Gendered analysis of Kenya’s health finance market
July 2022

FSD Kenya's 2022-2026 puts gender at the centre of our programme activity. In 2022, FSD Kenya with support from Dalberg Advisors carried out gendered analyses of the Kenya's health finance market to deepen our understanding of the health finance needs that women and households face and the extent to which these are met. The findings from this work formed the basis in design of our current five-year Health finance project whose aim is to “Facilitate and advocate for value adding finance that enables improved health and financial resilience to health shocks for women and households”.

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## Abbreviations

| CHE | Catastrophic health expenditure |
| DFI | Development financial institutions |
| GDP | Gross domestic product |
| HCF | Healthcare facility |
| HISP | Health Insurance Subsidy Programme |
| KHHEUS | Kenya household health expenditure and utilisation survey |
| MCF | Medical Credit Fund |
| MoH | Ministry of Health |
| MSEs | Micro and small enterprise |
| MSMEs | Micro, small, and medium enterprises |
| NCDs | Non-communicable diseases |
| NGO | Non Governmental Organisation |
| NHIF | National health insurance fund |
| ODA | Official Donor Aid/Official Development Assistance |
| OOP | Out of pocket |
| PE | Private equity |
| PEPFAR | U.S. President’s Emergency Plan for AIDS Relief |
| SSA | Sub-Saharan Africa |
| THE | Total health expenditure |
| UHC | Universal health coverage/care |
| VC | Venture capital |
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Health care financing is a critical element of the social and economic development of a country. An appropriate health financing system is needed to ensure equitable, access to affordable and quality healthcare as enshrined in Vision 2030. Kenya’s health financing is by the government (both national and county), households, the private sector and donors/development agencies as illustrated in figure 1 below (most recent data available).

Notably, the government health financing has increased by a third while expenditure by households has reduced by about 40% in the last decade. Financing by the private sector has been minimal (below 10%), with donors contributing about a quarter of the expenditure.

The government financing is typically from revenue allocations and is insufficient and so many households have to co-finance either directly by incurring out of pocket expenditure for healthcare services or through paying for health insurance. Besides the private sector financial service providers, there are several donors supporting the Kenya health sector working in partnership with the government and other private and non-government organisations/programmes.

The financial resources mobilised for health are managed by various entities as shown in figure 2. These include government units (e.g., the Ministry of Health, National Health Insurance Fund, NHIF), households, non-profit making organisations (NGOs), county governments, private organisations (insurance companies and other hospitals), etc.
As shown, county governments (Government – sub-national) are emerging as a key player and resource manager in health since the devolution of the health function - managed approximately 20% of the expenditure by 2016. This budget/revenue reallocation has meant less expenditure by the national government/Ministry of Health. Also notable, the management of health expenditure by non-profits shrank by half between 2010 and 2016 to 13.7%. The significance of the role of public insurance (NHIF) has remained relatively the same over the years (between 4.5% and 4.8%) while that of the private sector increased by about 70% (from 6.5% to 11.1%) during this period.

Although this is the most recent comprehensive data on health expenditure, the government expenditure has largely been on an upward trend (figure 4 below). Official donor aid (ODA) and other bilateral donor contributions have also increased since 2016, with the health sector getting the biggest share of the allocation contributed by bilateral donors between 2018 and 2020 (figure 3). However, the donor allocations to the health sector fell by 31.1% between 2019 and 2020. Some of these donations were direct Covid-19 response support.

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1 Development Initiatives website (Accessed July 2022)
2 Ibid
2.1 Government expenditure on health

The Kenya government's appreciation of the need and commitment to universal health care has been evident over the years as indicated in figure 4 below.

Figure 4: Kenya Government’s health expenditure

Source: Kenya Economic Survey 2022, 2022/2023 Budget
However, at a rate of 4.48% of gross domestic product (GDP) in 2019, Kenya falls far short of the 15% target agreed as per the Abuja Declaration of 2001. The proportion of government health expenditure has varied over time, with a high of 6.12% of GDP in 2010 and a low of 4.84% in 2017 as illustrated in figure 5. Overall, the expenditure per capita trend has been upward.

![Figure 5: Health expenditure (% of GDP and per capita)](source: Macrotrends website using World Bank data (Accessed July 2022))

This challenge to balance budget across the various competing priorities has, however, not been unique to Kenya only but applies to others in the continent. Figure 6 shows how Kenya’s health expenditure compared with other countries in the continent in 2014.

![Figure 6: Kenya’s health expenditure vs other countries](source: UHC in Africa: A Framework for Action, World Bank website (Accessed July 2022))

Kenya’s government expenditure on health is outlined in table 2. About 60% of the 2021/2022 total government (both national and county) budget was on recurrent expenditure (such as staff salaries), with the balance going to development (capital investments).
Table 1: Kenya national vs county governments health expenditure

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th>2018/19</th>
<th>2019/20</th>
<th>2020/21*</th>
<th>2021/22*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recurrent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>804.9</td>
<td>2,650.0</td>
<td>2,633.7</td>
<td>3,392.2</td>
<td>2,749.5</td>
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<tr>
<td>Hospital services</td>
<td>13,618.6</td>
<td>22,952.4</td>
<td>27,496.3</td>
<td>26,898.5</td>
<td>24,328.2</td>
</tr>
<tr>
<td>Public health services</td>
<td>7,735.6</td>
<td>9,897.8</td>
<td>12,740.0</td>
<td>3,969.8</td>
<td>1,720.2</td>
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<tr>
<td>Health expenditure n.e.c</td>
<td>6,476.3</td>
<td>6,971.9</td>
<td>18,517.6</td>
<td>14,623.3</td>
<td>12,875.1</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td>28,635.3</td>
<td>42,472.1</td>
<td>61,387.6</td>
<td>48,883.8</td>
<td>41,672.9</td>
</tr>
<tr>
<td><strong>Development</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient services</td>
<td>8,388.2</td>
<td>9,364.0</td>
<td>6,681.2</td>
<td>7,108.5</td>
<td>9,071.1</td>
</tr>
<tr>
<td>Hospital services</td>
<td>503.1</td>
<td>487.2</td>
<td>2,349.7</td>
<td>1,562.5</td>
<td>2,577.1</td>
</tr>
<tr>
<td>Public health services</td>
<td>23,067.2</td>
<td>23,993.1</td>
<td>32,233.2</td>
<td>31,595.0</td>
<td>46,195.7</td>
</tr>
<tr>
<td>Health expenditure n.e.c</td>
<td>1,267.5</td>
<td>367.6</td>
<td>1,507.0</td>
<td>5,371.4</td>
<td>10,635.7</td>
</tr>
<tr>
<td><strong>Sub-Total</strong></td>
<td>33,206.0</td>
<td>34,211.9</td>
<td>42,771.1</td>
<td>45,637.4</td>
<td>68,479.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>61,841.3</td>
<td>76,684.0</td>
<td>104,158.8</td>
<td>94,521.2</td>
<td>110,152.6</td>
</tr>
</tbody>
</table>

**TOTAL OUTLAYS**

|                      | 2,576,065.00 | 2,944,798.04 | 2,999,607.35 | 3,291,828.39 | 3,416,797.68 |

**County governments expenditure (KShs billion)**

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<tbody>
<tr>
<td><strong>Recurrent</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development</td>
<td>71,813.3</td>
<td>75,940.0</td>
<td>89,139.2</td>
<td>90,554.6</td>
<td>92,625.9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>83,978.3</td>
<td>92,023.6</td>
<td>106,727.1</td>
<td>108,838.6</td>
<td>116,528.7</td>
</tr>
</tbody>
</table>

**TOTAL EXPENDITURE**

|                      | 336,397.48 | 405,531.74 | 417,153.55 | 425,039.63 | 514,271.66 |

2.2 National Health Insurance Fund

The National Hospital Insurance Fund (NHIF) was established in 1966 through an Act of parliament. Its importance has been amplified in the last decade as part of the universal health coverage (UHC) agenda and efforts which started in 2010 under the amended Constitution, Vision 2030 and the subsequent implementation policies. For instance, the Linda Mama free maternity services introduced in all public healthcare facilities (HCFs), introduced in 2013 and the Health Insurance Subsidy Programme (HISP) are both administered/managed by NHIF. Besides the basic cover, NHIF also provides enhanced medical insurance schemes through negotiated arrangements with employers such as the Civil Servant Scheme and the National Police Service Insurance Scheme.

NHIF was chosen as the vehicle for UHC through which Kenyans would access quality healthcare without suffering from financial hardship in accordance with the Constitution and Vision 2030. In the 2018/2019 fiscal year, four counties (Machakos, Kisumu, Nyeri and Isiolo) were chosen for a UHC pilot dubbed Afya Care, which entailed input financing model, where public facilities were supported with technologies, human capital, equipment, and commodities which allowed the public to access services free of charge in Level 1 and 2 HCFs. Shano, Guyo, and Ileana Vîlcu (2020): A review of Afya Care – the Universal Health Coverage pilot program – in Isiolo county. Kenyabrief 5. Washington, DC: ThinkWell.
registration of households in these community in three of these counties (Machakos, Kisumu and Nyeri) using CarePay’s M-Tiba platform – Isiolo county piloted a different approach with support from Living Goods. The pilot was in February 2022 rolled out to the rest of the county to attain universal coverage.4

The 2022 Amendment of the NHIF Act envisages significant reforms. Key among these is the change from National Hospital Insurance Fund to National Health Insurance Fund. While previously NHIF was expanded to cover outpatient healthcare services for its members, this recent amendment means that besides HCFs, it will identify and include other healthcare providers such as pharmacies, labs, and private consultants, and increase the panel to about 8,000 providers. According to NHIF, this will enable the fund to enter value adding strategic purchasing agreements to cover a wider section of healthcare services, including mental health. The inclusion of pharmacies to the NHIF cover is crucial given that Remem pharmaceuticals account for 40 -70% of the total cost of healthcare.

The reforms will also include the roll out of an e-Claims system which will digitise the claims and reimbursement process and make it more efficient. The manual claims process has been riddled by fraud and been extremely slow, compounding the working capital challenge already faced by the small HCFs. According to NHIF, the new reimbursement system has turnaround time of about one month.

NHIF will also roll out a biometrics system to reduce instances of fraud and improve service delivery. Currently, the cards are issued to the principal member (normally men who are more likely to be formally employed or to buy insurance).5 In some circumstances, their wives are either not included in the cover or are not aware that they are, so they don’t get to use it. There have also been limitations in verifying if non-principal members are covered due to lack of the physical cards for each household member covered. To drive the envisaged reforms, NHIF will promote and create awareness about its services across the nation.

The NHIF is largely sustained through government and donor subsidy. It has been prone to adverse selection, with those subscribing and making contributions to it being those who need the cover. The recent NHIF Act amendment mandates that all adult Kenyans (over 18 years) contribute to NHIF. This requirement would address the adverse selection issue in addition to ensuring that households are cushioned against health shocks. NHIF’s current subscription is estimated at about 9m principal members, with half of these accounts being inactive/dormant.7 (FinAccess 2021 reported about 5.6m NHIF accounts, 20.5% of Kenyans).

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4 The Standard website: Uhuru set to roll out UHC for 47 counties (Accessed July 2022)
5 Daily Nation (08 July 2022): How new NHIF rules will boost benefits package for members
6 2021 FinAccess household survey report
7 The Standard, (5 Jul 2021): NHIF incurs losses as half of registered members are dormant
Donor funding for health

Kenya’s health expenditure is substantially complemented by donor funding - a quarter of the total health expenditure (THE) in 2015/2016 as indicated in figure 2 above.\(^8\) Between 2012 and 2017, Kenya received an average of roughly US$3 billion per year as shown in figure 7 below, with the health sector receiving a third of this Official Development Assistance (ODA).\(^9\)

Previously, Kenya had a high donor dependency rate but the share of the health expenditure by donor funding has declined. However, the absolute amount of donor support increased by over 20% from 19.7 billion KShs in 2016/2017 to 23.7 billion KShs in the 2018-2019 fiscal year.\(^10\) The country’s transition to a middle-income country may have been perceived as an increase in capability to finance its own development. There has also been an evident donor paradigm shift to other development priorities such as climate change. Additionally, financial leakages have also led to this drop. For example, the United States suspended approximately $21 million (KShs 2.1 billion) in assistance to the Ministry of Health in 2017 due to corruption.\(^11\)

The country faces the risk of health sector donor concentration. In 2017, about 90% of all the health ODA came from four donors namely: the United States (62 percent), the Global Fund to Fight AIDS, Tuberculosis and Malaria (18 percent), the United Kingdom (5 percent), and Gavi (4 percent) as presented in figure 8.\(^12\) This makes Kenya vulnerable to shifts in donor funding as happened in 2017 when the United States suspended its support.

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\(^8\) The Centre for Policy Impact in Global Health (2021): Development finance in transition - Donor dependency and concentration in Kenya’s health sector

\(^9\) Ibid

\(^10\) Ibid


\(^12\) McDade, C. et al (2021): Reducing Kenya’s health system dependence on donors, Brookings Institute
There is also concentration in each of the top five recipient sub-sectors for health ODA as indicated in figure 9 below. In 2017, the United States made up 84% of all ODA for the control of sexually transmitted diseases — including HIV/AIDS, the Global Fund to Fight AIDS, Tuberculosis and Malaria and the United States 99% of the malaria ODA, Gavi (The Vaccine Alliance) and the International Development Association 86% of basic health care ODA, Japan, Denmark, and Germany 85% of health policy and administration ODA, and Germany, the U.K. and the U.S. 85% of the reproductive health ODA.\(^\text{13}\)

Kenya’s HIV management programmes are particularly donor dependent, with donors contributing US$2.2 for each dollar spent by the government in 2017.\(^\text{14}\) Over 50 percent of total HIV/AIDS funds and over 80 percent of all external HIV/AIDS funds have each year come from the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR) since 2012.\(^\text{15}\) Figure 10 presents Kenya’s financing for HIV and the related dependency ratio.

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\(^{14}\) Ibid

\(^{15}\) Ibid
In its 2021 donor dependency report, the Brookings Institute proposes the following measures for Kenya to reduce this health sector donor dependency: proactively prepare for transition, even where transition is not an immediate reality, increase domestic resources for health, even in the light of competing priorities and the challenges posed by Covid-19, improve tracking and reporting on external reliance on health aid, and identify clear pathways for sustaining effective coverage. Some of these might not be easy to implement but donor dependency is not a tenable way to realising UHC given emergent global priorities and developments such as the Covid-19 and Ukraine-Russia war related challenges which have had global economic impacts.

Other direct and indirect donors in the Kenya health sector include the Bill & Melinda Gates Foundation, the World Bank Group, Rockefeller, GIZ, and KFW. These donors support a range of actors across the sector such as the government (technical assistance to the Ministry of Health and NHIF), AMREF (research), and (health research, strategic purchasing and financing). Besides directly supporting these local health interventions, the Gates Foundation is a major funder of Gavi (has provided USD 1.6 billion for Gavi’s next 2021-2025 strategic period) which in 2017 financed 4% of Kenya’s health expenditure as indicated in figure 8 above.

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**Figure 10:** Kenya’s financing for HIV and dependency ratio

Source: The Centre for Policy Impact in Global Health: Development finance in transition - Donor dependency and concentration in Kenya’s health sector

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17 Gavi’s website (Accessed July 2022)
Households are an increasingly important pooling and management agent as they mobilise resources and make decisions on how to use them. Households require resources for prevention, accessing care, to meet costs at point of care, and at times for post-care and management depending on the health event or condition. The finance needs related to this journey and the current situation is outlined in figure 11 below.

In addition to the expenditure by government and donors, households make significant contributions towards financing healthcare. These contributions are through purchase of insurance or out of pocket (OOP) payments for health at the point of care, but also other costs related to accessing care such as transport. While insurance is the most value adding form of health finance (delivers more value per shilling than other financial solutions to households), many Kenyans lack health insurance.

4.1 Health insurance

According to the 2021 FinAccess survey, only 23% of Kenyans have access to health insurance. This coverage is primarily driven by NHIF, accounting for 83% of health insurance. Figure 12 shows that the proportion of Kenyans with insurance dropped between 2019 and 2021, most likely due to the economic impacts of Covid-19.

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Figure 11: The patient’s journey

Furthermore, health insurance coverage is significantly lower for women (19.5%) compared to men (25.9%). This could be due to factors such as lower income and education levels. Yet, women shoulder most of the healthcare burden as the core care givers and also economically – spend more out of pocket. On the other hand, access to health insurance in rural Kenya is just about half that in urban areas. There was a decrease in the proportion of Kenyans who have insurance across all livelihood types apart from those who were employed during the pandemic.21

Private health insurance, contributed to 3.8% of health insurance (1 million policies) as illustrated in figure 13 below. About 50% (1.8% in 2021) of those who have private insurance also tend to be members of NHIF – in compliance with the legal requirement (for those formally employed) or using private insurances to complement NHIF which is deemed to be insufficient. Women are less likely to be formally employed than men hence to have lower access to employer-based private health insurance. Generally, men tend to be the principal insurance policy holders and there are situations of the women (and children) not using the cover (especially) NHIF due to lack of awareness.

21 2021 FinAccess household survey report
Besides NHIF, several private health insurance products exist in the market (about 1.5m private policies). In 2020, medical insurance was the largest class in the general insurance business, accounting for 34.4% of the total gross direct premium income (KShs 45 billion). There were 34 licensed insurance companies underwriting medical insurance in Kenya in 2020, the top 5 providers by market share being Jubilee, UAP, AAR, CIC, and Resolution Insurance, respectively. Most of their health insurance products are targeted at the higher income segments and the formally employed. A few underwriters such as Britam and CIC have health microinsurance products, but these haven’t scaled yet although some like Britam’s Afya Tele, is a group medical insurance product, show promise.

According to FinAccess 2021, cost is the largest barrier to taking insurance, followed by limited awareness and understanding, utility, and trust as indicated in figure 15.

22 2021 FinAccess household survey report
24 Ibid
The core drivers of high premiums are:

- High and rising cost of healthcare. There are limited measures to control rising costs, and expectations of benefits in the market are mismatched.

- High administrative costs due to inefficient processes. The use of traditional distribution channels such as agents is costly, but insurance companies are limited in the use of digital channels due to issues around trust, digital literacy, and infrastructure. Expense ratios against claims have typically been three times the global benchmarks.

- Lack of data on low-income segment healthcare needs causes insurers to inflate costs to cover perceived risks. Insurers end up providing and provision of ‘one-size fits all’ products.

- The cost of credit—health service providers typically increase fees when services are paid through insurance. This is to account for the fact that payment will usually be paid after a certain period, incurring a cost of credit.

Inflexibility of insurance premium payments also contributes to affordability challenges. Premium payments for private health insurance requires an upfront lumpsum payment due to the ‘cash and carry’ regulatory requirement in Kenya. This means that premiums must be paid upfront or at the point at which the cover is issued to ensure that the insurer is able to settle claims appropriately. While this requirement safeguards the interests of the insured (minimises the risk of their claims being dishonoured due to lack of resources by the underwriters), it is challenging for many households to afford the lumpsum premium upfront especially where incomes are irregular. Individual members who fail to pay their NHIF premiums on time (9th of every month) are subjected to a 50% penalty and employers a penalty of 25% of the outstanding contribution.

b) Limited awareness and understanding of insurance: Lack of understanding about insurance and where to get it is the second biggest reason for low uptake across all population segments. Limited awareness and understanding of insurance is driven by gaps in channels used, and the complexity of terms. The channels used to market products are not creating sufficient awareness among households, especially women who have lower awareness and literacy levels and rely on trusted family members and friends for information about products. Notably, low-income households indicate low awareness and understanding as a barrier at more than twice the extent of other income segments, indicating that the awareness and understanding gap is more prominent for this segment than other income segments. This gap is also reflected among the other segments with least uptake – rural, younger and older segments. This implies that channels used to create awareness of insurance miss these segments.

Insurance companies are still largely reliant on physical agents as their primary channel of awareness. However, these are concentrated in urban areas, and mostly target wealthier households. New channels such as digital are also more likely to miss excluded segments e.g. women and rural households given factors that contribute to the digital divide such as lower literacy levels (both general and digital) and limited access to Internet and digital devices especially where apps are used – only 35% of Kenyans have access to smartphones.

The gap is perpetuated when insurance agents only explain how insurance works to the person who registers for the insurance (the policy holder), leaving out other beneficiaries. For example, in the new NHIF indigents scheme, there is limited awareness creation to the households on who benefits – consequently some women don’t seek healthcare under the scheme because they are not aware that they are beneficiaries.

4.2 Out of pocket health expenditure

Due to the low uptake of health insurance, households’ out of pocket (OOP) expenditure on health is a significant share of their spending and often results in catastrophic health expenditure (CHE) and impoverishment for some households especially when faced by severe health events. As shown in figure 16, OOP health expenditure has consistently accounted for at least 25% of total national expenditure since 2009.

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26 Dalberg & FSD Kenya (2022): Gendered health finance market analysis key stakeholders’ interviews
27 FSD Kenya (2021): Gendered financial products and services for women in Kenya
28 2021 FinAccess household survey report
29 Dalberg & FSD Kenya (2022): Gendered health finance market analysis key stakeholder interviews
30 CHE: When OOP health spending exceeds 10% of total income or 40% of non-food expenditure.
Figure 16: OOP expenditure as a share of health expenditure and incidences of CHE

Kenya’s catastrophic health spending is at 5.4%, pushing more than half a million Kenyans a year into poverty, although Kenya fares slightly better than the sub-Saharan Africa (SSA) average. The Covid-19 pandemic has exacerbated this, with an additional two million Kenyans pushed into poverty in 2020. 31 Health shocks are particularly devastating for low-income households (see figure 17), most of which lack access to insurance and hardly save towards such eventualities due to a myriad of competing daily priorities, and particularly for women who shoulder a disproportionate share of the care burden.

Figure 17: OOP share in health expenditure, OOP per capita and OOP per wealth quintile

OOP expenditure is higher for women, who are charged with unpaid care work such as looking after children, than for men despite the lower health insurance access – on average they report paying 29% more than men. 32 This higher OOP expenditure is driven by the fact that women are more likely to be the primary caregivers in the household and therefore responsible for not just for their health needs, but also for those under their care like children. Women are also more likely to seek care than men (women made 4 visits per capita per year compared to 3 visits by men) 33, but urban households have significantly higher OOP than rural ones as illustrated in figure 18.

29 The World Bank (2019): The 22nd edition of the Kenya Economic Update, Navigating the Pandemic
31 The World Bank (2019): The 22nd edition of the Kenya Economic Update, Navigating the Pandemic
32 KHHEUS, 2018
33 KHHEUS, 2018
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Figure 18: Health insurance coverage vs out of pocket expenditure

Not surprising, access to insurance is directly proportional to income levels, with low-income households having lower health insurance coverage and therefore higher OOP and CHE (See figure 19 below). The situation is worse for low-income women-headed households. A huge part of households’ OOP expenditure on health is on outpatient care which until recently was not covered by NHIF as shown in figure 19.

Figure 19: Health insurance coverage and out of pocket expenditure vs wealth quintiles

Households that do not have insurance mainly manage health shocks through support by friends and family, cutting back on expenses or by selling assets (figure 20). Some can use both formal and informal financial solutions, while others forego care. According to FinAccess 2021, 54.1% of Kenyans indicated that they had foregone healthcare (treatment or medicines), up from 35.8% in 2019. Anecdotally, this is attributable to Covid-19, both the reduced ability to pay for healthcare due to reduced incomes and the general restriction of visits to healthcare facilities to those deemed essential during the pandemic.
Based on previous work and other research, low-income households face a challenge in saving for health given inadequate incomes and other competing priorities. The fact that health shocks are uncertain and not constantly demanding financial attention like other needs such as food makes saving for health even more unlikely. Such households save but locking these savings to health is not attractive to them – they prefer to save and be able to access their money to deal with all sorts of eventualities. Not surprising, only 9% of adults consider health a major life priority – a decline from 13.2% in 2019, mainly attributable to the greater economic challenge occasioned by Covid-19. As a result, there are very few formal health savings products in the Kenyan market. Experience from the M-Tiba wallet, a health savings product provided by CarePay in partnership with Safaricom, confirms the views here. Only little amounts (average KShs 200) were saved and used to cater for small health expenditure in the about 2,000 healthcare facilities listed in the platform. Consequently, only 13-17% of the about 250,000 M-Tiba accounts are active.

Although Kenyans use credit to deal with health shocks, the value derived from it is sub-optimal compared to other solutions like insurance. However, the value is enhanced when used to pay insurance premium. When it comes to mode of payment, many Kenyans use mobile money to pay for insurance (NHIF) as shown in figure 21.

Figure 20: Dealing with medical shocks (% of population)
Source: 2021 FinAccess household survey report

Figure 21: Paying for insurance (NHIF)
Source: 2021 FinAccess household survey report

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35 2021 FinAccess household survey report
36 Dalberg & FSD Kenya (2022): Gendered health finance market analysis key stakeholders’ interviews
37 Ibid
The private sector plays a complementary role to the government in provision of healthcare. These healthcare providers include health care facilities, pharmacies, laboratories, and emergency service providers. As earlier noted, urban locations have a higher concentration of healthcare providers than rural ones because of higher number of private health businesses and this enhances the physical access to healthcare. Access for appropriate finance can help healthcare businesses improve the range and quality of their services.38

Like other businesses, health entrepreneurs mainly rely on personal savings and support from family and friends. Development financial institutions (DFIs) and impact funds have increased their interest in healthcare as a business and investment target, especially since the establishment of the Africa Health Fund in 2009, with approximately 6-7% of the about US$650m impact investments in Kenya between 2010 and 2014 going to the healthcare sector.39 More recently, a greater number of funds than in the past are targeting healthcare business exclusively or among other sectors – for example: Investment Funds for Health in Africa and Leapfrog Investments. Yet, across Africa, venture capital (VC) and private equity (PE) investment in healthcare remains relatively small (8% in 2019-2020 but down to 4% in 2021), with Kenya likely receiving an even smaller share in 2022.40

Besides venture capital and private equity, health businesses access financing from the Kenyan financial sector. As illustrated in figure 22, access to credit from commercial banks by health MSMEs varies from that of other businesses.

5 The Global Impact Investing Network and Open Capital Advisors (2014): The Landscape For Impact Investing in East Africa
Typically, the border between the MSE owner and the business is blurred and thus a significant part of this credit is likely to be personal loans that would cater to working capital needs and are not appropriately tailored to the needs of the health businesses such as capital investments. However, Equity Bank has health MSME financial solutions that are tailored to the needs of the franchisees under the group’s Equity Afya chain (and others). These include: equipment financing, office space acquisition financing, invoice discounting (to address delays in NHIF reimbursements), construction loans, trade financing, and working capital loans among others.41

The financing gap has necessitated other interventions such as the Medical Credit Fund, MCF (funded by the Bill & Melinda Gates Foundation and the UK government).42 In 2016, MCF partnered with Sicilian Bank to finance 2,500 private medical services providers, health facilities, health training institutes and suppliers to the health sector in Kenya. The bank was to provide loans between KShs 100,000 and 250 million for the purchase or maintenance of medical equipment and expansion of facilities and receive technical know-how from MCF.43

To further this health business financing effort, Sicilian Bank has now partnered with Strathmore University’s Business School, which has been providing capacity building to healthcare business owners and managers. The Strathmore programme which started in 2017 has supported approximately 200 healthcare businesses.44 Additionally, the IFC through its Africa Medical Equipment Facility recently partnered with Co-operative Bank and health equipment manufacturers (Philips, GE Healthcare and Karl Storz, with plans to include more vendors later) to offer healthcare SMEs local currency loans for purchase or lease of medical equipment.45

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41 Dalberg & FSD Kenya (2022): Gendered health finance market analysis key stakeholders' interviews
42 Ravishankar, N. & Lehmann, J. (n.d.): Improving access to finance for health care businesses in Kenya
43 Sidian Bank website (Accessed July 2022)
44 Nation (4 July 2022): Sidian Bank, Strathmore University sign deal to support health care service providers (Accessed from website)
45 Business Daily (14 Feb 2022): Co-op Bank, IFC in health equipment funding partnership
Kenya has made strides towards realising the desired health outcomes, but significant gaps remain. The cost of accessing care, the distance to HCFs, and the poor quality of care pose significant barriers to seeking healthcare. Besides the inability to access care, there are risk factors that expose women and households to non-communicable diseases (NCDs) such as use of unclean energy, poor sanitation and lack of awareness about some of the risk factors. While affordability plays an important role in driving healthy behaviours, social norms and stigma in relation to diseases such as HIV/AIDS are notable contributors. For instance, a pilot undertaken in rural Kenya on use of male-only clinics (all male staff serving only male patients) significantly improved men’s health seeking behaviour compared to the control. 66 The digital economy presents great opportunity to address these barriers to accessing care.

Households play a significant role to financing healthcare and this is expected to continue despite the increasing public health expenditure. The households’ contribution is mainly through direct OOP expenditure given the low insurance uptake or by paying for health insurance which delivers much more value to women and households than other financial solutions. The government has identified Universal Health Coverage as a key health agenda, with NHIF as a strategic tool for realising this goal. Having an NHIF cover is the entry point to health insurance for many Kenyan women and households. The 2022 NHIF Act Amendment made NHIF mandatory for all Kenyans over 18 years. Given the current membership of only 5.6m (about 22.4m Kenyans, assuming a household of 4), and the additional 1m indigent households (approximately 4m people) covered through the government’s Health Insurance Social Protection programme (HISP), about 30m people (approximately 7.5m households) will be left without NHIF cover.

The government’s health subsidy to low-income households (indigents) through HISP has been increasing and the expectation is that it will expand even more in future to cover more Kenyans. However, as emphasised in different key health stakeholders’ forums, attaining UHC in Kenya requires both public and private interventions. There is need to facilitate these 7.5m Kenyan households who are likely to be left of NHIF by providing appropriate financial solutions to help them pay for themselves or for others to pay for them. However, from experience, the NHIF cover is sub-optimal and many households in addition buy private health insurance or incur OOP expenditure to access healthcare. While comprehensive health insurance would deliver the most optimal value to women and households, other financial solutions to underpin health and healthy seeking behaviours are required. These include financial solutions for health businesses (MSEs) to deliver quality healthcare and expand their operations and to support the transition to healthier lifestyles.

Provision of value-adding financial solutions for women and households will require a sound understanding of the various demographics (from the current NHIF and other data analysis and further research), development and testing of appropriate financial solutions (e.g., payment and financing for insurance premium) and streamlining of processes within NHIF and in the private insurance sector which can be complex and inefficient, significantly pushing up costs. A similar approach is needed in tackling the health MSEs challenge to enable delivery of quality healthcare.

There is a great opportunity to leverage digital technology and use data as an alternative collateral for financing health businesses. All these financial solutions should be underpinned by an environment that enables innovation while at the same time monitoring the potential risk. Work on private health financial solutions can help to strengthen public solutions through testing and innovating on more effective and efficient delivery methods. The project will aim to cross fertilise learnings to ensure that the aim of building a strong healthcare system is attained. Research and evidence will be used as tools for advocacy and stakeholder engagement to bring about the necessary health finance system change.
Gendered analysis of Kenya's health finance market
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The supply of healthcare in Kenya.

Kenya has a wide array of organisations or actors participating in the provision of healthcare services, including health facilities, health workers, including community health workers (CHWs), pharmacies, laboratories, imaging, and digital health service providers as shown in figure 2.1 below.

Figure 2.1: The patient’s journey
Source: Dalberg (2022): Gendered health sector analysis

The supply of healthcare services in Kenya spans the full spectrum of patient needs from preventive/promotive care through to post-treatment management and follow up. Different actors offer services along these points. Preventive and promotive care is largely provided by Community Health Volunteers/Workers (CHWs) and Community Health Assistants (CHAs) and Officers (CHOs).

Pharmacies serve as an important first point of care for many households, especially low-income segments in urban locations. Some estimates suggest that 13.2% of Kenyans visit pharmacies as their first point of contact with the healthcare system, while others indicate that small clinics, pharmacies, and drug shops in East Africa provide over 60% of primary healthcare. Emergency services are often the first point of contact for urgent care, with transport providers being a key component given the high rates of injury in Kenya. However, in most of these cases, the available transport is not specialised so the first point of care is the healthcare facility. Efforts to improve emergency medical care and access are being driven by the Emergency Medical Care Strategy (2020-2025) and the Emergency Medical Care Policy (2020-2030).

Besides the health care facilities (hospitals), screening and diagnostic services are also offered by laboratories and imaging providers. There are about 900 active laboratories in Kenya, with most (522, 58%) of those licensed in Nairobi and the vast majority (505, 96%) being private for-profit labs. The number of computed tomography (CT) scanners in the private sector in urban areas (14.6 units/million) is higher than the Organisation for economic co-operation and development (OECD) average (13.3 units/million) but lower compared than the World health organisation’s (WHO) recommended 20 units/million. The cost and this tilted geographical distribution of diagnostic services affects the equity of access to healthcare.

Digital providers are playing a growing role in the provision of patient services as well as services to providers and the ecosystem. At the patient service level, digital providers offer education and engagement support services, consultation and treatment for conditions that are digitally treatable, screening services, and follow-on support/referral services.

2.1 Healthcare facilities

Kenya has approximately 14,137 healthcare facilities (HCF), with about 46% of these being government owned and the rest are either private, faith-based or non-governmental organisation (NGO) owned. The distribution of the healthcare facilities is skewed with the majority in urban and peri-urban locations as shown in figure 2.2.