IPF
INSTITUTE OF PUBLIC FINANCE

POLICY BRIEF

JAN 2026

Social Health Insurance Reforms in Kenya and its Progress Toward Universal Health Coverage

Authored by Collins Nzuya

www.ipfglobal.or.ke

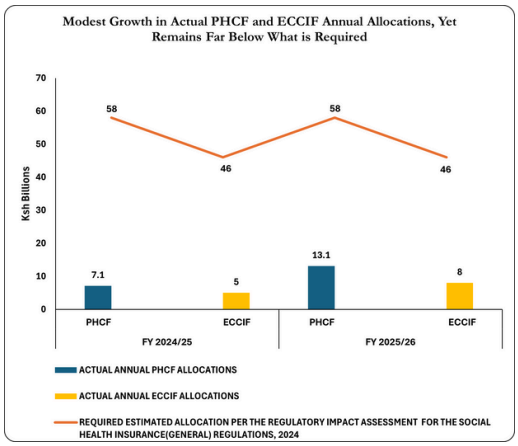
Introduction

In October 2024, Kenya implemented Social Health Insurance (SHI) reforms with the aim of achieving Universal Health Coverage (UHC). One year into implementation, the reform has generated mixed outcomes, with both gains and setbacks. This brief assesses the progress of key reform elements: government funding (the Primary Health Care Fund and the Emergency, Chronic, and Critical Illness Fund) to SHI, the digitization of claims and reimbursement processes, the standardization of the benefit package and tariffs, and the introduction of a 2.75 percent salary-based contribution for formal sector employees.

There is currently no comprehensive assessment of the 2024 SHI reforms on the achievement of UHC in Kenya. Much of the available research work was generated before or during the early stages of SHI reforms implementation, using data available at that time.[1] However, a year after implementation began, few publications have examined the impact of the reforms, identified key challenges, or provided recommendations. This paper draws on secondary data to fill this gap across several reform elements and serves as a guide for future studies. SHI reforms remain partly effective as the Primary Health Care Fund (PHCF) and the Emergency, Chronic and Critical Illness Fund (ECCIF) remain underfunded, facilities continue to engage in fraudulent practices, essential service access remains limited for beneficiaries, and legal challenges against the SHA persist, highlighting the need to strengthen the reforms already in place.

SHI Reforms and Their Progress One Year After Implementation[2]

1.Establishment of Government Funding: Primary Health Care Fund (PHCF) and Emergency Chronic and Critical Illness Fund (ECCIF)[3]



Despite increased allocations to the PHCF and ECCIF since FY 2024/25, these health funds remain underfunded. In FY 2025/26, allocations to these two funds increased significantly, by 84.51% and 60%, respectively.[4] Nevertheless, the current funding of Ksh 13.1 billion and Ksh 8 billion remain far below the estimated costs, Ksh 58 billion for PHCF and Ksh 46 billion for ECCIF.[5] The funding gap is potentially attributed to insufficient domestic revenue to fully fund the national budget, in addition to rising debt-service obligations, which continue to constrain the fiscal space for budget allocations. The government should strengthen domestic resource mobilization and utilization by expanding the tax base, improving tax compliance, reducing wastage, and ensuring efficient budget execution.

2. Digitization of Social Health Insurance Processes[6]

The continuous digitization of SHI processes was introduced to reduce fraud and enhance efficiency but has not fully achieved its intended impact. The government has been significantly scaling up the digitization of processes and services through an information system.7 However, the fact that some key digital processes have not yet been fully implemented has led to persistent cases of facility-level fraud that continue to undermine efficiency, weaken the effective use of pooled resources and slow progress toward Universal Health Coverage (UHC). For example, incomplete implementation of Biometric Health Identification (BHI), allow facilities to submit false claims, engage multiple billing, and falsify records.8 The Social Health Authority should fast track the rollout of BHI to all level of facilities, as it is currently implemented only in level 4 to 6 facilities. With features such as fingerprint verification, the BHI system aims to prevent misuse of benefits and reduce malpractices such as multiple billing, claims for "ghost" patients, and claims for services never offered by facilities.

"The fact that some key digital processes have not yet been fully implemented has led to persistent cases of facility-level fraud that continue to undermine efficiency, weaken the effective use of pooled resources and slow progress toward Universal Health Coverage (UHC)."

3. 2.75 percent Salary-Based SHA Contribution for Formal Sector Employees[12]

Comparison of NHIF and SHIF Premium Contributions by Gross Income (KSh)

Gross income (Ksh)	NHIF Premiums (Ksh)	SHIF Premiums (Ksh) *(2.75% of gross income)*
5,999	150	165
6,000-7,999	300	165 – 220
8,000-11,999	400	220 – 330
12,000-14,999	500	330 – 412
15,000 -19,999	600	413 – 550
20,000 -24,999	750	550 – 687
25,000 – 29,999	850	688 – 825
30,000 -34,999	900	825 – 962
35,000 -39,999	950	962.5 – 1,100
40,000 – 44,999	1,000	1,100 – 1,237
45,000 – 49,999	1,100	1,238 – 1,375
50,000 – 59,999	1,200	1,375 – 1,650
60,000 -69,000	1,300	1,650 – 1,898
70,000 – 79,999	1,400	1,925 – 2,200
80,000 – 89,000	1,500	2,200 – 2,448
90,000 -99,000	1,600	2,475 – 2,723
100,000 – and over	1,700	2,750 - and over
Self employed (special)	500	*2.75% of gross income, as determined by proxy means testing.*

The 2.75 percent salary contribution for formal sector employees under SHIF has enhanced equitable contribution but has been found problematic and unlawful by the high court of Kenya. The previous National Health Insurance Fund graded system capped contributions at Ksh 1,700 for employees earning above Ksh 100,000 and at Ksh 150 for those earning below Ksh 6,000.[13] The new reform removes the contribution limit and requires income employees to contribute 2.75 percent of their salary. For example, an income earner earning Ksh 100,000 who previously contributed Ksh 1,700 is now contributing Ksh 2,750.A recent High Court judgement found the mandatory 2.75 percent contribution by the formal sector to the Social Health Insurance Fund to be problematic.[14] The judge ruled that mandating formal sector contributors to pay 2.75 percent of their gross income to SHIF after already paying income tax on the same income constitutes double taxation and renders the regulation unlawful. The Social Health Authority should review and revise the SHIF contribution regulations to ensure they comply with the Income Tax Act that guided the High Court's decision. The contribution should be revised so that it is treated not as a tax on gross income but as a statutory social health insurance premium, to adhere to Part IV of the Income Tax Act, which allows only income tax to be deducted from gross income of formal employees.

4. Standardization of Social Health Authority Benefits Package and Tariffs.[9]

The standardized benefits package and tariffs have not yet guaranteed Kenyans access to the full range of essential health services. The equal benefit package was designed to ensure that all covered Kenyans have equitable access to health services, irrespective of income or employment status. The revised SHA coverage remains low compared to the actual cost of services in health facilities, particularly private ones. For example, outpatient care is set at Ksh 900 per person per annum, while optical health services are capped at Ksh 950 for consultation and dispensing of eyeglasses.[10] In comparison, the Kenya Demographic and Health Survey (KDHS) reports an average outpatient visit cost of Ksh 1,735 per patient per month.[11] This forces Kenyans to pay out of pocket for health services after they have exceeded the tariffs cap for each year. The SHI should continuously review and expand the standardized benefits package to ensure full coverage of essential health services.

Conclusion

Kenya's Social Health Insurance reforms still have gaps in areas such as underfunding of PHCF and ECCIF, the digitization of claiming and reimbursement process and the design of the benefits package. Additionally, SHI coverage remains below half of Kenya's population, just as it was before the reforms, indicating limited progress in expanding financial protection. Strengthening the Social Health Insurance reforms by increasing allocations to PHCF and ECCIF, reviewing and expanding the standardized benefits package, and enhancing the SHA digital system is essential to accelerating Kenya's progress toward Universal Health Coverage.

References

1 *https://www.elibrary.imf.org/downloadpdf/view/journals/002/2024/014/article-A002-en.pdf*

2 *Notably, this policy brief did not cover other aspects of the reforms, such as establishing Proxy Means Testing to determine informal sector premium contributions or the consolidation of the fragmented pooling system into a single pool (SHIF), due to limited available data since the reforms were implemented.*

3 *The Primary Health Care Fund (PHCF) and the Emergency, Chronic, and Critical Illness Fund (ECCIF) are tax-allocated funds established under the Social Health Authority (SHA) to finance primary healthcare services and cover emergency, chronic, and critical illness care for all Kenyans registered with the SHA, without requiring any contribution.*

4 *https://www.treasury.go.ke/wp-content/uploads/2025/07/Recurrent-Vol.-1.pdf*

5 *https://health.go.ke/sites/default/files/2024-01/RLA%20-%20SHIA%20Regulations.pdf*

6 *Digitization of Social Health Insurance processes ensures that all key operations (such as member registration, identification, contributions, facility empanelment, contracts, notifications, and claims) are conducted through secure, efficient, and integrated digital systems.*

7 *https://www.health.go.ke/government-scales-digital-health-reform-drive-accountability-and-efficiency*

8 *https://www.health.go.ke/40-health-facilities-suspended-over-fraudulent-claims-social-health-authority*

9 *Standardization of Social Health Authority Benefits Package and Tariffs involves establishing a uniform set of healthcare benefits package under the SHA that is accessible to all enrolled members.*

10 *https://sha.go.ke/resources/categories/7*

11 *https://www.knbs.or.ke/wp content/uploads/2023/07/Kenya-DHS-2022-Main-Report-Volume-2.pdf*

12 *Formal sector employees in Kenya are mandated to contribute 2.75 percent of their gross income to the Social Health Authority (SHA) as a health insurance premium.*

13 *https://www.kenyalaw.org/kl/fileadmin/pdfdownloads/RepealedStatutes/NationalHealthInsuranceFundCap255.pdf*

14 *https://www.knbs.or.ke/wp-content/uploads/2023/07/Kenya-DHS-2022-Main-Report-Volume-2.pdf*

INSTITUTE OF PUBLIC FINANCE

This policy brief was authored by Collins Nzuya with guidance from IPF's Senior Technical Advisor, Jason Lakin, PhD. Immense gratitude to Daniel Ndirangu for his leadership.

PREPARED BY:

INSTITUTE OF PUBLIC FINANCE
P.0 BOX 21753-00100, Nairobi, Kenya
Tel: +254758728882 Email: info@ipfglobal.or.ke
www.ipfglobal.or.ke