor funding (e.g. 23.4% of total health expenditure) created sustainability concerns, making long-term health financing vulnerable to external economic, policy, and political shifts, which ultimately underscored the need for continued reforms [5].

The NHIF Reform

Established in 1966 to provide basic medical coverage for formal sector employees, the NHIF has undergone several reforms aimed at expanding its coverage and improving service delivery. First, the *NHIF Act No. 9 of 1998* transformed it from a ministerial department into a state corporation, allowing it to expand its scope beyond inpatient services to outpatient services. Income-tiered insurance provisions were also amended to expand coverage among the informal sector workers who were required to make voluntary contributions, as opposed to formal workers whose contributions are mandatory [6]. Second, the *Civil Servants Scheme (CSS) (2012)* provided an expanded coverage to formal sector government workers and their dependents, whose funds were managed separately from NHIF funds, and beneficiaries enjoyed a comprehensive benefit package [7]. Third, the Linda Mama Programme, established in 2013 and placed under the responsibility of NHIF in 2016, offered free maternity services in all public healthcare facilities [8]. Fourth, the Health Insurance Subsidy for the Poor (HISP) pilot program, initiated in 2015, provided fully subsidised comprehensive cover to selected orphans and vulnerable children under government cash transfer scheme [6]. Finally, the UHC policy of 2018 was adopted with mandatory NHIF enrollment for civil servants and other public sector workers, which increased financial protection for employees and introduced biometric registration and e-claims processing to enhance efficiency and transparency [9].

Beyond 2023: The Social Health Authority (SHA)

To further enhance sustainability and equity of health financing mechanisms, the government introduced further reforms leading to the establishment of the Social Health Authority (SHA) through the *SHA Act* [10]. Under one umbrella body, the SHA created three funds – primary healthcare, social health insurance, and emergency, chronic, and critical illness funds. It is designed to provide UHC for all Kenyan citizens, regardless of their employment status, by pooling resources, spreading financial risk across the entire population, reducing out-of-pocket expenses, reducing dependency on donor funding and improving access to quality healthcare services. Nonetheless, it is important to consider potential challenges and unintended consequences that may arise from such significant structural changes in healthcare financing. The success of these reforms will depend on effective implementation, ongoing evaluations, and necessary readjustments.

Kenya Vision 2030 and Health Financing

Kenya has made significant strides in healthcare reforms, aligning its efforts with Kenya Vision 2030 and the SDGs to achieve UHC. The adoption of the 2030 Agenda for Sustainable Development in 2015 reinforced Kenya's commitment to global goals such as ending poverty (SDG 1), reducing inequality (SDG 10), addressing climate change (SDG 13), and ensuring healthy lives and promoting well-being for all (SDG 3).

Kenya Vision 2030 has influenced healthcare infrastructure development by emphasising the need for comprehensive and interoperable health information systems that support primary and secondary healthcare roles [11]. For example, in rural areas of Kenya, the investment in Level 5 hospitals has led to an increase in the number of specialised medical services available to residents who previously had to travel long distances for care. Additionally, the rehabilitation of health centers has allowed for better preventative care and early intervention, ultimately reducing the burden on higher-level facilities and improving overall health outcomes in these underserved communities. Furthermore, the implementation of electronic health records has streamlined patient care and improved communication among

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different healthcare providers. Although Kenya is on track to provide quality healthcare services to all its citizens, there is a gap in structured guidelines for the development and implementation of digital health policies across the African continent.

A Roadmap to UHC

Kenya's commitment to achieving UHC was further reinforced through the *Kenya Health Policy (2014–2030)*, which aimed at attaining the highest possible health standards in a manner responsive to population needs [12]. The policy set ambitious targets, including increasing life expectancy from 60 years in 2010 to 72 years by 2030 and reducing annual deaths per 1,000 persons from 10.6 to 5.4 [12]. Additionally, the *Kenya Health Sector Strategic and Investment Plan (KHSSP) (2013–2017)* emphasised preventive, promotive, curative, and rehabilitative care to reduce the financial burden of healthcare on households [13]. The integration of SDGs into Kenya's health policies has influenced the health financing reforms for UHC by providing an enabling environment for necessary legislation, reforming health financing organisations, and revising national health policies to align with national commitments to UHC.

Towards Health Equity

At the heart of Kenya's health financing reforms is a commitment to addressing disparities in healthcare access, particularly among vulnerable populations, rural communities, and underserved regions. Over the past decade, the Kenyan government has undertaken significant policy initiatives to address financial barriers and improve health equity. The reforms introduced under *NHSSP-II,* NHIF, and subsequent transition to the SHA, as well as enshrining healthcare as a constitutional right of every Kenyan citizen, underscores this commitment to health equity.

The *Constitution of Kenya (2010)* introduced a transformative legal framework that reinforced a rights-based approach to healthcare. Under Article 43, healthcare was recognised as a fundamental human right, placing an obligation on the state to ensure accessible and affordable healthcare for all citizens [14]. The devolution of healthcare services to county governments improved resource distribution, helping to reduce regional disparities and enhance equity in service delivery. However, this is still fraught with challenges including mismanagement and understaffing of the health workforce and inadequate funding [15].

The *Free Maternity Services (FMS) Policy (2013)*, later renamed Linda Mama Initiative (2016), abolished user fees for all Kenyan women seeking maternity care in public health facilities leading to increased institutional deliveries vis-a-vis unsafe home deliveries. The government also rolled out the UHC Pilot Program (2018) in four counties (Kisumu, Nyeri, Isiolo, Machakos), which offered free healthcare services to registered members, with lessons learned informing the nationwide rollout. In order to improve the digital and physical infrastructure, the Health Infrastructure Development and *Digital Health Innovations Policies* were adopted and implemented in 2023. Investments in Level 5 hospitals and rehabilitation of health centers under Kenya Vision 2030, as well as the implementation of e-health systems, improved healthcare accessibility, particularly in marginalised regions, streamlined NHIF reimbursements, reduced fraud, and improved accountability in healthcare financing. In addition, through the Public-Private Partnerships and Health Insurance Innovations, Kenya has partnered with various private organisations and companies to provide quality and subsidised services to its citizens and improve the health infrastructure. These efforts included the Managed Equipment Service partnership (2015) that leases and maintains specialised medical equipment across county hospitals [16].

Conclusion and Recommendations

Kenya's health financing journey reflects significant progress in improving healthcare access, financial protection, and health equity. Despite these advancements, significant health financing challenges still exist. Government spending on healthcare accounts for only about 6.7% of total healthcare spending, which is less than half of the 15% benchmark recommended by the Abuja Declaration, thus limiting resources available for critical health services [6]. High out-of-pocket expenditures persist, placing a financial burden on many Kenyans and restricting access to necessary medical care. Although NHIF has expanded its coverage, informal sector workers and vulnerable populations remain underinsured with high attrition rates from the pool. Furthermore, inefficiencies and corruption within health financing institutions, including NHIF (now SHA), undermine service delivery and trust in the system.

To achieve sustainable health financing and equitable healthcare access, the Kenyan government must implement strategic reforms geared towards addressing these challenges.

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Increasing government investment in healthcare will reduce reliance on out-of-pocket spending and enhance service delivery. Expanding coverage to informal sector workers, improving governance, and increasing efficiency are essential steps to strengthening SHA. Public-private partnerships should be leveraged further to attract investment from private insurers, donors, and non-governmental organizations and boost health-financing resources. Additionally, embracing investment in digital health technologies, such as mobile health financing and digital insurance platforms, will enhance accessibility and transparency. Policy reforms supporting sustainable UHC and integrating community-based health insurance schemes will be crucial in achieving long-term health goals.

Ongoing reforms and innovative financing models hold promise for realising the country's long-term health objectives under the Kenya Vision 2030 and the SDGs, especially UHC. Effective implementation strategies, periodic evaluations, skilled workforce, and proper resource allocation will be critical in the success of these reforms. Through enhanced government commitment, effective health financing strategies, and robust partnerships, the Kenyan government can take forward steps to expand accessible and affordable healthcare for all its citizens.

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