



Kenya's universal health coverage

Enhancing value through national/social health insurance

August 2025



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August 2025

This publication presents insights from the health finance tracker survey undertaken **mid-2024**, supplemented with insights from the 2024 FinAccess Household Survey (data collected **September - October 2024**). It is the result of the partnership, expertise, and work of specialists from Financial Sector Deepening Kenya (FSD Kenya) and the Kenya National Bureau of Statistics (KNBS).

About Financial Sector Deepening Kenya (FSD Kenya)

Financial Sector Deepening Kenya (FSD Kenya) is an independent trust dedicated to the achievement of a financial system that delivers value for a green and inclusive digital economy while improving financial health and capability for women and micro and small enterprises (MSEs). [Read more about FSD Kenya here.](#)

About the Kenya National Bureau of Statistics

The Kenya National Bureau of Statistics (KNBS) is a vital institution in Kenya, founded in 2006 with a mandate to collect, analyse, and disseminate statistical data. KNBS provides essential economic indicators like GDP, inflation rates, and unemployment rates, enabling informed policy decisions. [Read more about KNBS here.](#)

Authors: Wanza Mbole, Nancy Atello, Amrik Heyer (FSD Kenya) and Tabitha Mwangi (KNBS)

Contributors: Lucas Sagire, Silvester Mwendwa, Zachary Ochola & Felix Kemboi (KNBS), Sharon Juma (FSD Kenya) and Paul Gubbins (Independent consultant)

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Context

Legal

- Constitution of Kenya, 2010: Access to health a fundamental right.
- The Kenya Vision 2030: 'Provide equitable, affordable & quality healthcare to all citizens' – Universal Health Coverage
- Devolution: Healthcare delivery is a devolved function executed by the 47 counties

Socio-economic

- 52.4 million people (28.3 million aged 20+)
- About 68.9% of population lives in rural areas. Majority of workers including women, are employed in informal sector at 83.6%
- Livelihoods: Agriculture (17.9%), employed (13.2%), casual work (26.5%), own business (16.7%), dependents (22.3%)
- 39.8% (20.2 million) below the national overall/absolute poverty line (rural KShs 4,358 & urban KShs 8,006/month)



Background: National/social health insurance

Kenya's National Health Insurance Fund (NHIF)

- Established in 1966, as the National Hospital Insurance Fund targeting those in formal employment and their dependents - mandatory contributions to meet cost of hospitalisation.
- 1972: Mandate extended to volunteers in the informal sector.
- 2022: Renamed National Health Insurance Fund with an aim of broadening the scope of services/benefits and partner healthcare providers, a step towards UHC

Universal health coverage (UHC)

- Aim: To provide comprehensive care to Kenyans without predisposing them to catastrophic health expenditure (CHE). At least 10% of households' incomes spent on healthcare.
- In Dec 2018, Kenya introduced UHC pilots in 4 counties which entailed subsidised NHIF contributions for all residents in the 4 counties.
- Mixed results: Improvements in health service utilisation in pilot counties but faced design issues, health system and implementation challenges. Pilot insights informed the new Social Health Insurance (SHI) policy.
- SHI policy entails compulsory contribution of 2.75% of gross income by all adult Kenyans to the Social Health Insurance Fund (SHIF) & promises access to comprehensive healthcare.

Understanding the potential impacts of the SHI policy

- [FSD Kenya](#) and [Kenya National Bureau of Statistics](#) (KNBS) designed a health finance tracker, baseline survey undertaken **mid-2024** - about 1,900 completed interviews drawn from FinAccess 2021 (see methodology and interpretation of results).
- Objective: To understand the potential impact of the SHI policy on universal health coverage in Kenya and provide evidence-based policy recommendations
- Tracker survey results were triangulated and/complemented with the bi-annual national [FinAccess household survey 2024](#) (FinAccess 2024) – undertaken in partnership with KNBS and [CBK](#) **late 2024**. Sample: 28,000. Representative at both the national and county levels
- These two surveys serve as a baseline and provide some insights on:
 - How Kenyans were paying for healthcare in the pre-SHI policy era,
 - The value provided by the National Health Insurance Fund (NHIF), and
 - How value under the new social health insurance system might be conceptualised.

Core elements of social/national health insurance in relation to UHC

Insurance coverage

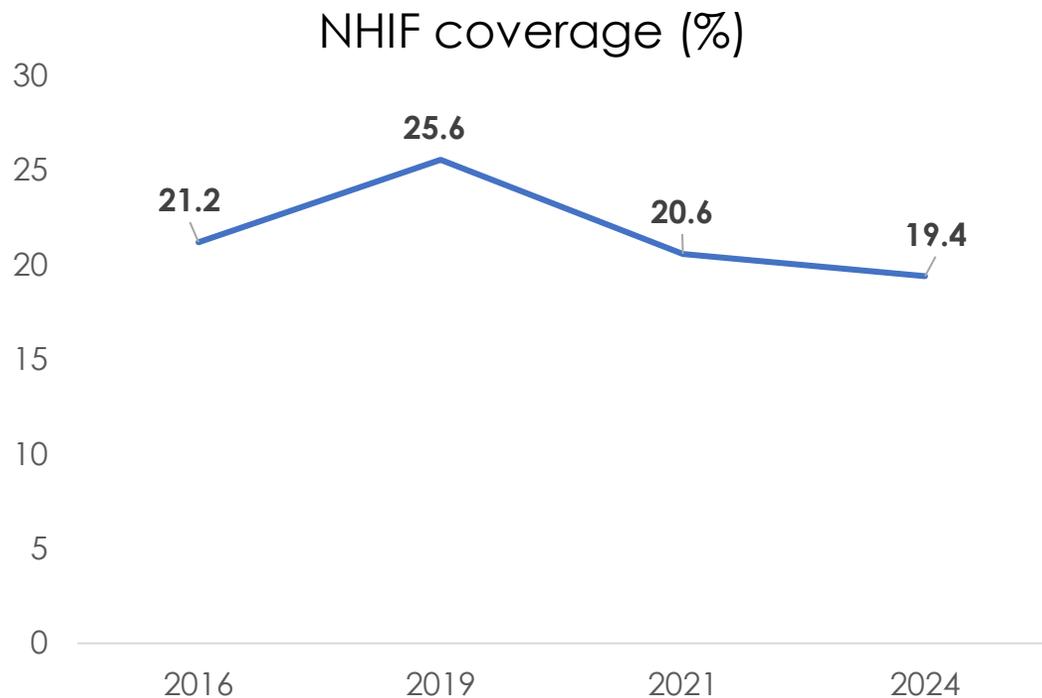
- Ensures inclusivity of all who are targeted
- Financing – public finance and/or those targeted can pay the premiums

Value

- Extent to which the insurance cover is delivering quality healthcare and financial/economic benefits e.g. minimising out of pocket expenditure (OOP)

Insurance coverage

- : **NHIF coverage** was a big problem, reaching only 1/5 of Kenyans,
- : and with very low retention rates in the informal sector.



Source: FinAccess 2024

NHIF retention rate (%)

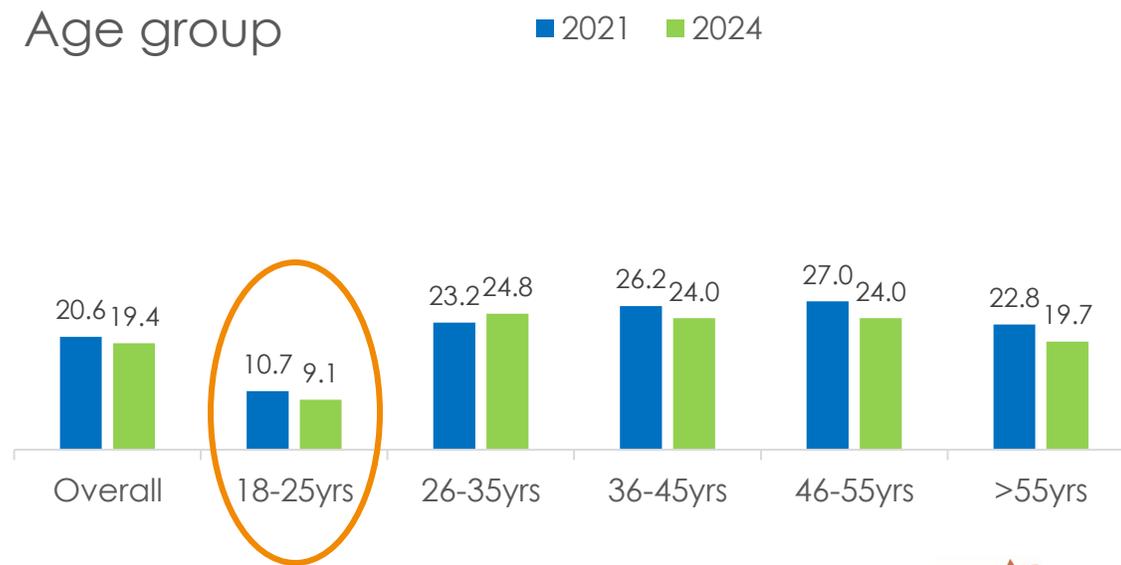
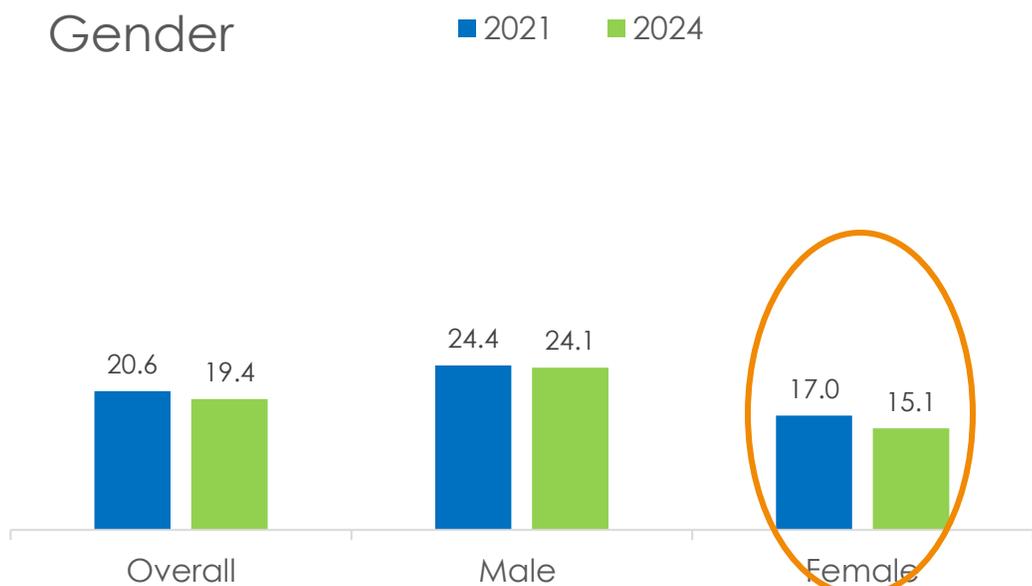
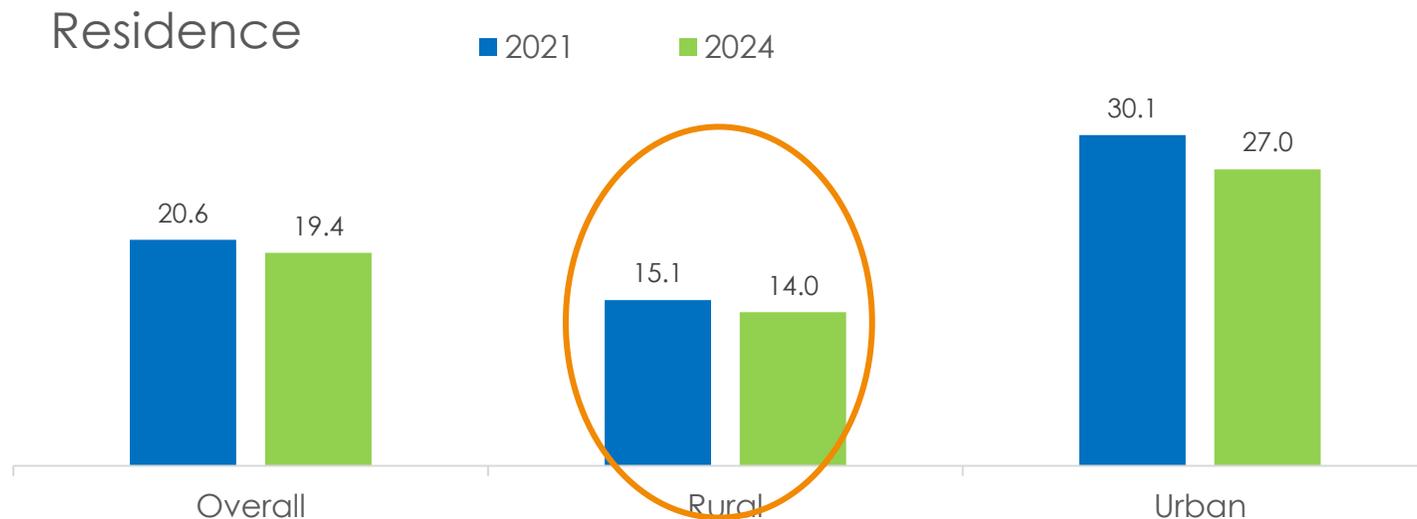
	2021 (NHIF)	2023 (OAG)
Formal	72%	78%
Informal	24%	22%

*Total adult population 28m, 23m in the informal sector.

<https://www.nhif.or.ke/wp-content/uploads/2023/05/REGULATORY-IMPACT-STATEMENT-FOR-NHIF.pdf>

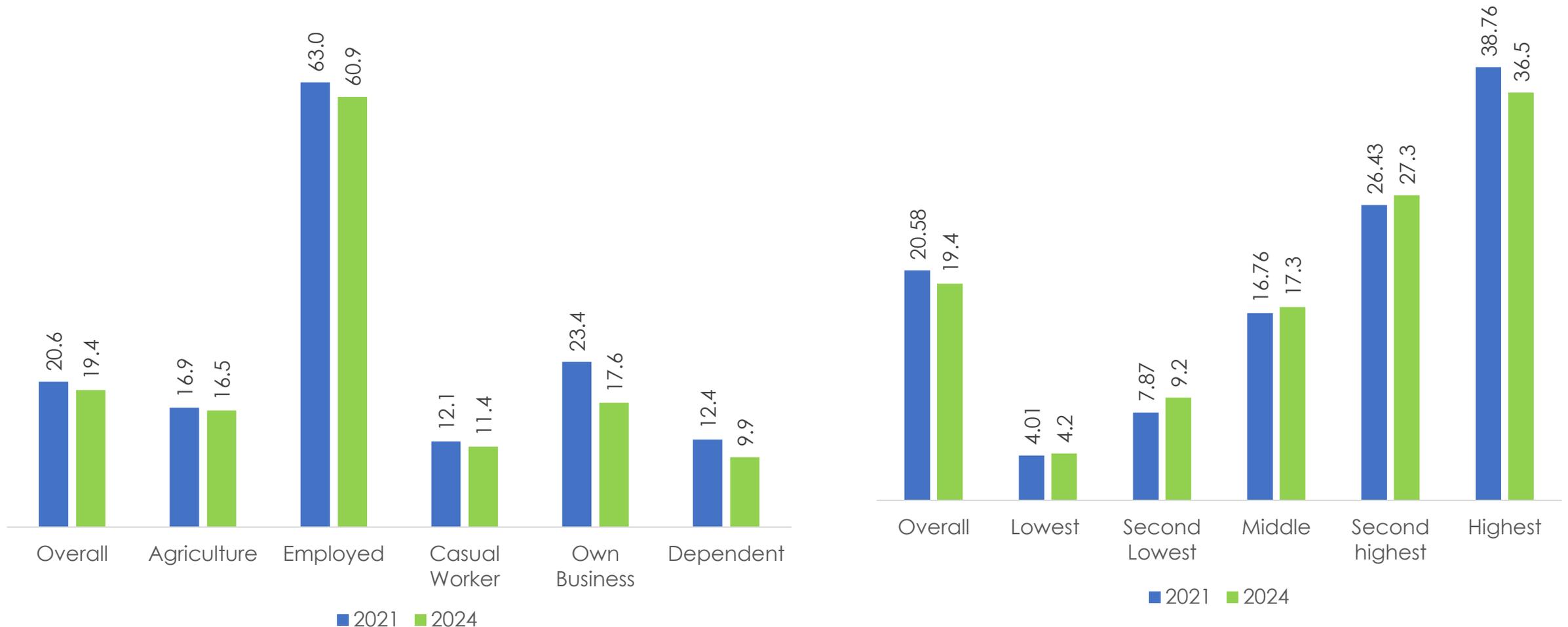
<https://www.oagkenya.go.ke/wp-content/uploads/2024/06/National-Hospital-Insurance-Fund-.pdf>

NHIF coverage (%) varied across residence, gender & age



Source: FinAccess 2024

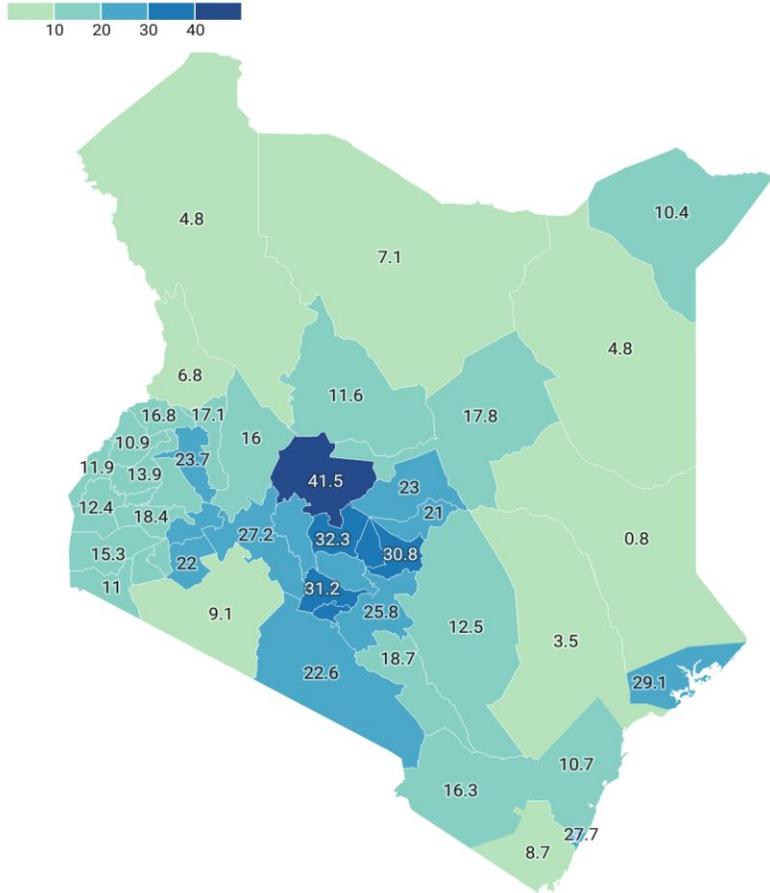
- ... and was concentrated among higher wealth quintiles and the employed



Source: FinAccess 2024

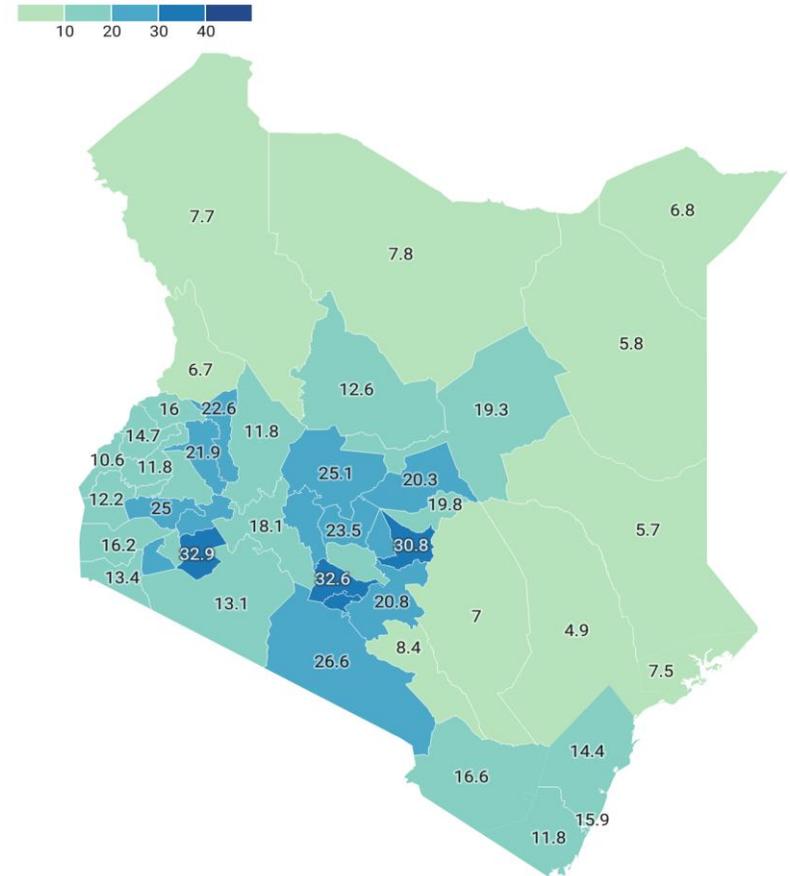
NHIF coverage across counties and time

NHIF by county 2021



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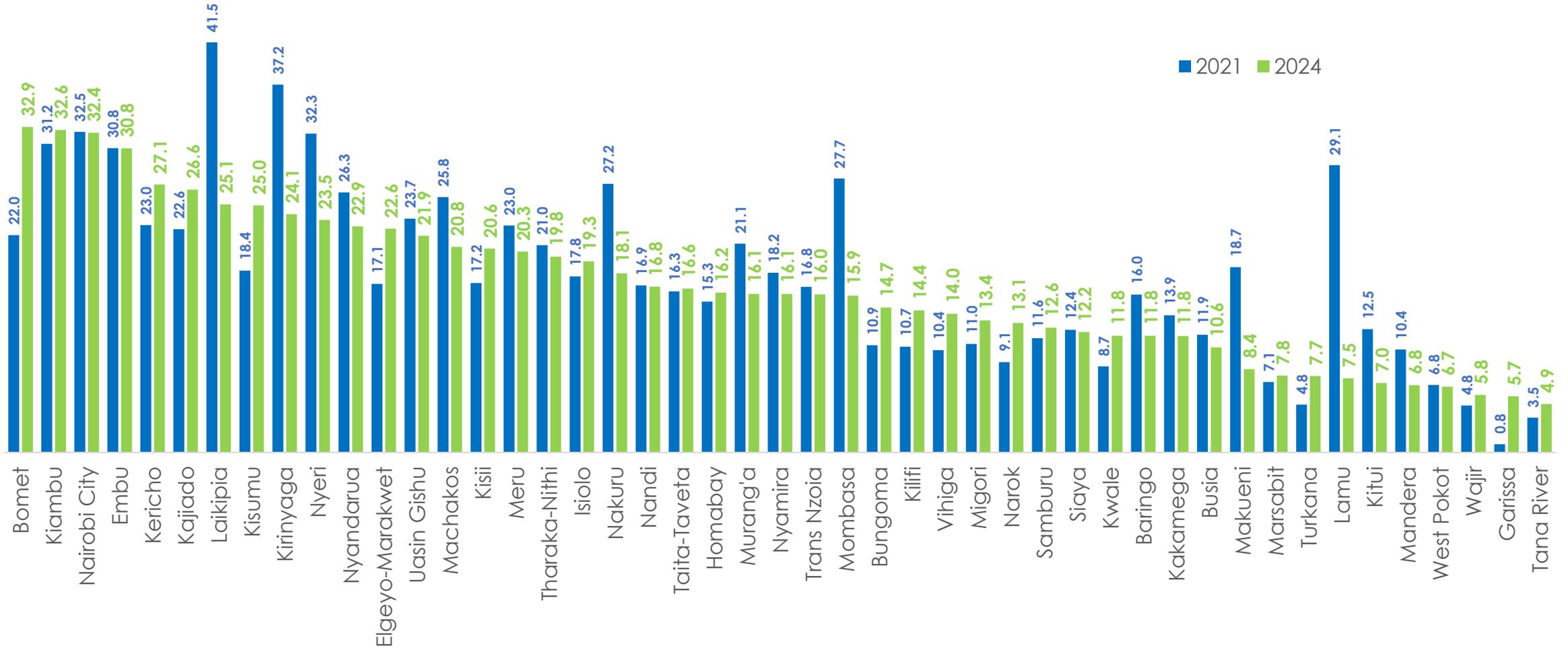
NHIF by county 2024



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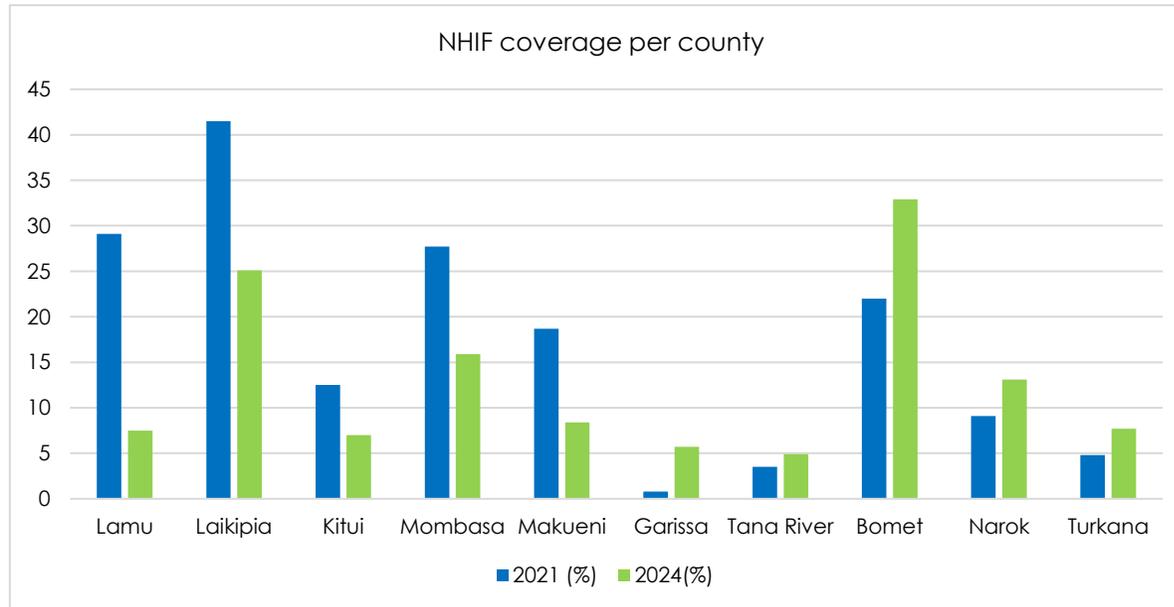
Source: FinAccess 2024

NHIF coverage across counties and time



Source: FinAccess 2024

UHC financing efforts have not been consistent



County	2021 (%)	2024(%)	Change (%)
Lamu	29.1	7.5	-74%
Laikipia	41.5	25.1	-40%
Kitui	12.5	7	-44%
Mombasa	27.7	15.9	-43%
Makueni	18.7	8.4	-55%
Garissa	0.8	5.7	613%
Tana River	3.5	4.9	40%
Bomet	22	32.9	50%
Narok	9.1	13.1	44%
Turkana	4.8	7.7	60%

Source: FinAccess 2024

Drop

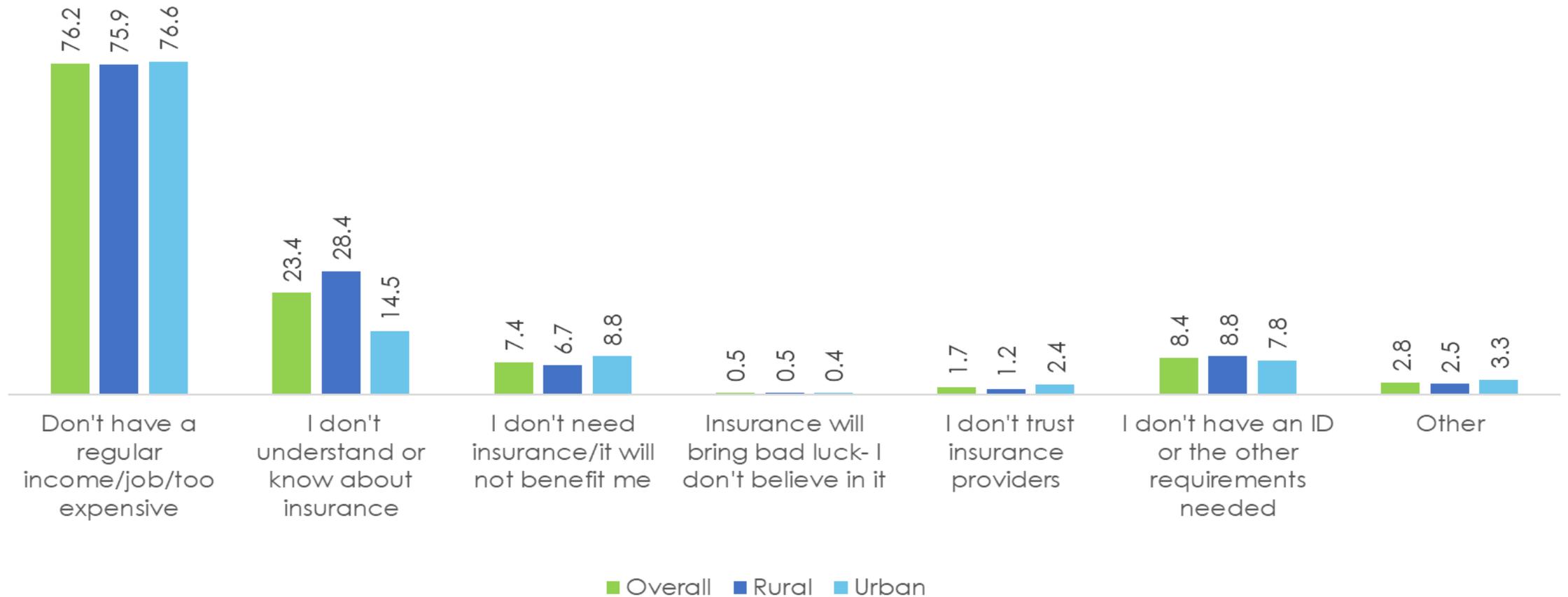
- Lamu (-74%): UHC programme subsidised contributions by the county government to NHIF was discontinued.
- [Makueni](#) (-55%): MakueniCare (community healthcare insurance) by county government discontinued.

Increase

- [Garissa](#) (+613%): NHIF subsidy programme by the national government.
- [Turkana](#) (+60%): Subsidised NHIF contributions as part of the World Bank funded Kenya Social and Economic Inclusion Project (KSEIP).
- [Bomet](#) (+50%): NHIF subsidy programme by county government.

- **Affordability was the biggest barrier to NHIF uptake followed by lack of awareness**

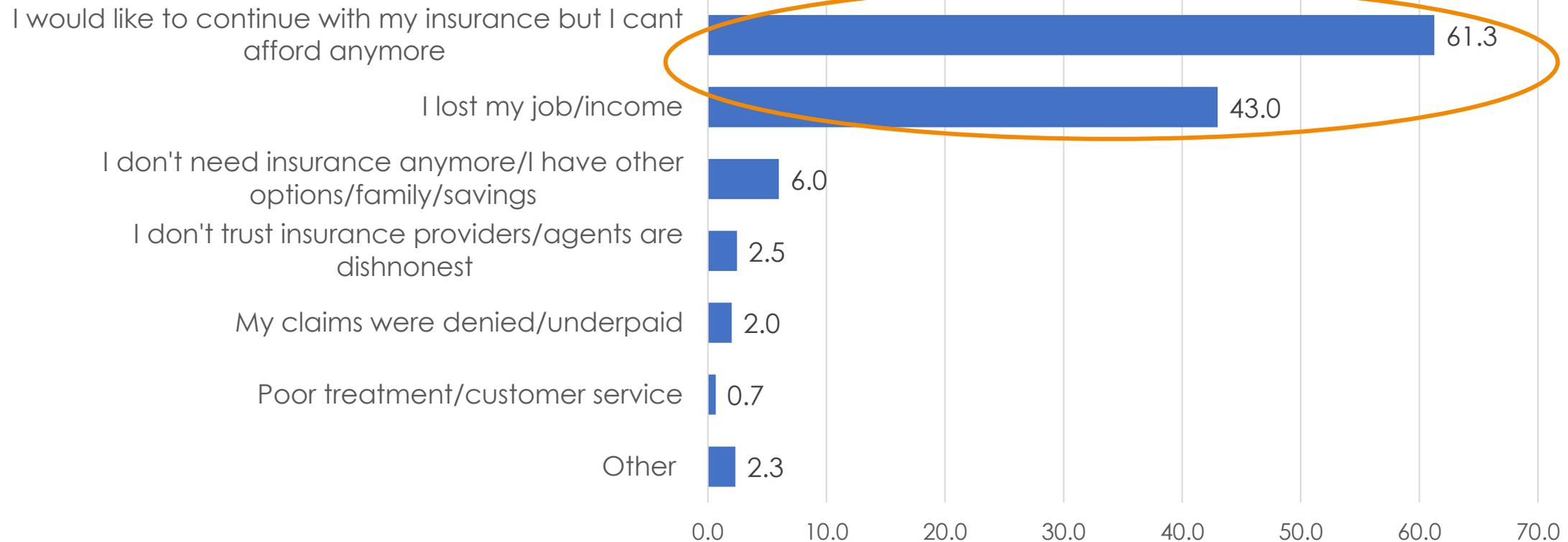
Reasons never had NHIF insurance



Source: FinAccess 2024

- NHIF premiums (@KShs 500 -1,700/month) were a burden and the
- main reason for low coverage and retention

Reason for stop of use of NHIF (%)

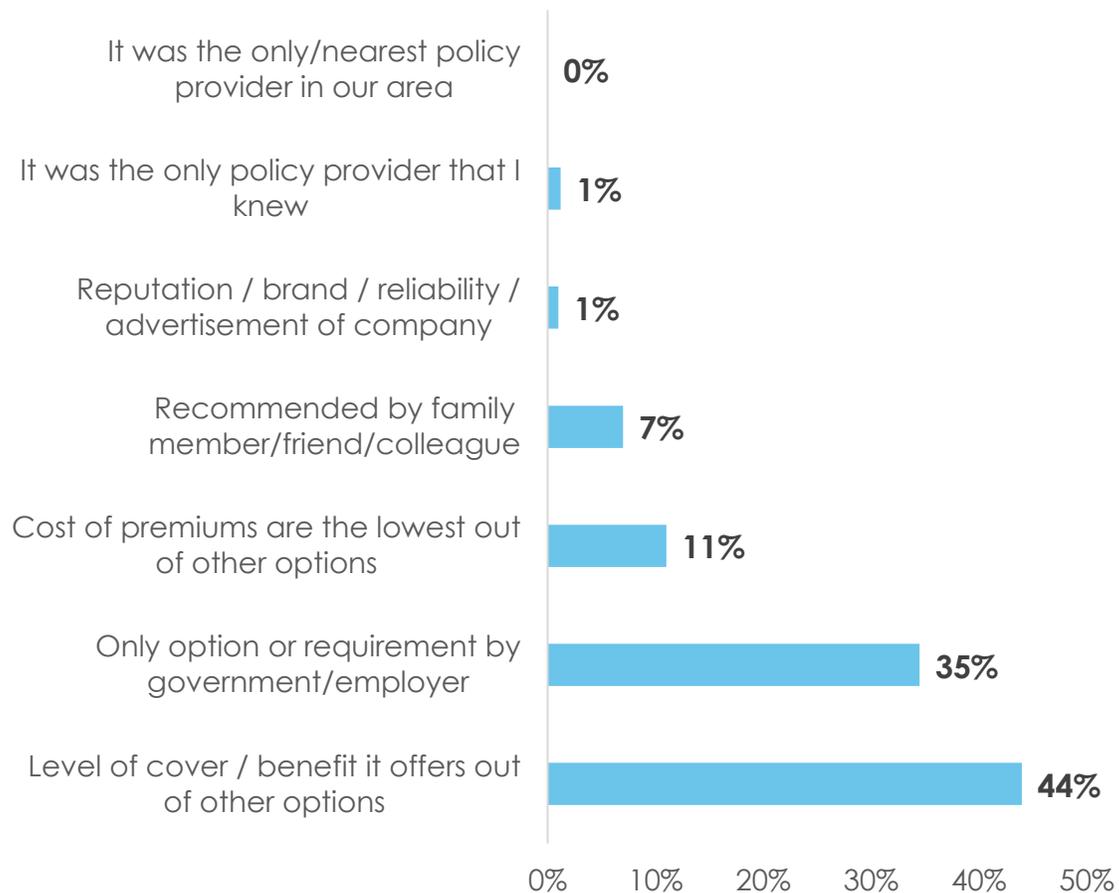


Source: Health finance tracker survey, 2024

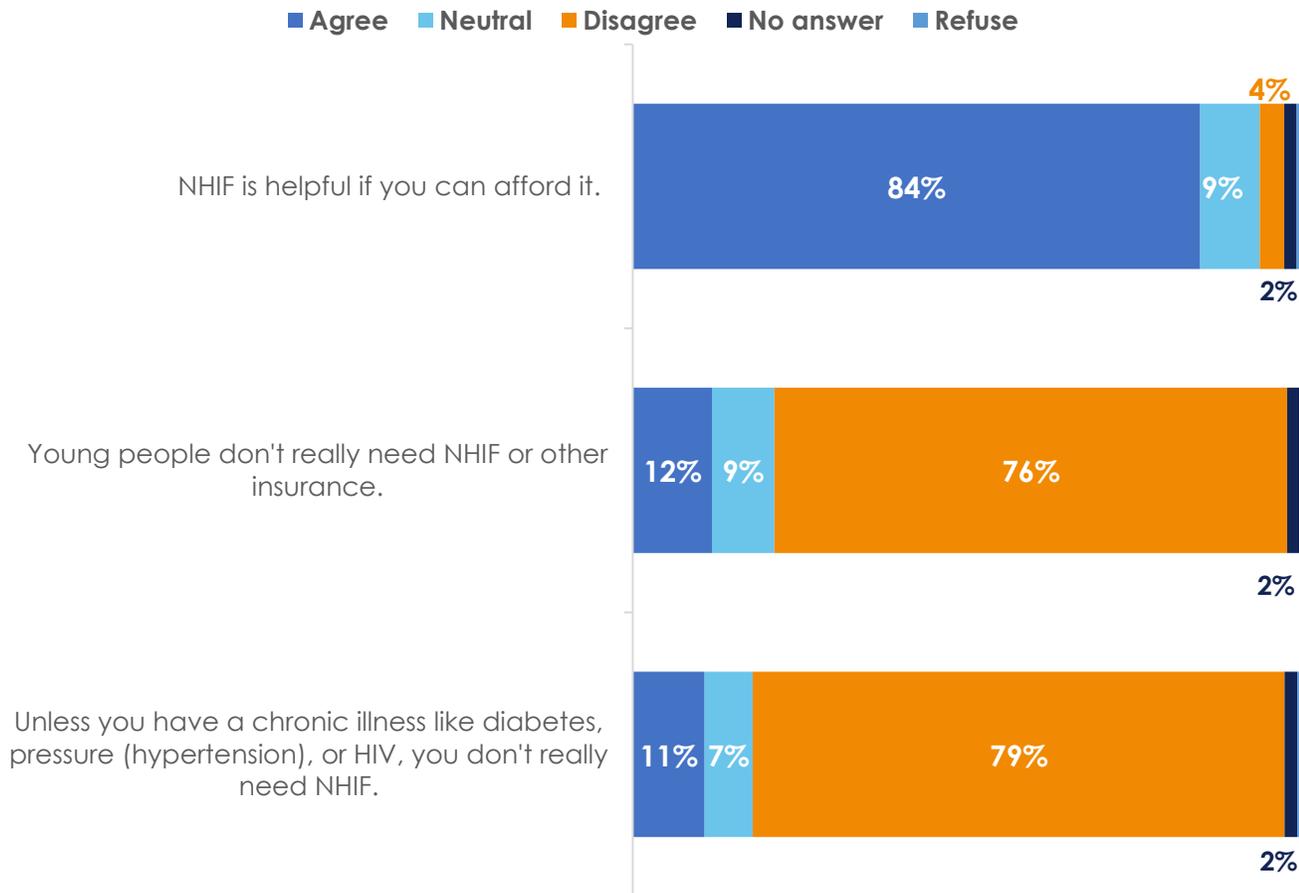
Value

The perceived **value** of NHIF to most Kenyans was high.

What was the main reason you chose NHIF?

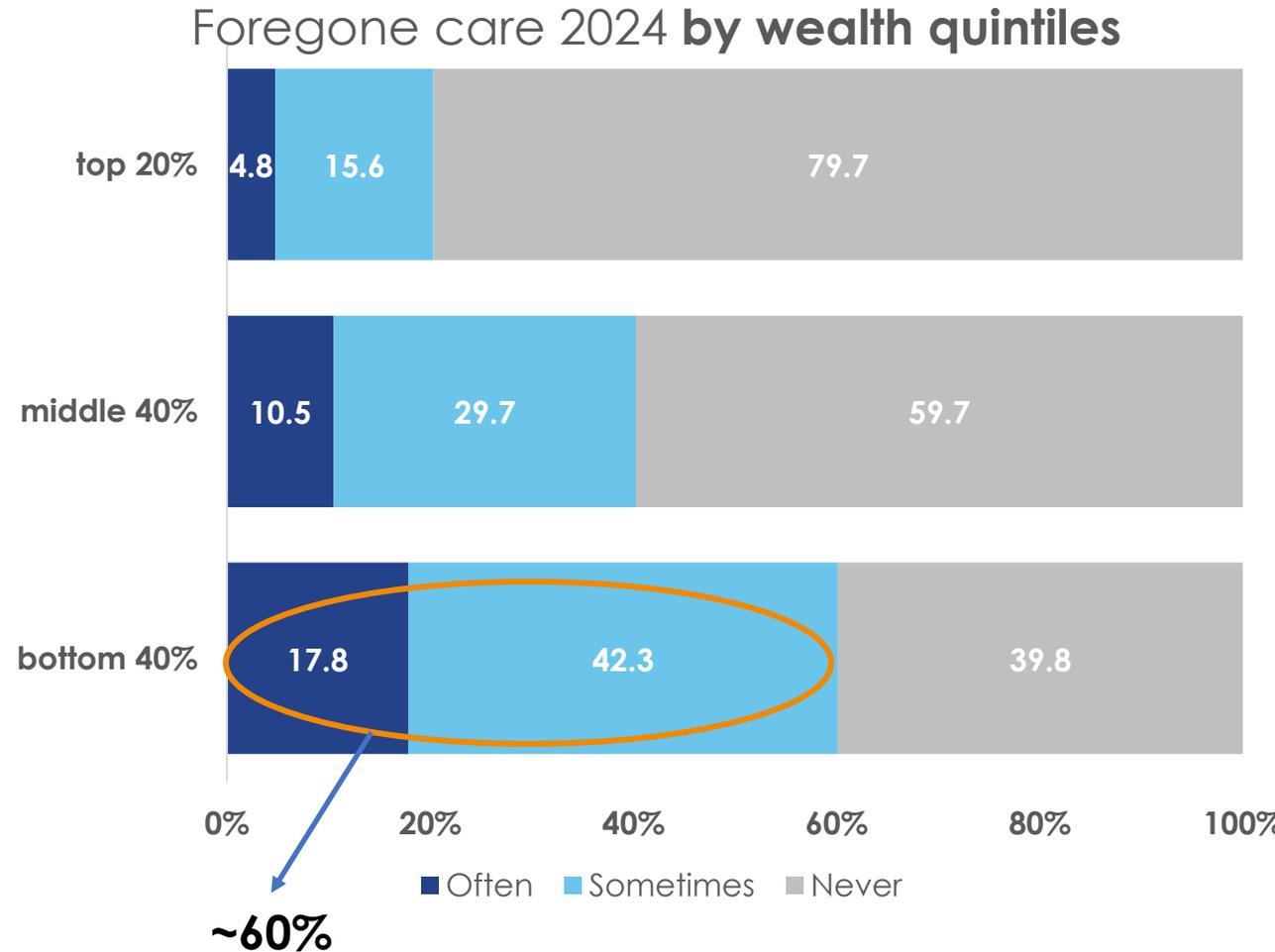
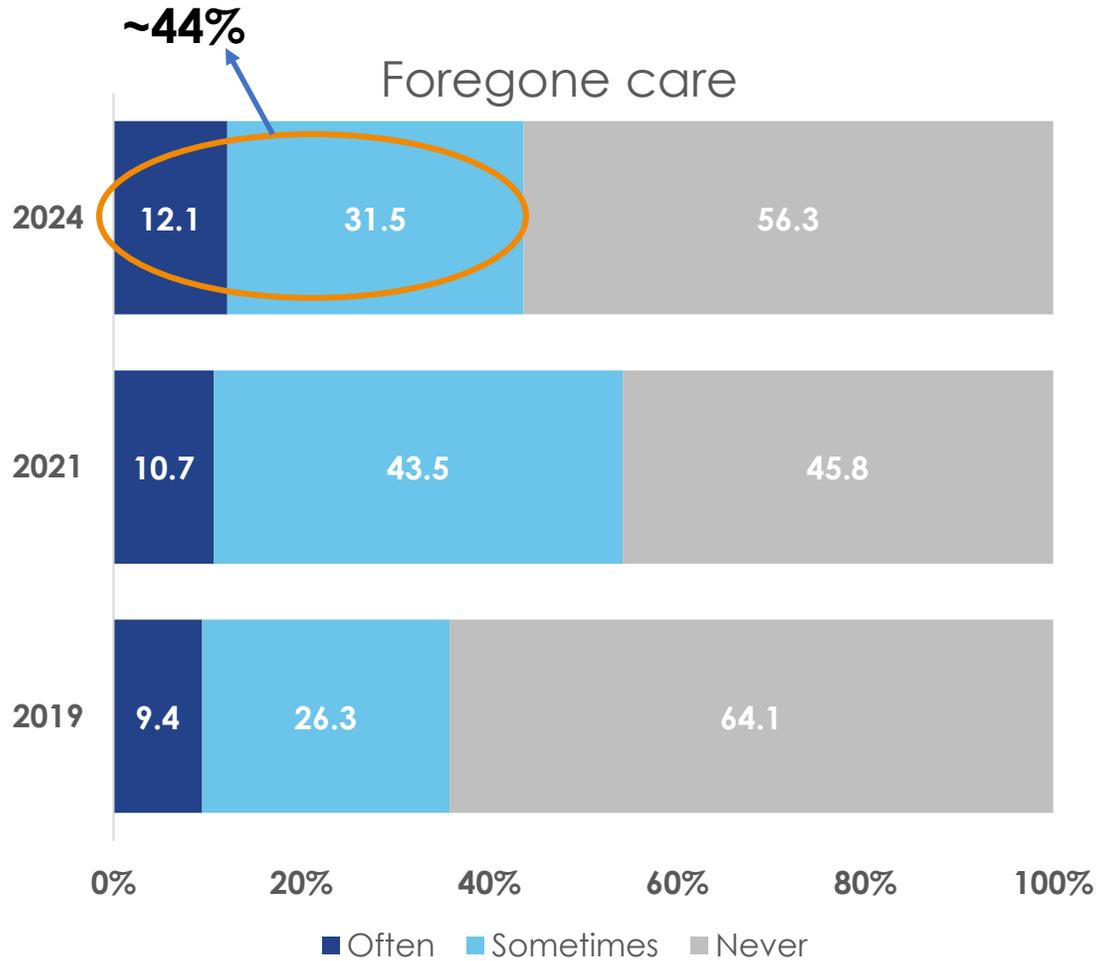


Perceptions about NHIF (users and non-users)



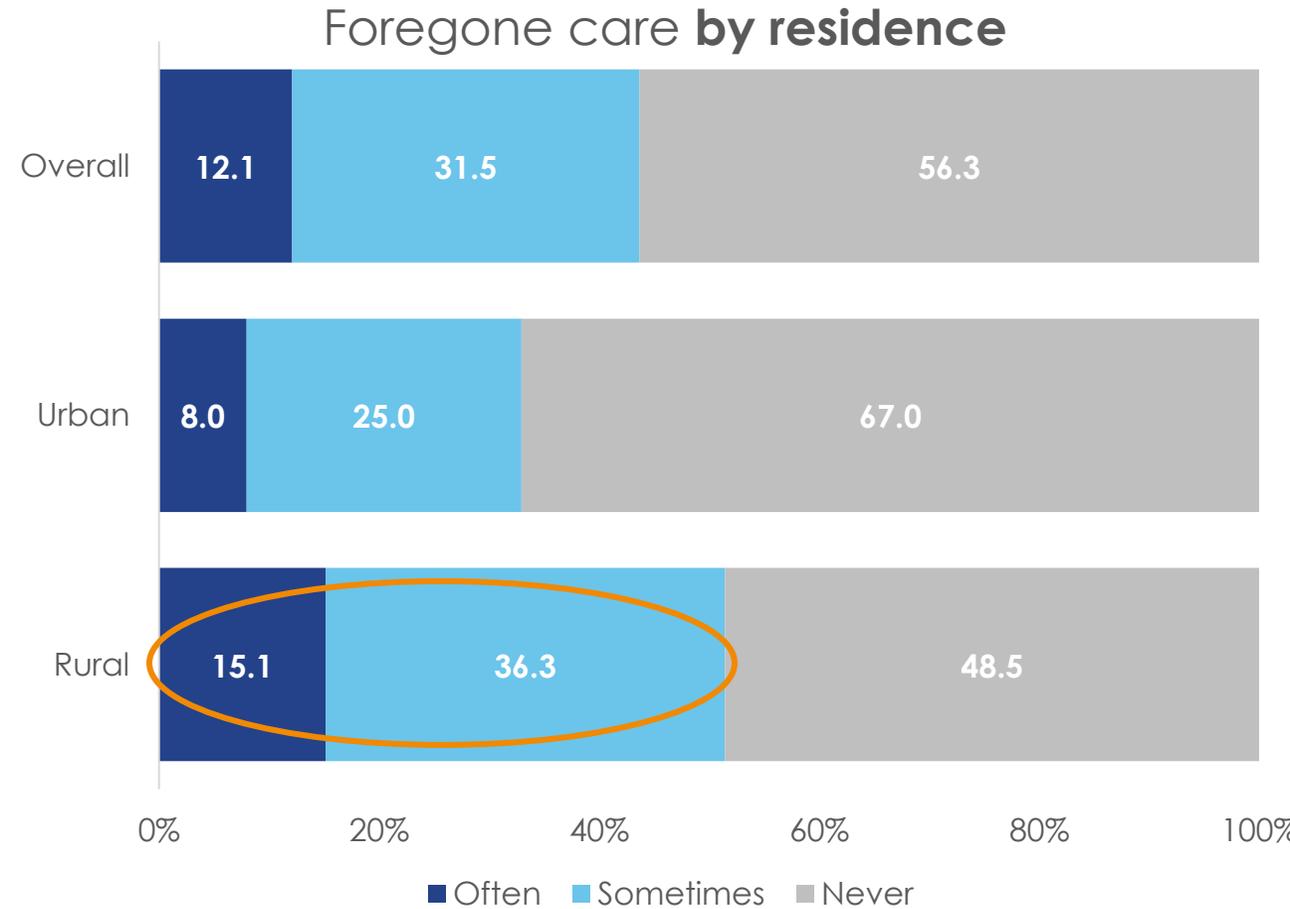
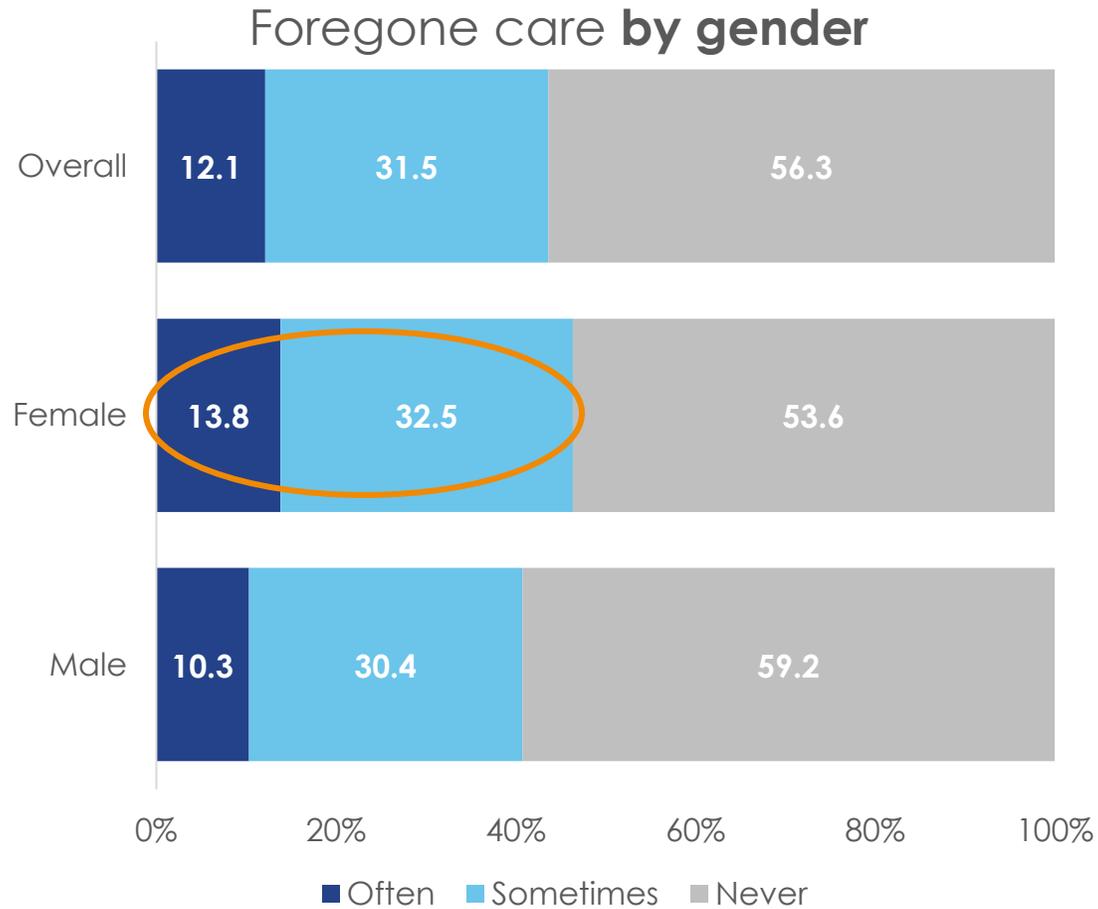
Source: Health finance tracker survey, 2024

- Many Kenyans went without healthcare, especially poorer households (60%)



Source: FinAccess 2024

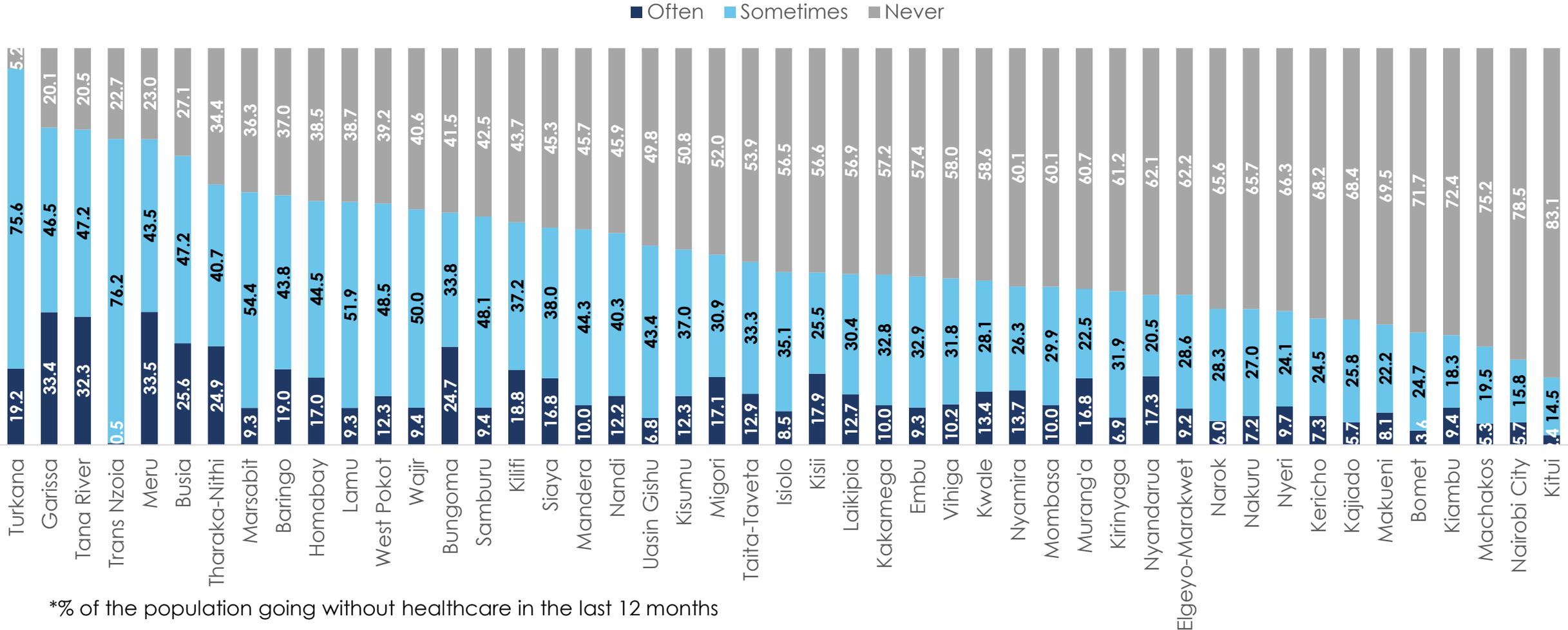
- More Kenyans in rural areas and women went without care compared to those in urban areas and men.



Source: FinAccess 2024

Going without healthcare also varied across counties

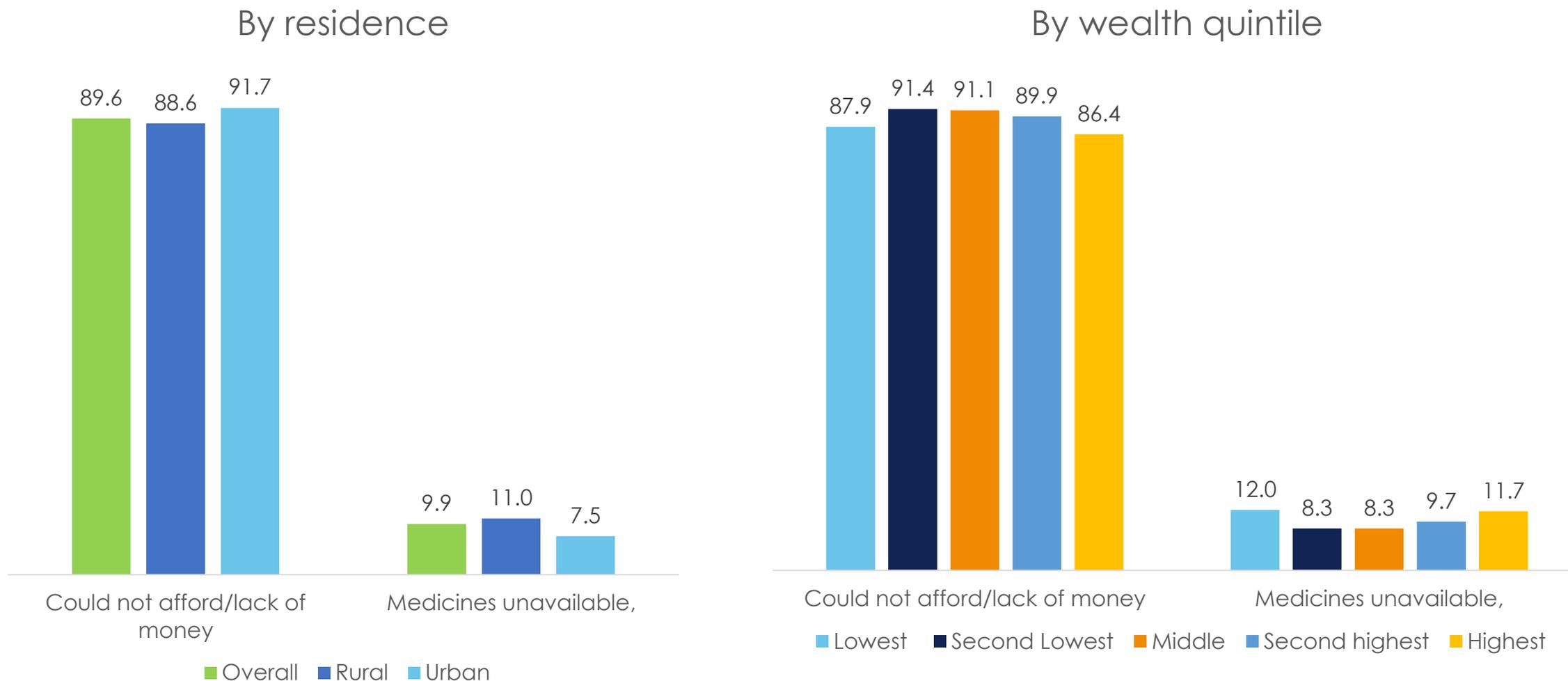
Forgone care by county (%)



*% of the population going without healthcare in the last 12 months

Source: FinAccess 2024

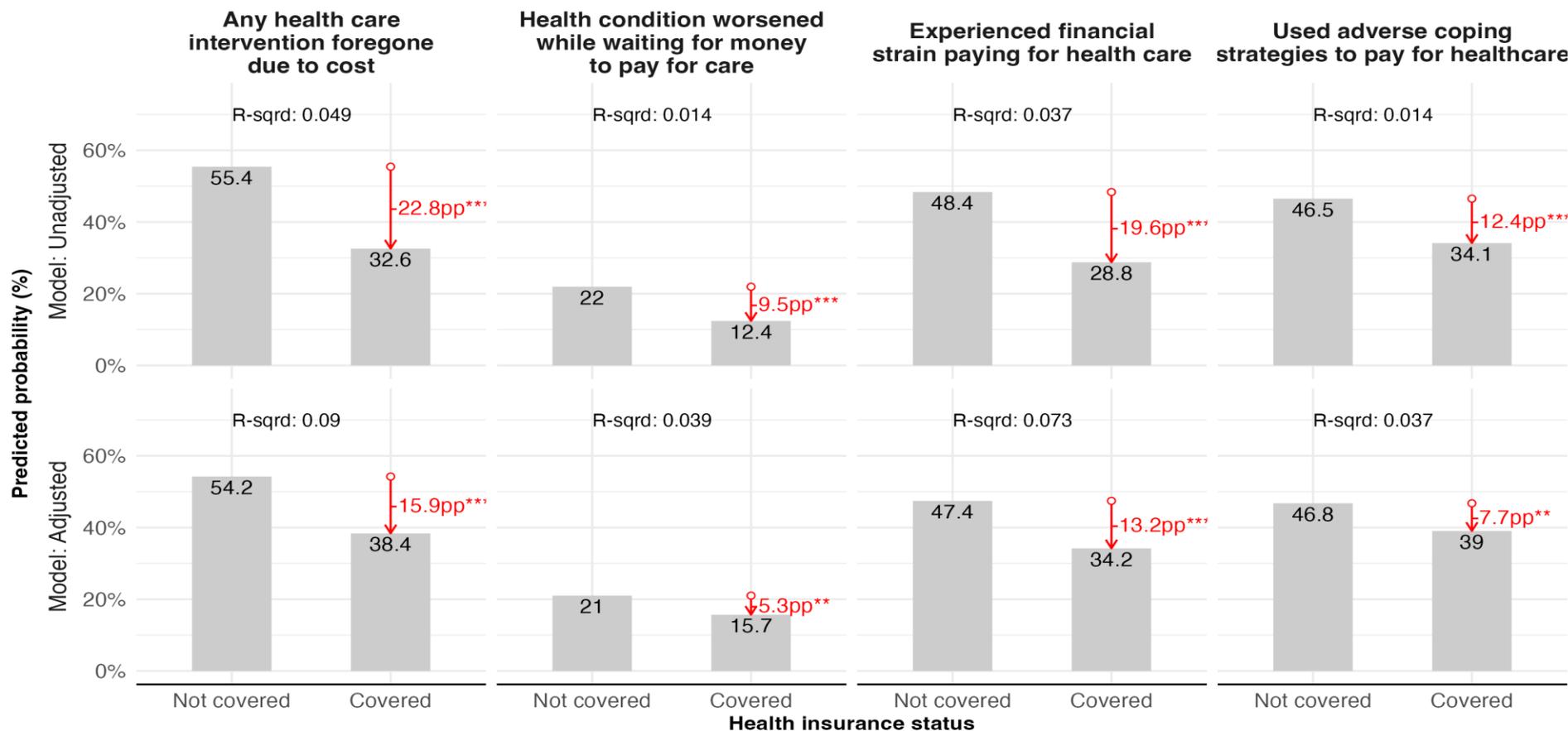
Affordability was the main reason for foregoing healthcare



Source: FinAccess 2024

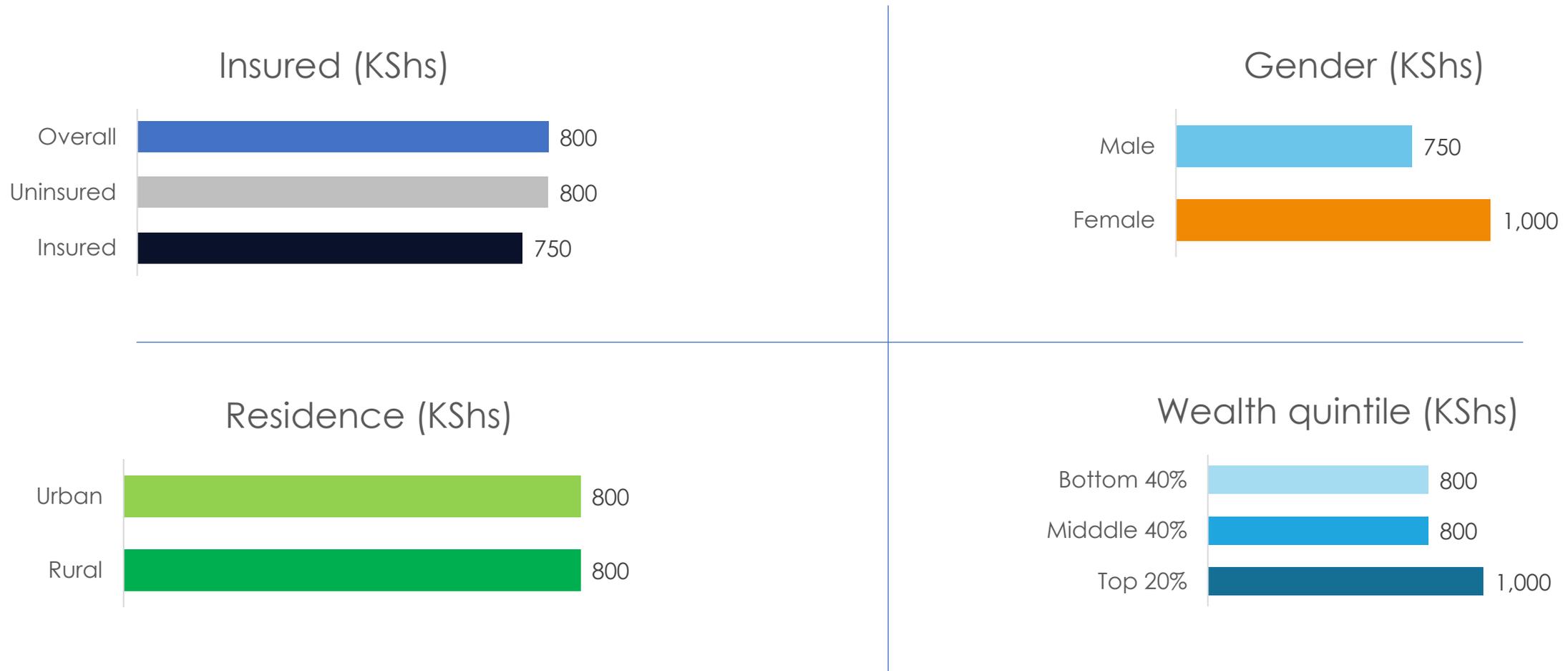
Having health insurance (NHIF) minimised foregone care and financial strain from health events

Observational estimates of the effect of health insurance on care-seeking and financial wellbeing



Notes: The results shown are based on a linear regression model that measures the effect of health insurance coverage on several outcomes of interest. The 'unadjusted' model does not include any additional controls, while the 'adjusted' model includes controls for three variables that theoretically confound the relationship between insurance and the outcomes explored here: years of education, an asset index (to proxy income) and employment. The regression parameters are used to compute predicted probabilities for adults whose main source of income is not from employment and who have mean levels of educational attainment and wealth, with and without health insurance coverage.

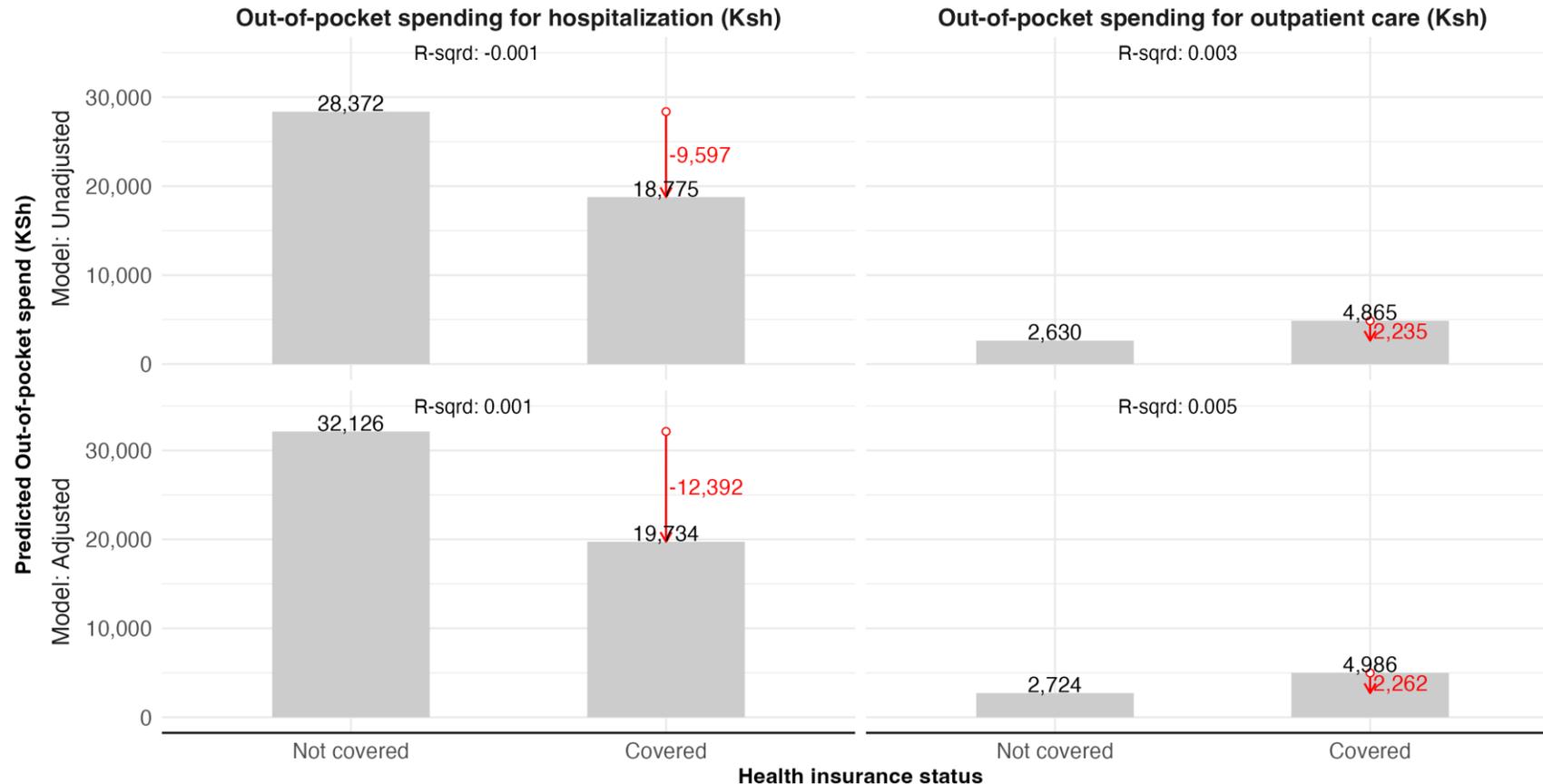
- However, even those with health insurance (NHIF)
- still spent notable amounts OOP on healthcare



Source: FinAccess 2024

- Having health insurance (NHIF) seemed to reduce OOP spending on hospitalisation but results were not statistically significant.

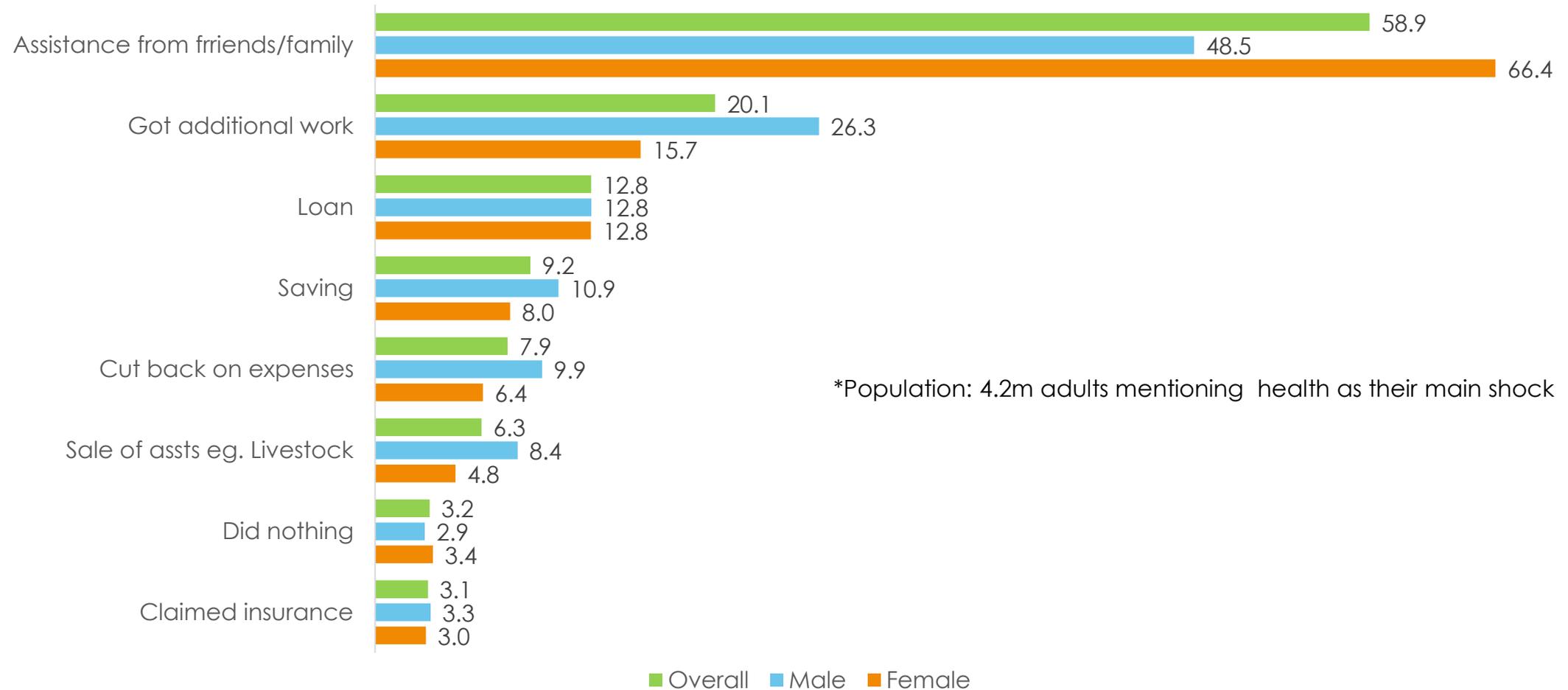
Observational estimates of the effect of health insurance on out-of-pocket inpatient spending



Notes: The results shown are based on a linear regression model that measures the effect of health insurance coverage on how much a household incurred in out-of-pocket (OOP) spending from a recent hospitalization. The 'unadjusted' model does not include any additional controls, while the 'adjusted' model includes controls for three variables that theoretically confound the relationship between insurance and OOP spending: years of education, an asset index (to proxy income) and employment. The regression parameters are used to compute the predicted spending for adults whose main source of income is not from employment and who have mean levels of educational attainment and wealth, with and without health insurance coverage.

Source: Health finance tracker survey, 2024

In absence of health insurance (NHIF) Kenyans largely relied on friends and family to deal with health shocks



Source: FinAccess 2024

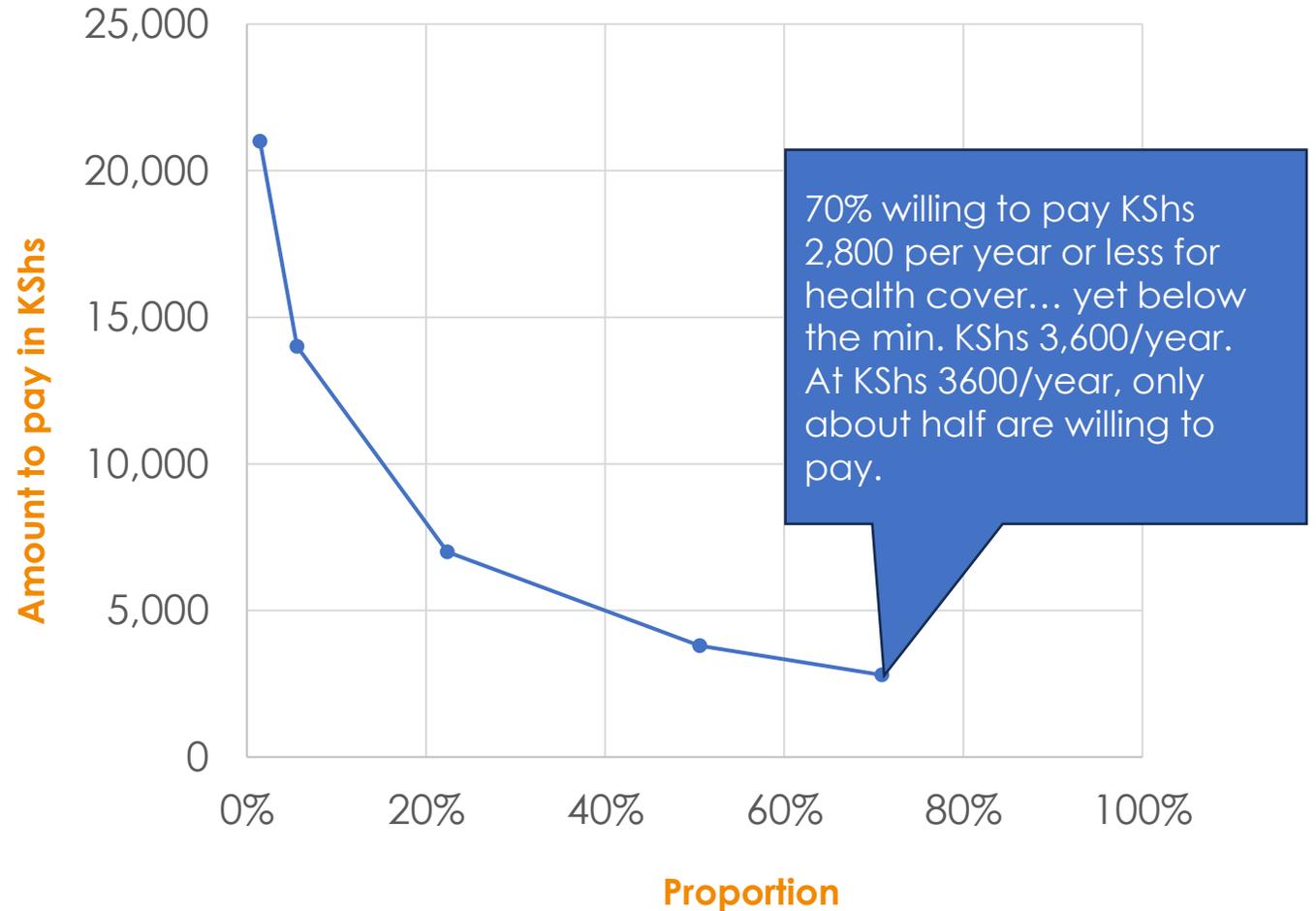
Implications for social health insurance and universal health coverage

- **Affordability: Ability and willingness to pay are likely to remain significant challenges to enrollment and retention**

70% of individuals were willing to pay a maximum of KShs 2,800/year for SHIF if it covers all their health needs – no OOP.

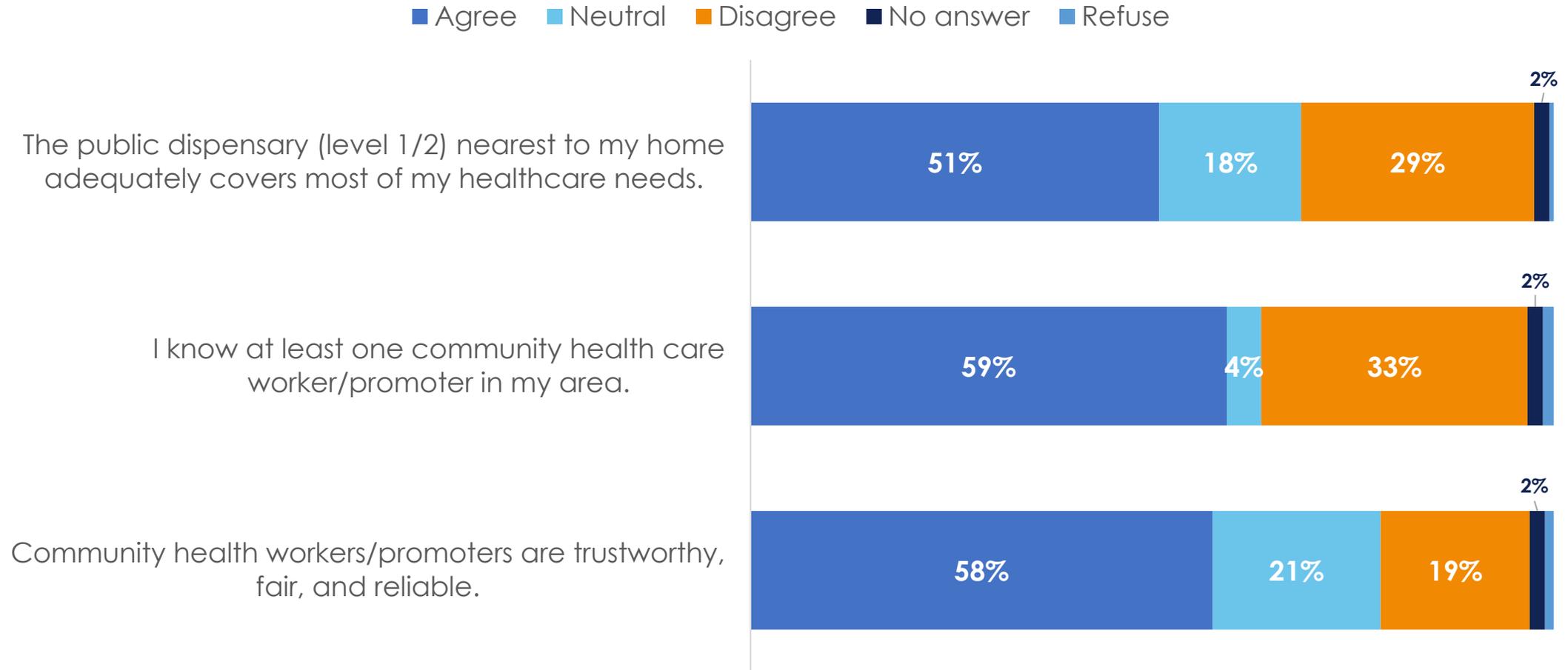
At 2.75% of gross income/salary, SHIF is more expensive than NHIF for about 20% of those formally employed (those earning more than KShs 35,000/month)

Informally employed: Minimum premium KShs 300/month or (KShs 3600/year) based on means testing; indigents contributions to be subsidised by government



Source: Health finance tracker survey, 2024

- **Accessibility: Dispensaries meet about 50% of the health needs & community health promoters (CHPs) are known and trusted by about 60%**



Source: Health finance tracker survey, 2024

SHI policy current status : Insurance coverage & value

Insurance coverage

- The intention of the SHI policy is universal coverage
- [21.3m Kenyans enrolled by April 2025 but only 4.4 were contributing](#) (mainly those in formal employment with only 1.4m in informal sector)
- Hard to collect premiums from those in the informal sector
- Premiums for those in the informal sector are unclear (based on means testing)
- Willingness and ability to pay is modest, even for a higher value cover.

Value

- Only ~20% of Kenyans were previously paying for health insurance
- Current SHIF benefits not yet as comprehensive as NHIF's
- Not clear extent to which cover will affect out of pocket spending on healthcare – need for continuous monitoring
- Bigger role envisaged for CHPs and local dispensaries - not certain they can deliver the envisaged care
- Opportunity costs of paying SHIF premiums for households not yet known - could be substantial

Source: Health finance tracker survey, 2024

How could the impact of the new SHI policy be assessed?

Insurance coverage

- What is SHIF overall coverage and retention rates and for specific wealth quintiles/demographics?
- How much are premiums in nominal terms and as a share of household income?

Value

- Are Kenyans able to access quality and comprehensive healthcare within reach?
- Does the SHIF reduce OOP spending and foregoing care for households?
- Does SHIF reduce CHE across wealth quintiles?
- Does it improve health outcomes?
- What are the opportunity costs of SHIF premium financing? e.g. going without food, children staying out of school, etc

Conclusion and recommendations

- NHIF was highly valued by both the insured and uninsured. It set the baseline in relation to perception of value and expectations from a public/social health insurance. Affordability (KShs 500 for the 85% informal sector) was the main reason for low overall coverage (20%), with retention rates very low especially for the informal sector.
- Implications of new SHI policy
 - Proposed rates not affordable for most Kenyans – may need to be reduced or subsidised.
 - Maternal and neonatal care was subsidised by the government under [Linda Mama programme](#) and may need to be sustained.
 - Expectations in terms of value will be high – comparable to NHIF. It needs to decrease out of pocket expenditure (OOP) by households and increase access to quality healthcare.
 - Determination and collection of premiums for the informal sector is likely to remain a big challenge due to lack of visibility of incomes and a way of tapping of premiums at income source
 - SHI initiatives at county level need to be sustained across administrative cycles for impact on UHC
- Need to continue to monitor the impacts of the SHI policy on Kenyans'
 - Insurance coverage especially ability to pay
 - Ability to access quality healthcare and households' OOP expenditure, and
 - To provide evidence-based policy recommendations

Methodology and interpretation of results

Methodology and interpretation of results

Sampling methodology: Identification of target respondents

- The sample for the tracker survey was drawn from respondents of the FinAccess 2021 survey who had consented to follow-up interviews and provided a telephone number. The sample was explicitly stratified by livelihood categories and usage of insurance (specifically NHIF and private insurance).
- The number of individuals to be interviewed was influenced by:
 - The list of persons from the FinAccess 2021 survey who owned phones, consented to follow-up interviews and were successfully contacted and interviewed during the tracker survey.
 - Experiences from previous tracker surveys regarding attrition rates of telephone interviews and feasibility of data collection within a 15-day period.

Source: Health finance tracker survey, 2024

Methodology and interpretation of results

Explicit stratification and weighting

- The study weights are based on the FinAccess 2021 survey. The base weights were adjusted based on the selection probability and non-response for the tracker survey.
- The sample was explicitly stratified by livelihood categories and usage of insurance (specifically NHIF and private insurance).
- The study weights are based on the FinAccess 2021 survey and an additional weight is calculated based on their selection probability in the tracker survey from the number of individuals that consented. A significant challenge was non-response, with more than half of the selected sample not participating due to issues like phone numbers being off or owned by someone else.
- After correction for non-response and even with weighting, the sample over-represents certain groups (e.g., those with insurance, those in higher wealth quintiles) compared to national averages.

Source: Health finance tracker survey, 2024

Methodology and interpretation of results

The regression analysis controls for:

- Income (proxied with asset-index): Individuals with higher incomes are more likely to afford health insurance and have savings to cover the costs of healthcare. Income was proxied using the continuous version of the asset index.
- Main income source is employment: Employed individuals have benefits that often include health insurance, they also have more stable incomes which increase their ability to pay for care when needed
- Years of education: Individuals with higher education are more knowledgeable about the importance of health seeking and also more likely to understand insurance. To calculate years, we assign individual years to each of the attainment categories.

Interpretation of findings

- The analysis and interpretation of results is based on the limitations of the survey study (telephone interviews) and sampling.
- Due to the specific sampling strategy that focused on livelihood categories and insurance usage (NHIF and private insurance), the reporting is informed by the defined categories.
- For example, comparisons have been made between insured in agriculture versus uninsured, rather than making broad claims about the overall insured or uninsured population in general.

Source: Health finance tracker survey, 2024



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Green Suites Palm Suite,
Riverside, Riverside Drive,
P.O. Box 11353, 00100,
Nairobi, Kenya.

www.fsdkenya.org

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