

MINISTRY OF HEALTH

Regulatory Impact Statement for

The Social Health Insurance Regulations,

2024 and the Social Health Insurance

(Tribunal Procedure) Rules, 2024

This Regulatory Impact Statement (RIS) has been prepared by the Ministry of Health in consultation with the Social Health Authority for the Social Health Insurance Regulations, 2024 and the Social Health Insurance (Tribunal Procedure) Rules, 2024 pursuant to Section 6 and 7 of the Statutory Instruments Act (No. 23 of 2013)

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DEFINITION OF TERMS

"Injuries" means results from road traffic crashes, falls, drowning, burns, poisoning and acts of violence against oneself or others, among other causes.

"Regulation-making authority" means any authority authorized by an Act of Parliament to make statutory instruments.

"Purchasing" means the process by which pooled contributions are used to pay providers to deliver a set of health interventions.

"Statutory instrument" means any rule, order, regulation, direction, form, tariff of costs or fees, letters patent, commission, warrant, proclamation, by-law, resolution, guideline or other statutory instrument issued, made or established in the execution of a power conferred by or under an Act of Parliament under which that statutory instrument or subsidiary legislation is expressly authorized to be issued.

CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 PURPOSE OF THE REGULATORY IMPACT STATEMENT

The *Statutory Instruments Act, 2013* under sections 6 and 7(1) and (2) requires a Regulatory Impact Statement to be prepared by the regulation-making authority for any proposed statutory Instrument that is likely to impose significant costs on the community or a part of the community. It also requires that there is a process of public consultation in developing the proposed regulatory measures. The Regulation-making Authority for **Social Health Insurance Regulations, 2024 and the Social Health Insurance (Tribunal Procedure) Rules, 2024** is the Cabinet Secretary for Health and the Board of the Social Health Authority.

Under the *Statutory Instruments Act, 2013*, a regulatory impact statement shall contain;

- a) a statement of the objectives of the proposed legislation and the reasons for them;
- b) a statement explaining the effect of the proposed legislation, including in the case of a proposed legislation which is to amend an existing statutory instrument the effect on the operation of the existing statutory instrument;
- c) a statement of other practicable, means of achieving those objectives, including other regulatory as well as non-regulatory options;

- d) an assessment of the costs and benefits of the proposed statutory rule and of any other practicable means of achieving the same objectives;
- e) the reasons why the other means are not appropriate;
- f) any other matters specified by the guidelines; and
- g) a draft copy of the proposed statutory rule.

The Regulatory Impact Statement process is intended to ensure that regulations are only implemented when there is a justified need and that only the most efficient forms of regulations are adopted. The Regulatory Impact Statement (RIS) process involves an assessment of regulatory proposals and allows members of the community to comment on proposed regulations before they are finalized. Such public input provides valuable information and perspectives and improves the overall quality of regulations.

Section 5 of the *Statutory Instruments Act, 2013* requires that a regulation-making authority conducts public consultations drawing on the knowledge of persons having expertise in fields relevant to the proposed statutory instrument and ensuring that persons likely to be affected by the proposed statutory instrument are given an adequate opportunity to comment on its proposed content.

1.2 Scope of the Regulatory Framework

The Social Health Insurance Regulations, 2024 (Regulations) and the Social Health Insurance (Tribunal Procedure) Rules, 2024 (Rules) (hereinafter referred to as "statutory instruments" are made pursuant to Sections 24, 30, 44(6), 46(2), 47(5) and 50(1) of the Social Health Insurance Act, No. 16 of 2023(hereinafter referred to as "the Act"). The regulations seek to provide for the management of the three Funds, payment of claims to healthcare providers and health facilities and ensure equitable access to essential healthcare for all Kenyans.

The scope of the statutory instruments is to:

- a) set out the procedure for procedure for the registration of members and change of beneficiaries;
- b) set out the manner of making contributions;
- c) set out the criteria and procedure for empanelment and contracting of healthcare providers and health facilities;
- d) provide for the measures that the Funds shall take to enhance access to safe and quality services offered by healthcare providers and to ensure that the public can access healthcare services from qualified and licensed healthcare providers;
- e) implement a system for pooling of resources and risks based on the principles of solidarity, equity and efficiency to guarantee access to health care services for all;
- f) define the benefits package;
- g) outline the benefits payable and how the payment of claims will be processed; and
- h) establish a Centralised Digital Platform for purposes of claims administration, recording beneficiaries' data and healthcare service delivery data and maintaining healthcare providers' data; and
- i) operationalize the Dispute Resolution Tribunal.

1.3 Objectives of the Statutory Instruments

The objective of the Statutory Instruments is to give full effect to the Act. In particular, Social Health Insurance Regulations, 2024 have given a focus on key areas under the Act

that must be operationalized as a matter of priority to facilitate the attainment of Universal Health Coverage (UHC).

1.3.1 THE OVERALL OBJECTIVE

The overall objective of the statutory instruments is to provide for the implementation of the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund and the operationalization of the Dispute Resolution Tribunal established under the Social Health Insurance Act, 2023.

1.3.2 SPECIFIC OBJECTIVES

Specifically, the statutory instruments cover:

- (a) how health facilities will be empanelled and contracted for the provision of quality health care services, which are based on the tariffs prescribed pursuant to Section 32 (2) of the Act;
- (b) the registration of beneficiaries and mode of identification under the Social Health Insurance Fund;
- (c) the benefits package under the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund established under the Social Health Insurance Act;
- (d) the establishment of a pool for receipt and payment of funds for social health insurance in the country;
- (e) the establishment of the emergency medical care code for purposes of handling medical emergencies;
- (f) stakeholder engagement through the convening of fora through meetings, colloquiums, webinars, workshops or such other consultative platforms for

purposes of facilitating consultations, coordination and collaboration in the implementation of the Act and these Regulations;

(g) the means testing instrument in the manner provided in Regulation 21 to identify the indigent households that require financial assistance and for whom the National Government or the County Government is liable to pay their contributions, according to Section 27 of the Act; and

(h) modalities of addressing disputes and complaints arising from the decisions made under the Act and the Social Health Insurance Regulations, 2024.

1.4 JUSTIFICATION FOR THE REGULATIONS

The Regulations will:

- I. provide a framework for health financing to ensure equitable access and improved health outcomes for all Kenyans without exposing them to financial hardship;
- II. provide a framework on how emergency healthcare services will be financed through a non-contributory mechanism to safeguard the population from catastrophic health expenditure;
- III. provide a framework for purchasing healthcare to ensure value for money;
- IV. address the high burden of communicable and non-communicable conditions on households and the health system; and
- V. cushion the health system from emerging and re-emerging disease outbreaks and changing demographic patterns.

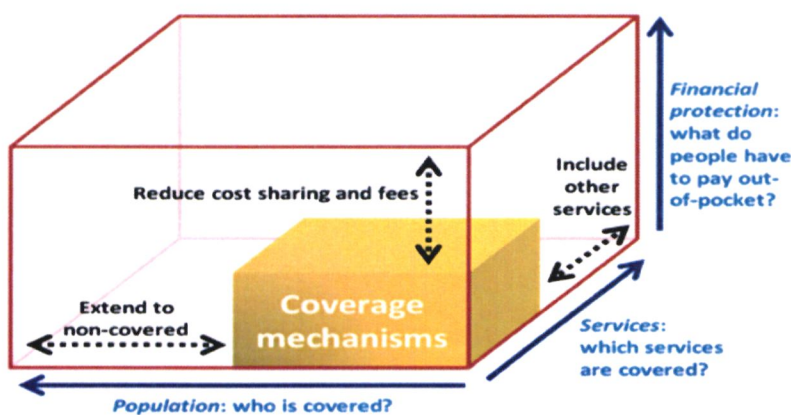
CHAPTER 2

CONTEXT FOR THE REGULATIONS

2.1 UNIVERSAL HEALTH COVERAGE (UHC)

Universal health coverage (UHC) is the access to safe, effective, quality essential health care services, including affordable essential medicines and vaccines for all without suffering financial hardship.

The UHC aims to expand access to healthcare services to all, including indigents and vulnerable populations, while progressively increasing the healthcare services provided and minimising out-of-pocket spending on healthcare.



Source: *World Health Organization, 2010*

Universal Health Coverage (UHC) is firmly based on the World Health Organisation (WHO) Constitution of 1948 declaring health a fundamental human right, and on the Health for All agenda set by the Alma-Ata of 1978. The goal of attaining UHC was also established by global nations as part of the 2015 Sustainable Development Goals (SDGs). This commitment was reiterated by countries during the United Nations General Assembly High-Level Assembly on UHC in 2019. The incorporation of UHC within the SDGs offers a chance to advance a holistic strategy for healthcare, centred around bolstering health systems. Nations moving towards UHC will concurrently advance other health-related objectives as well as broader goals. Consequently, achieving universal health coverage has emerged as a key aspiration for healthcare improvement across various countries including Kenya. It reaffirms the country's commitment to the African Union Agenda and commitment to the Astana Declaration on Primary Health Care (PHC) 2018 – galvanizing commitment and action on PHC for the 21st century and stimulating global investment for it.

2.2 Universal health coverage in Kenya

The Constitution of Kenya, under the Bill of Rights, Article 43 provides for socio-economic rights which under Article 43(1) (a) gives citizens the right to the highest attainable standards of healthcare.

Currently, limited progress has been made in attaining this goal. According to the Tracking Universal Health Coverage 2023, Global monitoring report in 2015, Kenya's Universal health coverage (UHC) service coverage index (SCI) was 53 as compared to the global average index of 65 (the 2030 target is 100). In the same year, 5.2% of the Kenya population incurred catastrophic health expenditure (at 10% of household total consumption or income) leading to 1.3% of the population being pushed into poverty

by the out of pocket (OOP) health spending (at the 2017 PPP US\$ 2.15 a day poverty line) and 14.7% further pushed into poverty.

UHC is expected to enhance socio-economic development and contribute to poverty reduction as well as build solidarity and trust. To accelerate progress towards UHC in the past, Kenya has implemented several key reforms with varied degrees of success. While these reforms have facilitated progress towards UHC, health insurance coverage remains low at 25 percent and lowest among the low-income group at less than five percent (5%). The out-of-pocket payment by households for health stands at Kshs. 150 billion shillings annually; this expenditure is catastrophic to households and is responsible for pushing five percent (5%) of households into poverty every year as many sell their wealth to pay for health bills, while many more do not seek care when they fall ill due to affordability barriers.

The Social Health Insurance Act, 2023 establishes the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund. These three (3) Funds demonstrate concrete steps taken by the government to ensure UHC for all Kenyans. These interventions include:

- (a) a fully publicly financed primary healthcare comprising preventive, promotive, curative, palliative and rehabilitative services;
- (b) integrating Information Communication and Technology systems to enhance telemedicine and health management information systems to improve efficiency, address fraud and enable patient data portability;
- (c) ring-fencing funds for healthcare at the facility level to enable the availability of funds at the public facilities for the improvement of health services in collaboration with County Governments;
- (d) setting up an emergency medical treatment fund to cater for emergencies, cancer treatment and referrals; and

- (e) providing a Social Health Insurance Fund coverage for all Kenyans without exclusion in the policy of “Leaving No One Behind”.

2.3 The Concept of Social Health Insurance

Social health insurance is a system where a group of people collectively pool resources and funds to provide health coverage and services to its members. It involves the mandatory or voluntary participation of individuals, usually through contributions or premiums, to finance the cost of healthcare. The pooled funds are then used to cover medical expenses, ensuring that individuals have access to essential healthcare services without facing financial hardship. This model is often managed or regulated by the government or other governing bodies to ensure equitable access to healthcare for the population.

It is important to note that there is no Free Healthcare (FHC) anywhere. If one accesses health services for free, someone else somewhere is paying for it or must pay for it in the future. The government has been subsidizing and providing funding for the provision of free services or supplemented through conditional grants, user fee foregone, output-based financing as well as providing in-kind support through the supply of medicines, vaccines and medical equipment.

The Government has often provided policy direction that eliminated user fees at the point of service for Level 2 and 3 health facilities, and for selected population groups usually characterised by medical or economic vulnerability.

The Global Burden of Disease ranks Kenya at an approximate UHC index of 55 percent and predicts that by 2030, the UHC index will be at 60 percent. The Social Health Insurance Act is a strategic initiative to progressively enable everyone to access the services that address the most important causes of disease and death and ensure that

the quality of these services is good enough to improve the health of Kenyans for the country to achieve close to 100 percent UHC.

The Social Health Insurance Regulations will accelerate the realisation of Universal Health Coverage in Kenya by making the Social Health Authority a strategic purchaser of health services with a sustainable revenue base.

CHAPTER 3

PROBLEM DEFINITION

3.1 INTRODUCTION

The health sector in Kenya is governed at two levels: national and county. The national level has overall stewardship, policy formulation, standards and regulations, capacity building and national referral health facilities, while the counties are responsible for policy implementation and service delivery. The levels conduct their activities based on mutual consultation, collaboration and cooperation. Kenya has a mix of public (41%), private (49 %), faith-based and NGO (10 %) health service providers (KMHFL, 2023).

The country has made massive investments in health infrastructure, which has improved access to and coverage of health services in the country, albeit with substantial variation across counties. The number of government health facilities increased by 33.6 percent from 4,456 to 5,953 nationally from 2013 to 2018. As the number of health facilities increased, access to health services also improved, especially in previously neglected

and remote areas. Today, more than 90 percent of Kenyans live within five kilometres or one-hour travel time to a health facility.

Most public health facilities are managed by county governments. All healthcare providers are organised in levels or tiers of health service provision ranging from community health services (Level 1), dispensaries and health centres (Level 2 and 3), primary referral hospitals (Level 4), secondary referral hospitals (Level 5) and tertiary referral hospitals (Level 6). Each of these levels is expected to provide the Kenya Essential Package for Health (KEPH): a life-cycle-oriented package of preventive, promotive, curative and rehabilitative health services.

The health workforce comprises a variety of cadres developed through both private and public training institutions. The workforce is likewise engaged in both public and private sectors. Also, the country has made progress in filling the gap in skilled human resources for health (HRH), yet availability remains a major bottleneck to improving the quality of care. Since FY 2014/15, Kenya has increased the total number of health staff (national and county levels) by 68 percent, reaching 17,000 staff in total in the health sector, with most of the increases occurring at the county level following devolution. However, counties report that they continue to be constrained by health worker shortages. When compared to the Kenya normative requirements for HRH, Kenya had an average gap of 281 percent in 2016. This reduced to 152 percent by FY 2019/20, following recruitment in light of the UHC agenda suggesting that in a large number of some counties, even a double in the current number of technical staff would not be enough to meet the normative requirement.

Access to health products and technologies is through three main channels: public by the Kenya Medical Supplies Authority (KEMSA); private not-for-profit (PNFP) by the Mission for Essential Drugs and Supplies (MEDS); and private for-profit (PFP) suppliers. However, insufficient funds result in delays in payment to suppliers, which creates a lack

of trust between the suppliers and purchasers. Poor quantification and delays in procurement have also been big challenges in the country. This poor coordination has led to an overestimation and underestimation of drugs, which created large stock-outs and inefficiencies in the procurement process. The devolved government system has significantly increased county-level decision space in deciding and purchasing their own drugs. Although some counties experienced improvements in health products and technologies procurement, many counties also experienced shortages, wastages, and stock-outs.

The Kenya Health Information System (KHIS) provides the overall framework for health information management in Kenya. Over the last two decades, Kenya has increased investments towards strengthening Health Information systems. To accomplish the vision for the health sector, "to provide equitable and affordable quality health services to all Kenyans", the first Medium Term Plan 2008- 2012 of Vision 2030 identified the need to strengthen the national health information systems with timely and understandable information on health. Furthermore, health information was identified as a key investment area in the Kenya Health Policy, 2014-2030 to ensure the generation and management of information to guide evidence-based decision-making in the provision of health and related services at the national and county levels. However, inadequate Government financial allocation to health information monitoring and evaluation activities leads to over-reliance on donor support at both the national and county levels, under-prioritisation of HIS activities at both the national and county levels, irregular data review meetings due to inadequate funding and inadequate data collection and reporting tools at the service delivery points.

Kenya is facing a changing health financing landscape with the government taking an increasing role, while contributions from donors and corporations are shrinking. Over

the past 20 years, total health expenditures have increased continuously, with varying contributions by each source. The government's contribution to financing health care increased from 27 percent of the total health expenditure in 2009/10 to about 52 percent in 2018/19. During the same period, the role of households declined from 30 percent of total health expenditures in 2009/10 to 24 percent in 2018/19, showing the impact of reforms to increase the financial protection of the poor and of households in the informal sector. According to the Kenya National Health Accounts 2018/2019, the Total Health Expenditure (THE) in Kenya in FY 2018/19 was Kshs. 497.7 billion (USD 4,920 million), a 13 percent increase from Kshs. 442 billion (USD 4,315 million) in FY 2016/17. Total health expenditures in FY 2018/19 were 5.6 percent of GDP, a slight increase from 5.5 percent in FY 2016/17. The government expenditure on health as a percent of total government expenditure increased from 10.8 percent in FY 2016/17 to 11.7 percent in FY 2018/19. The per capita spending on health also increased by 9 percent from USD 97.4 in FY 2016/17 to USD 105.8 in FY 2018/19.

3.2 FINANCIAL BARRIERS AS THE BIGGEST OBSTACLES TO ACCESS AND QUALITY HEALTHCARE.

Impoverishing health spending continues to be a problem globally¹. In 2017, approximately half a billion people were pushed or further pushed into extreme poverty, and 2.2 times as many went further into relative poverty. Across all country income groups, the poor spending any amount of out-of-pocket (OOP) on health represented between 83 and 89 percent of the people incurring impoverishing health spending.

According to the Kenya Household Health Expenditure and Utilization Survey (KHHEUS) 2018, out-of-pocket expenditure was at 32%, while the incidence of catastrophic health expenditure was estimated to be 4.9%, an improvement from the 6% recorded in 2013.

¹ Global monitoring report on financial protection in health 2021 (WB and WHO)

As mentioned in Section 2.2 above, in 2015, 1.3% of the Kenya population was pushed into poverty due to OOP health spending (at the 2017 PPP US\$ 2.15 a day poverty line) and 14.7% were further pushed into poverty.

Further, that approximately 28% of Kenyans do not seek healthcare shows the dire need to pay attention to ensuring coverage policies aim to reduce financial hardship among the poor, even in relatively well-resourced health systems.

Although out-of-pocket expenditure has gradually reduced over the years, Kenyans are still at risk of being exposed to huge health expenditures.² When out-of-pocket payments are required, households with elderly, persons with disability, or chronically ill members are generally more likely to be confronted with significant health spending than others. This is both because they usually have a greater need for health services and because they lack financial resources.³ The regulations will cushion the members from out-of-pocket payments by ensuring enrolment in social health insurance for all and highlighting the benefits payable to healthcare providers.

The regulations have designed a benefit package which covers emergency, chronic and critical illnesses that are often associated with catastrophic health expenditures.

Moreover, the Primary Health Care (PHC) fund promotes increased investment in the provision of primary health care services and strengthens PHC systems. The strengthening of PHC systems is the most cost-effective pathway towards the attainment of UHC. A very robust and well-resourced PHC system can meet more than 80% of the population's essential health needs.

3.3 FRAGMENTED POOLING OF FUNDS

² World Health Organization Global Health Expenditure database (apps.who.int/nha/database)

³ World Health Organization. (2005). Designing health financing systems to reduce catastrophic health expenditure. World Health Organization. <https://apps.who.int/iris/handle/10665/70005>

Pooling is the accumulation and management of prepaid financial resources on behalf of some or all of the population. Pooling is an enabling function, creating opportunities for efficient redistribution of resources to support equitable access to needed services, with financial protection from any given level of prepaid funding.

The pooling arrangements in Kenya's public health financing system are fragmented due to the many schemes with different entitlements and associated high costs of administration. Evidence has shown that the pooling function of a health financing system works better and optimally if there is more consolidation than fragmentation. Fragmented pools do not achieve a high level of redistributive effect through cross-subsidization and consequently offer low levels of financial risk protection. Given this, funds must be pooled in a way that enables their redistribution towards people with the greatest health needs, to ensure that they can access the services they need, without financial hardship. This is fundamental to the goals and objectives of universal health coverage.

These regulations aim at progressive financing such that payments for health care rise as a proportion of an individual's income as it rises. Fragmented and overlapping schemes within the current NHIF (Linda Mama, indigents, civil servants' scheme, secondary school children and elderly support) and the various disease-based donor-driven financing schemes, undermine the principle and benefits of the widest possible risk pooling that a social health insurance scheme is supposed to provide. This financing system has significant poverty/equity implications given that households directly bear most health-care costs.

These Regulations seek to enhance the capacity of the Social Health Authority to effectively deliver UHC in the following ways:

1. Revision of the contribution rates to be a percentage rate of gross income for employed households. A monthly statutory deduction contribution to the Social Health Insurance Fund at a rate of 2.75% of the gross salary shall be paid;
2. Revision of the contribution rates for non-salaried households to an annual contribution to the Social Health Insurance Fund at a rate of 2.75% of the proportion of household income as determined by the means testing instrument;
3. Provision for government contributions for the indigent and vulnerable in society at a base premium rate calculated using statistical data and actuarial models and guided by the essential healthcare benefits;
4. The provision of a benefit package that offers inpatient care, outpatient care, emergency care and several specialised services;
5. The digitalization of several core functions including claims management, member registration and premium contributions; and
6. Streamlining the empanelling and contracting process for healthcare providers and health facilities to ensure that beneficiaries have access to affordable and quality healthcare services.

3.4 LOW INSURANCE COVERAGE

Prepayment mechanisms have been shown to be more equitable than payment at the point of seeking care. Over-reliance on out-of-pocket payments means that access to health is based on the ability to pay rather than on the need for services. This puts the lower socio-economic groups at a disadvantage. (The uptake of health insurance coverage is still relatively low in Kenya at approximately 26%.) Many Kenyans do not access health services due to cost factors and when they do, access is limited by socio-economic and geographical barriers. Health insurance coverage is inequitably

distributed across socio-economic status and geographically (rural vs urban). Health insurance coverage is higher among the rich than among the poor and also higher in urban areas than in rural areas. The 2022 KDHS report shows that in the poorest quantile, insurance coverage is 5% among both men and women but 56% and 60% among women and men respectively in the richest quantile of the population. Similarly, insurance coverage is higher in urban areas ((39% among women and 41% among men) as compared to rural areas (20% among women and 19% among men (KDHS 2022).

The goal of UHC under the Bottom-Up Economic Transformation Agenda 2022-2027 has been to eliminate the social and economic challenges that Kenyans face due to the cost of healthcare by purposefully restructuring the health financing landscape. Prepayment for health services through insurance has been shown to cushion households from impoverishment in the event of illness. Additionally, the community health and private health insurance scheme pools operate independently and are not linked to other insurance pools, which undermines the principle of social insurance. To accelerate the achievement of UHC through health insurance, the regulations will implement mandatory health insurance for all Kenyans to bring coverage to 100% of the population. This will see sufficient resources raised for health, making healthcare services affordable and equitably accessible to all Kenyans irrespective of their ability to pay or where they happen to live.

3.5 LIMITED ACCESS TO EMERGENCY SERVICES

Emergency medical care is the necessary immediate health care that must be administered to prevent death or worsening of a medical situation. Emergency services are life-defining and protect life. Nevertheless, emergencies occur daily in Kenya contributing to increased morbidity and mortality. Emergencies are presenting to emergency departments across the country occasioned by an increase in the incidence

of NCDs (such as cancer, diabetes, and hypertension), trauma mostly due to road traffic crashes (RTC), and communicable diseases. The leading causes of injuries in Kenya are assault (42%), road traffic crashes (28%), (occasioned by the increase in the number of motorcycles), unspecified soft tissue injuries (11%), cut-wounds, dog bites, falls, burns and poisonings (each at <10%). Globally, up to 54% of deaths are due to a lack of optimal emergency care, yet this is their constitutional right. This is attributed to a lack of access to the needed emergency health services due to weak financial protection. The regulations cover Kenyans' access to life-saving emergency health services across the health service providers, a move that will lead to reduced incidents of premature mortality among Kenyans and significant improvement in quality-adjusted life years (QALY) for Kenyans faced with life-threatening health emergencies.

3.6 FINANCIAL SUSTAINABILITY

Ensuring health insurance coverage for all allows for better risk pooling by allowing the higher costs of the less healthy to be offset by the relatively lower costs of the healthy, either in a plan overall or within a premium rating category.

The multiple sources of revenue for the SHI and strategic purchasing guarantee the scheme's financial viability. The financial sustainability of the SHI depends on how the scheme ensures both technical and allocative efficiencies, identifies new sources of financing, and supports county governments in making tough choices based on evidence.

The renewed focus on and investment in primary health care implies that up to 90% of the people's health needs could be addressed at lower levels and hence controlling escalating expensive specialised curative services at higher levels.

3.7 THE URGENCY TO IMPLEMENT RECOMMENDATIONS FROM THE HEFREP REPORT

The Health Financing Reforms Experts Panel (HEFREP) which was appointed by the Cabinet Secretary for Health in 2018 was tasked to spearhead reforms towards the transformation and repositioning of NHIF as a Strategic Purchaser of Healthcare services towards the attainment of UHC. In their report, the panel discussed recommendations on

- a) Healthcare Purchasing;
- b) Business Process Re-engineering;
- c) Strengthening the Financial Sustainability of NHIF; and
- d) Governance, Legal and Regulatory Reforms.

Since independence, the core of the former NHIF had been the insurance of the payrolled population, who make up roughly 20% of the Kenyan population. While the economic structure of the Kenyan economy changed after independence, the need to ensure the majority of the Kenyan population who are non-payrolled has never been the key point of address by the former NHIF. NHIF relied heavily on salaried Kenyans to finance health care for the whole country.

The financing mechanism of NHIF was unsustainable since the employed (payroll) persons cannot contribute enough to cater for the health needs of 80% of non-salaried Kenyans. This promoted inequality and disadvantages for many Kenyan households.

Moreover, the lack of a robust end-to-end digital system for NHIF constrained the unique identification of patients causing the insurer the loss of billions of shillings through fraud and poor management of claims.

The former NHIF contribution structure was regressive and punished households for being poor. How the determination of contributions was done was not based on the principle of social insurance where there is more risk pooling in relation to the risk of incurring medical expenses. This is the same case for the employed and the non-

employed. The less income a household has, the more they are charged for NHIF. This is unfair treatment of the less advantaged in society and is completely against the principle of natural justice.

Table 1: Former NHIF Formal Contribution Structure.

Gross Income (Kshs.)	Monthly Premiums (Kshs.)	% Proportion of contribution: Premium Income to	Number of contributors	% Change in premium under SHIF	Total contributors
0-5,999	150	5.00%	45,320	-2.25%	1,653,052 (54%)
6000-7,999	300	4.29%	76,689	-1.54%	
8,000-11,999	400	4.00%	209,585	-1.25%	
12,000-14,999	500	3.85%	386,039	-1.10%	
15,000-19,999	600	3.43%	343,995	-0.68%	
20,000-24,999	750	3.33%	247,457	-0.58%	
25,000-29,999	850	3.09%	195,224	-0.34%	
30,000-34,999	900	2.77%	148,743	-0.02%	
35,000-39,999	950	2.53%	136,317	0.22%	1,389,985 (46%)
40,000-44,999	1000	2.35%	150,055	0.40%	
45,000-49,999	1,100	2.32%	126,892	0.43%	
50,000-59,999	1,200	2.18%	181,566	0.57%	

60,000-69,999	1,300	2.00%	124,641	0.75%
70,000-79,999	1,400	1.87%	124,470	0.88%
80,000-89,999	1,500	1.76%	88,965	0.99%
90,000-99,999	1,600	1.68%	72,126	1.07%
100,000 and above	1,700	1.12%	384,953	1.63%

The former NHIF operated as a passive rather than a strategic purchaser. NHIF's sole focus was primary and secondary curative care, with a limited scope of primary health care, health promotion and preventive health services. This is the firefighting principle, where one waits for a disease to happen then invests in treatment of the disease, instead of preventing the occurrence of that disease.

The "defunct NHIF" performed the function of revenue collection, decided the benefit package, selected the providers, verified claims, paid the providers, and resolved disputes. With this arrangement as an entity, it was bedevilled with structural inefficiencies and governance challenges. Globally, best practice recommends the separation of functions to leave the social insurer as a strategic purchaser of healthcare services while other functions are handled separately. The Social Health Insurance Act aligns with global best practice.

It was against the backdrop above that the Ministry of Health proposed a paradigm shift in the provision of Social Health Insurance through the Social Health Insurance Act, 2023 that repealed the National Health Insurance Fund Act, No. 9 of 1998.

The repealing of the National Health Insurance Fund Act, No. 9 of 1998 was necessary and the Social Health Insurance Act essentially separates the functions of registration, claims management, empanelment and dispute resolution that were hitherto being performed by one entity (the former NHIF). This separation will enhance efficiency through the reduction of administrative costs. The monies saved from this reduction can

then be expended for the payment of comprehensive and optimal health coverage for Kenyans.

CHAPTER 4

POLICY, LEGAL AND INSTITUTIONAL FRAMEWORK

4.1 INTRODUCTION

An evaluation of the legal and policy frameworks related to the Social Health Authority is intended to bring out the context and legal environment within which the Regulations are being developed. Regulatory processes should be structured so that all regulatory decisions rigorously respect the principles of the 'rule of law'. This means that there should be explicit responsibility for ensuring that all regulations are authorised by higher-level regulations and are consistent with the supreme law and treaty obligations. In addition, they should complement other legal requirements and ensure statutory harmony of the entire statute book.

4.2 The Constitution of Kenya 2010

The Constitution of Kenya 2010 provides the overarching legal framework to ensure a comprehensive rights-based approach to health services delivery. It sets out the general rights and duties that a public body is expected to adhere to and the values of equity, social justice, equality, inclusiveness and public participation⁴.

More specific rights and duties are enshrined in the Bill of Rights under Chapter Four of the Constitution. Article 43(1)(a) provides that every person has a right to the highest attainable standard of health, which includes reproductive health rights. It further states that a person shall not be denied emergency medical treatment⁵ and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependants.

The Constitution requires the State and every State organ to observe, respect, protect, promote, and fulfil the rights in the Constitution and to take “legislative, policy and other measures, including the setting of standards to achieve the progressive realisation of the rights guaranteed in Article 43. These measures include addressing the needs of vulnerable groups within society and the international obligations regarding those rights⁶. Article 20 (5) (b) requires that in allocating resources, the State will give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of groups or individuals amongst other rights. These vulnerabilities are addressed in the Constitution which pays special attention to the health of children⁷, minorities, marginalised groups⁸ and the

⁴ Article 10(2)(b)

⁵ Article 43(2)

⁶ Article 22

⁷ Article 53(1)(c)

⁸ Article 56(e)

elderly⁹. As such, barriers to healthcare services of whatever kind should not hinder access and the government is duty-bound to remove such barriers so that health rights are genuinely met. It is to fulfil these constitutional obligations that the Cabinet Secretary for Health, in consultation with the Board of the Social Health Authority, has drafted these regulations.

4.3 The Social Health Insurance Act, 2023

The principal statute that governs the Social Health Insurance Fund and the other two Funds is the Social Health Insurance Act, 2023.

One of the objectives of the Act is to provide a framework for improved outcomes and financial protection in line with the right to health and universal health coverage. The Board intends to facilitate the registration of members, identification of beneficiaries, contributions to the Fund, claims and benefits and empanelment and contracting of Healthcare Providers.

The regulations will provide for the payment of claims (including those for emergency treatment), the functions and access to the centralised digital platform as well as the benefit package.

The Act further provides for contributions to the Fund.¹⁰This Act requires contributions by the national government on behalf of the indigent and vulnerable persons. The Regulations will implement the rates of contribution for each category of contributor.

⁹ Article 57(d)

¹⁰ Section 27, Social Health Insurance Act.

The empanelment and contracting of Healthcare Providers will be done in consultation with the body responsible for accreditation for quality of care.¹¹ It also sets out how the Authority will negotiate and enter into contracts with healthcare service providers.

The principal object of the Social Health Insurance Act, 2023 is therefore to establish a legislative framework to regulate the provision of social health insurance, promote the implementation of Universal Health Coverage and to ensure that all Kenyans have access to affordable and comprehensive quality health services. The Act establishes the Social Health Authority that is mandated to manage three public Funds established under the Act, namely the Primary Healthcare Fund, the Social Health Insurance Fund, and the Emergency, Chronic and Critical Illness Fund.

The Primary Healthcare Fund is intended to purchase primary health care services from health facilities in level 2 and 3. Kenyans need not pay any contribution to this Fund as the Fund will be financed by the exchequer through monies appropriated by the National Assembly. This Fund is a major shift from the current NHIF as the latter currently does not pay for healthcare services provided at the primary health care level. The Fund will therefore take services to the people and make them available closer to the people. The Fund also anchors the country's healthcare system on a prevention pathway. The Fund is therefore a game changer as prevention of disease is the only known sustainable health care financing model.

The Social Health Insurance Fund is intended to pay for healthcare services provided in the contracted Level 4, 5 and 6 health facilities. Kenyans will contribute 2.75% of their income to the Social Health Insurance Fund only. This is the first time that the social health scheme in Kenya will not punish the poor for being poor, as it abandons the regressive system and moves towards proportional contribution where one contributes based on the ability to pay. The 2.75% will be an equalizer, regardless of a person's

¹¹ Section 23(2), Social Health Insurance Act.

income and employment status. In addition, it is an actuarially fair premium based on the country's epidemiology and cost of health care. Actuarially fair premium sets the insurance premium to be paid that is equal to the insurer's expected pay out making the insurance payment stable and realisable in the event disease occurs.

The Emergency, Chronic and Critical Illness Fund is intended to cover the costs of emergency treatment (including 24 hrs stabilisation) and to defray the costs of management of chronic illnesses after the depletion of the social health insurance cover. The Fund is financed by the exchequer through monies appropriated by the National Assembly. In the past, due to the lack of a pool where health facilities could claim payment for responding to emergencies, hospitals have been unable to take care of Kenyans at their hour of need as the bills incurred would become a bad debt to a hospital constraining the hospital's existence.

Previously, the focus of health insurance coverage in the country has also only been on emergency evacuation, majorly ambulances, which has seen some health facilities refuse to take in patients as no one would pay for the cost incurred by the health facility in the provision of emergency hospital care. Through the Act, this will change as the government will provide two-pronged emergency medical treatment by paying healthcare providers for both the provision of emergency hospital care and ambulance services through the Fund. This depicts that the law is aligned to Article 43(2) of the Constitution which provides that no Kenyan should be denied emergency medical treatment.

The Emergency, Chronic and Critical Illness Fund will also pay for the treatment of chronic illnesses such as cancer which has impoverished numerous Kenyan families even after they have sought financial assistance through *harambees*. The Fund will therefore come in where a person has depleted their benefits under the Social Health Insurance Fund and still requires treatment for their chronic or critical illness.

The Social Health Authority is mandated to register beneficiaries and to receive all contributions from beneficiaries, to contract healthcare providers and health facilities upon successful certification by the relevant body responsible for quality of care in the country, to make payments to the contracted health care providers and health facilities, to advise the Cabinet Secretary on matters of social health insurance including the formulation of policies and to implement all government policies on social health insurance among others.

The Act also establishes a Claims Management Office within the Social Health Authority to review and process claims made by health care providers and health facilities. The Act further establishes a Dispute Resolution Tribunal to hear and determine complaints, disputes and appeals arising from decisions made on matters pertaining to social health insurance.

The Social Health Authority plays a key role in supporting the delivery of the aspirations of Kenya Vision 2030, under the social pillar, and the Bottom-up Economic Transformation Agenda (BETA) plan under the Big Four agenda, which envisions a nation that is healthy and prosperous as earlier mentioned. The Social Health Authority is intended to respond to the health needs of Kenyans as contemplated in the Kenya Universal Health Coverage Policy, 2020-2030. The Social Health Authority will further provide a healthcare package that is aligned to the Kenya Health Financing Strategy, 2020-2030 as there will be fairness in the financing of health services in a manner that guarantees that all Kenyans have access to essential high quality healthcare services based on their ability to pay.

The Act promotes the attainment of Universal Health Coverage in the country as it seeks to ensure that all Kenyans have access to affordable and comprehensive quality health services. This is through the provision of a health cover for older persons, indigents and other vulnerable persons in society including persons in lawful custody who have for a

long time been forgotten. In this way, the Act is therefore aligned to the policy of “Leaving No One Behind” and the Constitution of Kenya, 2010 which requires the government provide appropriate social security to persons who are unable to support themselves and their dependants.

The Act also provides for mandatory registration of members. The regulations on registration of members set out the details of how contributors to the Fund and their Beneficiaries will be registered. The regulations on identification of beneficiaries further provide for how those registered will be identified at the point of registration as well as at the point of access to healthcare services. The Act also provides for the use of a digitalized system to process claims and services.¹²

4.4 The Health Act, Cap. 241

The Health Act also mandates that every person has a right to emergency medical care¹³ which includes pre-hospital care, stabilisation and arranging for referral of the patient. This impacts the benefits payable by the Social Health Authority and will be relevant in the regulations which acknowledge that the Emergency, Chronic and Critical Illness Fund will cater for certain types of emergency care.

With respect to health insurance, Section 86 of the Health Act requires the government to:

- (a) develop mechanisms for an integrated national health insurance system including making provisions for social health protection and health technology assessment.
- (b) develop policies and strategies that ensure realisation of universal health coverage.

¹² Section 47 ,Social Health Insurance Act.

¹³ Health Act, Section 7

(c) define in collaboration with the department responsible for finance, public financing of healthcare framework, including annual allocations towards reimbursing all health care providers responding to disasters and emergencies as contemplated under this Act.

The SHI Act and the regulations are geared towards facilitating this financial access through UHC. The regulations set out the rates for contributors to pay (the main source of revenue for social health insurance) and how the Social Health Authority will reimburse the medical benefits its members and their beneficiaries receive from healthcare providers and health facilities.

The Ministry of Health is also required under Section 86 to provide for vulnerable groups and indigents as well as provide a framework for examining means of optimising usage of private health services. The Ministry has done this through various instruments including the Universal Health Coverage Policy, 2020-2030 which provides, amongst other matters, coverage for indigent Kenyans. This obligation requires contributions from the National and County government for vulnerable and indigent persons. The regulations will implement this aspect of the Health Act as they provide for the rate of contribution that the Government will pay for indigent and vulnerable persons.

Section 86 of the Health Act also affects the empanelment, contracting and payment of benefits to private healthcare providers. The Regulations provide how healthcare providers and health facilities will be empanelled and contracted including onboarding into the centralised digital platform.

Primary healthcare providers are also critical in the provision of primary health care and the Health Act sets out the division of duties between the national government and county governments with respect to public health facilities. PHC is being implemented through formation of primary care networks (PCNs). In the PCN model, the Community Health Units (level 1) are linked to the level 2(dispensary) and 3(Health centre) facilities

(spokes) which serve with both preventive and curative health services. The level 2 and 3 facilities are spokes that are then linked to a primary-level hospital (level 4) as the hub which provides support and coordination and acts as the first point of referral. The PCN is managed by a multidisciplinary team that coordinates primary health care services for the catchment population at the primary health facilities and the community level.

4.5 The Insurance Act, Cap. 487

The Insurance Act provides for, among other things, the regulation of the business of insurance in Kenya. The Social Health Insurance Act under Section 52 shall apply to the Social Health Authority only in respect to the administration of claims.

4.6 The Children Act, Cap. 141

The Children Act makes provision for parental responsibility, fostering, adoption, custody, maintenance, guardianship, care and protection of children. It makes both the parents of a child and the Government responsible for the health and medical care of children.¹⁴

The Act is important to SHI not only because it is the specific legislation that deals with the welfare of children (including their mental and physical health), but also because it is also the principal statute that domesticates Kenya's obligations under the Convention on the Rights of the Child.

The most relevant parts of the Children's Act with respect to the regulations are those with respect to protection for children in need of care and protection who are particularly vulnerable. These include the following:

- (a) orphan children;
- (b) adopted children;

¹⁴ Children Act, Section 9

(c) children living with mental or physical disability; and

(d) children in conflict with the law.

The Act provides for the appointment of guardians for children through testamentary documents, by deed or by a court of law.¹⁵ The Act also provides for the responsibility of guardians including for the medical treatment of these children.¹⁶ This is important because the SHI Act only recognizes that persons over the age of 18 will register as members and this may lock out orphaned children from access to affordable medical treatment unless a guardian can register them under his/her household. This is addressed by the regulations on registration of members which will provide for guardians registering the relevant child upon proof of guardianship.

The same issue arises with respect to adopted children. The Children Act provides for eligibility to adopt a child and the adoption process. Such children can only benefit from Social Health Insurance if there is proof of adoption and the adopting parent registers them as his/her household. The regulations provide for adopted children in line with the Children Act: these children can be registered for Social Health Insurance upon proof that they have formally completed the process of adoption.

4.7 The Digital Health Act, No. 15 of 2023

The Act provides a framework for the provision of digital health services and establishes a comprehensive integrated digital health information system. This system will provide data governance and protection of personal health information and service delivery through digital health interventions such as telemedicine, e-waste disposal and health tourism.

¹⁵ Children Act, Section 102

¹⁶ Children Act, Section 24 read with Section 27

The Act establishes the Digital Health Agency which is mandated to regulate the provision of digital health services in Kenya.

The Agency is required to develop, operationalize, and maintain a Comprehensive Integrated Health Information System. To this end, the Agency is required to establish registries to create a single source of truth; to facilitate collection and analysis of data to inform policy and research in the health sector; to strengthen existing health information systems; to certify digital health solutions based on best practices and standards, and to advise the Cabinet Secretary on matters related to digital health.

The Comprehensive Integrated Health Information System established under the Act is intended to generally manage the core digital systems and the infrastructure required for seamless health information exchange. Having an integrated system addresses the challenges posed by fragmented and siloed health data systems. Further, by centralizing health information in a secure and standardized manner, healthcare providers can access comprehensive patient data leading to more informed diagnoses and treatment decisions.

The system is, in particular, intended to facilitate a people-centered quality health service delivery, to facilitate data collection and reporting at all levels of health care provision, to enable secure health data sharing for timely and informed inter-facility health service delivery, to facilitate data processing and use for informed decision-making at all levels, to safeguard the privacy, confidentiality, and security of health data for information sharing and use, and to facilitate the tracking and tracing of health products and technologies in the country, among others.

Several other statutes affect the operating context of Social Health Authority, however because they have an indirect legislative impact on Social Health Authority's functions and role, they are simply listed below, these are the:

- (a) State Corporations Act

- (b) Public Finance Management Act
- (c) Public Audit Act
- (d) Data Protection Act
- (e) Primary Health Care Act
- (f) Consumer Protection Act
- (g) Criminal Procedure Code
- (h) Public Procurement and Assets Disposals Act
- (i) Work Injuries Benefits Act

4.8 Policy Framework

The following key policies informed the development of these regulations. These include the following:

- (a) Vision 2030 ;
- (b) The Kenya Health Policy, 2014 – 2030;
- (c) The Universal Health Policy ,2020-2030; and
- (d) The Bottom-Up Economic Transformation Agenda (BeTA), 2022-2027.

4.8.1 VISION 2030

Vision 2030 is an overarching national development policy that was unveiled in 2007 and has been implemented in rolling out 5-year plans. It is anchored on three pillars: economic, social, and political. It is under the social pillar that health-related goals are found. The aim is to improve the overall livelihood of Kenyans. With respect to health,

the country aims at an equitable and affordable healthcare system of the highest possible quality.

The strategy advanced by Vision 2030 includes:

- (a) Enhancing the regulatory regime.
- (b) Increasing finances available to the health sector and ensuring that they are utilised more efficiently.
- (c) Develop a social health insurance scheme.

The SHI Act and the regulations advance these strategies by providing for increased financing for the health sector through national government contributions for the indigent and vulnerable persons.

4.8.2 KENYA HEALTH POLICY

The Kenya Health Policy, 2014-2030 gives directions to the relevant implementation stakeholders to ensure significant improvement in overall status of health in Kenya in line with the Constitution of Kenya 2010, the country's long-term development agenda, Vision 2030 and Kenya's global commitments.

The goal of the Policy is to attain the highest possible standard of health in a responsive manner. This goal will be achieved by supporting equitable, affordable, and high-quality health and related services at the highest attainable standards for all Kenyans. Achievement of this goal involves Social Health Authority because the policy orientation, among other things, targets investment targeted towards health financing to improve access to, quality of and demand for services. The policy commitment anchoring this is that financial barriers hindering access to services will be minimised or removed for all persons requiring health and related services; guided by the concepts of Universal Health Coverage and Social Health Protection.

In particular, the policy's commitment is to progressively facilitate access to services by all by ensuring social and financial risk protection through adequate mobilisation, allocation, and efficient utilisation of financial resources for health service delivery. The primary responsibility under this Policy of providing the financing required to meet the right to health lies with the national and county governments.

These regulations will help ensure that indigent and vulnerable persons have adequate financial risk protection and lower their financial barriers to accessing health care by implementing national government contributions for these groups.

4.8.3 KENYA UHC POLICY 2020-2030

The Universal Health Coverage Policy, 2020-2030 provides a framework to ensure that all Kenyans have access to essential quality health services without suffering financial hardship. The Policy's objectives are to:

- (a) Strengthen coverage and access to health services;
- (b) Ensure quality of health services;
- (c) Protect Kenyans from the financial risks of ill-health, and
- (d) Strengthen the responsiveness of the health system in Kenya.

The policy embraces the principles of equity, people centredness, efficiency, social solidarity and a multi-sectoral approach. It focuses on four objectives and their related strategies to support attainment of the Government's goal in health. It is cognizant of the functional responsibilities between the National and County levels of Government with their respective accountability mechanisms and frameworks. It aims to ensure adequacy, efficiency and fairness in financing of health services in a manner that guarantees all Kenyans access the essential health services that they need, an all-

inclusive well-designed financing model through the health financing strategy. Primary health care shall be the vehicle for the delivery of Universal Health Care in Kenya and shall be repositioned as the foundational service delivery platform for the Kenyan health system. PHC seeks to improve access, availability, safety, efficiency, and equitable health service delivery. PHC will lead to the refinement of existing service delivery arrangements by establishment of PCNs that will result in a network of public and private facilities offering responsive, accessible, coordinated, comprehensive and continuous health services, while addressing the determinants of health to individuals, families and communities. The goal of adopting a PCN service delivery model is to ensure efficiency and continuity of care for clients. Good linkages and referrals within and outside the PCN will thus be required. The PCNs led by the Family Medicine Professionals and consisting of the MDTs will ensure availability of comprehensive UHC-EHBP services by facilitating seamless movement and referral services for needy patients and clients within the network. The private facilities shall be contracted to deliver services within the network to meet the needs of the community.

CHAPTER 5

PUBLIC PARTICIPATION AND CONSULTATION

5.1 LEGAL REQUIREMENTS RELATING TO PUBLIC PARTICIPATION AND CONSULTATION

It is a constitutional requirement to undertake public participation whenever a state or public officer enacts any law or makes or implements a public policy. This requirement is based on Article 1 of the Constitution on the sovereignty principle which vests all sovereign power to the people of Kenya. This power entitles the people access to the process of making public decisions through their involvement. Public participation ought to be inclusive, transparent and accountable.

Article 174 gives powers of self-governance to the people and enhances their participation in the exercise of the powers of the State and in making decisions affecting

them and recognize the rights of communities to manage their own affairs and to further their development.

The values and principles of public service require the involvement of the people in the process of policy making through provision of timely and accurate information to the public.

The Statutory Instruments Act obligates a regulation making authority to carry out appropriate consultations before making statutory instruments (Regulations) where the regulations are likely to have a direct, or a substantial indirect effect on business or restrict competition. It further provides that in determining whether any consultation that was undertaken is appropriate, the regulation making authority shall have regard to all relevant matters, including the extent to which the consultation:

- (a) drew on the knowledge of persons having expertise in fields relevant to the proposed statutory instrument; and
- (b) ensured that persons likely to be affected by the proposed statutory instrument had an adequate opportunity to comment on its proposed content.

The Statutory Instruments Act also states that the persons to be consulted should be notified either directly or by advertisement through representative organizations. They shall also be invited to make submissions by a specified date, which should not be less than 14 days or be invited to participate in public hearings concerning the proposed instrument.

5.2 INITIAL PARTICIPATION OF THE STAKEHOLDERS

To ensure nationwide public participation, the Ministry of Health invited the public and all stakeholders for public participation and stakeholder engagements through the print

media on 22nd January 2024 and 9th February 2024. The Ministry had also placed an advertisement in the print media on 28th November 2023 before the court case that stopped the implementation of the Act. The Ministry published the regulations on its website; therefore, the key stakeholders had an opportunity to review them in advance. Hardcopy booklets were also availed at the public participation forums. These engagements included consultations with key stakeholder and public engagement forums mobilised through the National Government Administrative Officers (NGAO).

5.3 APPROACH AND METHODOLOGIES

The Cabinet secretary appointed a Technical Working Group to spearhead the development of the regulations and thereafter ensure stakeholder consultations and public participation on the statutory instruments. Stakeholder mapping was conducted, and key Stakeholders were invited to submit memoranda either electronically through email regulations@health.go.ke, or submitting hard copies at the office of the Cabinet Secretary Ministry of Health through letters and an open invite to all interested stakeholders including members of the public through print media on 22nd January 2024 and 9th February 2024. The Ministry received written memoranda from several institutions as indicated in the stakeholder matrix.

Public engagements forums were conducted in all constituencies across Kenya by facilitators who had been trained on the regulations. The Forums were held in venues that were publicized in local newspapers on 9th February 2024. The sessions comprised presentations on the Social Health Insurance Regulations, 2024 including the Benefit Package, the Social Health Insurance (Tribunal Procedure) Rules, 2024 and the Regulatory Impact Statement complemented by the distribution of comprehensive handbooks detailing the two regulations.

To ensure inclusivity, presentations were delivered in multiple languages, including English, Kiswahili, vernacular languages and Kenya Sign Language, catering to the linguistic diversity of the populace.

Subsequently, all feedback obtained from the public participation exercise was collated, analyzed and the insights garnered were integrated into the regulatory framework.

There was a remarkable turnout of participants from diverse cross-section of society, including healthcare professionals, policymakers, community leaders and the members of the public as shown in Annexure 2.



Figure 1: Public Engagement Forum at Chepararia, West Pokot

CHAPTER 6

OVERVIEW OF THE STATUTORY INSTRUMENTS TO THE SOCIAL HEALTH INSURANCE ACT, 2023

6.1 THE SOCIAL HEALTH INSURANCE REGULATIONS, 2024

The regulations will bring effect to section 50 of the Social Health Insurance Act, 2023 and apply in respect to –

- (a) implementation of the Primary Healthcare Fund; and
- (b) implementation of the Social Health Insurance Fund;
- (c) implementation of the Emergency, Chronic and Critical Illness Fund;
- (d) empanelment and contracting of healthcare providers and health facilities;
- (e) benefits accruing to contributors and their beneficiaries;
- (f) determination of the tariffs applicable;

- (g) procedures for settlement of claims; and
- (h) processes and services under the Act.

The regulations provide for the following salient features: -

6.2. CLAIMS AND BENEFITS

The regulations for the establishment of Centralised Digital Platform that is accessible to the empanelled and contracted health care providers for purposes of claims administration, recording beneficiary data, inputting health care service delivery data, and maintaining healthcare providers data. The Platform will permit user rights to authorised persons who apply to the Board for rights and access to the system in line with Data Protection Act, Cap.411C and the Digital Health Act,2023. There is provision for the Platform to maintain an audit trail of all processes and have the capability of data retrieval.

Moreover, beneficiaries undergoing treatment for a chronic illness shall access services which shall be payable under the Emergency, Chronic and Critical Illness fund established under Section 28 of the Social Health Insurance Act. The funds for critical illness shall be limited to benefits that have been specified by the Fund. The Fund shall provide the benefits provided in the Fourth Schedule.

These regulations have provided for the provision of emergency treatment without discrimination as well as the provision of overseas treatment upon satisfaction of the requirements on overseas treatment as well as the relevant authorization.

6.3 REGISTRATION OF MEMBERS

The Social Health Insurance Regulations provide that persons who have attained the age of 18 years and are residents of Kenya shall register as members and make contributions to the Fund. The provisions of these regulations require each member to

provide their biometric details at the point of registration. Biometrics as defined in section 2 of the regulations means a physical or biological; attribute including a fingerprint, hand geometry, earlobe geometry, retina or iris pattern, toe impression, voice wave or blood typing in digital form or such other biological attributes that identifies an individual. To enhance registration for the accelerated achievement of UHC, the regulations have provided for the Social Health Authority to utilise existing National Population Databases to enable actualization of mandatory registration.

6.4 MEANS TESTING

These regulations provide for the use of a means testing instrument. Implementing a means-tested premium system ensures that the financial burden of healthcare is distributed based on individuals' ability to pay. This will promote equity in access to healthcare services and fosters social cohesion by ensuring that everyone contributes according to their means. The Ministry responsible for social protection will guide the identification of indigent and vulnerable households that require financial assistance and for whom the National Government or the County Government is liable to pay their contributions.

6.5 FEES AND ADMINISTRATIVE COSTS

The Authority particularly intends to collect the monies in order to minimize administration costs. Such costs include service, notices and information to be served to beneficiaries, healthcare providers or healthcare facilities centres through registered post, hand delivery, or email as deemed convenient.

The Authority proposes to charge contributions as prescribed in the regulations.

6.5 ADMINISTRATIVE MEASURES

The Authority will also digitalize all its processes including payment of contributions and settlement of claims so as to enhance its efficiency and minimize administrative costs.

6.6 THE SOCIAL HEALTH INSURANCE (TRIBUNAL PROCEDURE) RULES, 2024

The Social Health Insurance (Tribunal Procedure) Rules, 2024 are intended to guide the determination of any complaints, disputes and appeals arising from any decisions made under the Social Health Insurance Act.

Any party making a complaint to the Tribunal must have first exhausted the internal dispute resolution mechanisms that have been provided by Social Health Authority.

The Tribunal is required to hear and determine any complaints filed within six months from the date of filing of the complaint.

Any person who is not satisfied by a decision of the Tribunal may apply to the Tribunal for a review, or appeal to the High Court whose decision shall be final.

CHAPTER 7

THE COST-BENEFIT ANALYSIS FOR THE SOCIAL HEALTH INSURANCE REGULATIONS

7.1 INTRODUCTION

This section seeks to assess the changes proposed by the regulations in terms of their costs and benefits to justify the proposals pursuant to Section 7(d) of the Statutory Instruments Act.

7.2 BENEFITS AND COSTS ON THE SOCIAL HEALTH INSURANCE REGULATIONS, 2024

The analysis of the expected costs and benefits of the regulations contained in this chapter seeks to answer the question of whether the benefits justify the costs. This enables the regulation making authority to estimate the total expected cost and benefit of every aspect of the Regulations. The objective of the Regulations is to provide a framework for improved outcome and financial protection in line with the right to health and universal health coverage.

In considering the benefits for the Regulations, the key questions to be answered include:

- 1) *What is the nature and extent of constraints faced by the Kenyan citizens in the access to quality essential healthcare services and financial protection to all people?*
- 2) *To what extent is it the role of the government to cushion the health system from emerging and re-emerging disease outbreaks and changing demographic patterns?*
- 3) *To what extent do Regulations contribute to addressing the high burden of communicable conditions and non-communicable conditions?*

Kenyans will benefit greatly from the Regulations. The Regulations will-

- (a) provide access to quality essential healthcare services and financial protection to all people;

- (b) provide access to quality essential healthcare services and financial protection to all people in Kenya
- (c) address the high burden of communicable conditions and non-communicable conditions; and
- (d) cushion the health system from emerging and re-emerging disease outbreaks and changing demographic patterns.

Annexure 1 provides a detailed analysis on the costs and benefits of the three options available in responding to the challenges in ensuring the implementation of these regulations.

CHAPTER 8

SOCIAL ECONOMIC IMPACTS

8.1 INTRODUCTION

Article 43 of the Constitution of Kenya, under the Bill of Rights, guarantees the right to healthcare for every Kenyan citizen. Specifically, it states: "Every person has the right to the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare."

This provision underscores the government's obligation to ensure that healthcare services are accessible, available, and of high quality for all citizens. It encompasses a wide range of healthcare services, including preventive, curative, and rehabilitative care, as well as access to essential medicines and treatment. Generally, Social Health Insurance would radically reform how health is accessed and financed. These reforms provide both opportunities and risks to the entire health system architecture.

Lessons from the UHC pilot in 4 counties in Kenya reveals that increasing access comes with a tendency of over-utilisation of insurance visits. The high utilisation puts significant strain on the pool thus challenging its sustainability. Consequently, enforcing mandatory health insurance contributions will create both positive and negative incentives. Also, to ensure *"no one is left behind"* significant investments are required at the different levels of the health system to ensure the availability of better healthcare services to beneficiaries. Further, enrolment of informal groups will be an expensive and challenging task.

8.2. IMPACT OF THE REGULATION ON COUNTY GOVERNMENTS

- Any delays in exchequer releases of funds earmarked to Primary Healthcare Fund will result in disruption in provision of healthcare particularly in the procurement and dispensing of medical commodities.

A mandatory Social Health Insurance means an increased number of people seeking care at health facilities (short-term) implying that county governments would need to invest more across all health pillars to ensure that the demand of members are met.

- The Social Health Insurance combined with Facilities Improvement Financing reforms would see public health facilities increase their own resources and consequently improving their purchasing capacity and medical stock.
- The gate-keeping mechanism envisioned under the Primary Care Networks would enhance efficiency by reducing unnecessary self-referrals and ensure better distribution of the SHI funds thus improving the financial status of health facilities.
- The comprehensive requirements for contracting and empanelling health facilities will standardise service quality and improve health outcomes.
- There is likely to be stiff competition from the private health providers who now have a level playing field.
- There is likely to be a conflict of interest by HCWs referring high net worth patients to private health facilities.
- Reduction in the cost of care due to economies of scale.

8.3. IMPACT OF THE REGULATION ON PRIVATE SECTOR

- Opportunity to expand coverage including to rural communities given the harmonised tariffs / level playing field.

- Cost escalation mainly in hiring HCWs. Private facilities rely on public health workers for some specialised services. They would need to hire own HCWs especially specialists (if the government ones are 'tied' to government facilities) which implies additional operational costs.
- Increased appetite to charge clients for co-payment over and above the SHA rebates.

8.4. IMPACT OF THE REGULATION ON INDIVIDUALS

- Reduced out-of-pocket health expenditure given all households would have a pre-payment mechanism.
- In the short to medium term, there is likely to be a significant strain on household income especially for formal employees who will pay more to the SHA than their current obligations.
- Inequitable access especially for specialised services. People in deprived communities will have limited access to all the services they are entitled to.
- Increased options between public and private health facilities and also access to services from individual healthcare providers.
- Improved access to health services for the indigent and vulnerable groups including access to emergency, chronic and critical services that is currently limited.

8.5 IMPACT ANALYSIS OF THE OPTIONS

Matrix of impact of options on key sectors

Impact on sectors	Option one: Maintaining the Status quo	Option two: Administrative measures	Option three: Developing Regulations to the Social Health Insurance Act, 2023
Impact on Public sector	<ul style="list-style-type: none"> ● Non-attainment of UHC ● Low registration by persons (over 18 years) who are qualified to register for Social Health Insurance. ● A burdened nation crippled by debilitating and expensive medical bills 	<ul style="list-style-type: none"> ● Difficulty in enforcement. 	<ul style="list-style-type: none"> ● The proposed measures in the Regulations will not only address the challenges but also create an enabling environment for investors. ● Provide for the registration of all persons over the age of 18 years as members of the SHIF, ● Increased Access to Healthcare; Ensure access to healthcare services for all citizens. ● Equity and Social Cohesion: Implementing a means-tested premium system ensures that the financial burden of healthcare is distributed based on individuals' ability to pay. ● Reduction in Out-of-Pocket Spending: significantly reduction in the burden of out-of-pocket spending on healthcare for individuals and families. This, in turn, can prevent families from falling into poverty due to catastrophic health

Impact on sectors	Option one: Maintaining the Status quo	Option two: Administrative measures	Option three: Developing Regulations to the Social Health Insurance Act, 2023
Impact on Private sector	<ul style="list-style-type: none"> The private sector will largely remain unaffected. 	<ul style="list-style-type: none"> There is no guarantee that administrative measures will address private sector concerns. 	<p>expenditures.</p> <ul style="list-style-type: none"> Ease the burden of health care. Revenue Generation: Private healthcare and faith-based providers can benefit from SHA by receiving payments for services rendered to insured individuals same as public healthcare providers. Create opportunities for public-private partnerships in healthcare service delivery. Private providers could partner with the government to expand access to care, improve infrastructure, and address gaps in healthcare services across different regions of the country. Regulatory Compliance: Private healthcare providers will need to adapt to the new regulations and reporting requirements associated with SHA implementation.
Economic Impact	<ul style="list-style-type: none"> Cost of healthcare services will continue to rise 	<ul style="list-style-type: none"> Administrative measures are inadequate to contain costs of healthcare 	<ul style="list-style-type: none"> Reduce the debilitating cost of health care. Reduced Out-of-Pocket Spending: SHA aims to reduce the financial burden on individuals and households by providing them with insurance coverage for healthcare

Impact on sectors	Option one: Maintaining the Status quo	Option two: Administrative measures	Option three: Developing Regulations to the Social Health Insurance Act, 2023
Social Impact	<ul style="list-style-type: none"> Families will continue being pushed to poverty because of catastrophic health expenditures 	<ul style="list-style-type: none"> Administrative measures are not sufficient to address out of pocket expenditure 	<p>services.</p> <ul style="list-style-type: none"> Productivity Gains: A healthier population resulting from increased access to healthcare services can lead to productivity gains across various sectors of the economy. Improved access to healthcare services across the population there's a higher likelihood of early detection and treatment of illnesses and diseases. This can lead to improved health outcomes, reduced morbidity, and increased life expectancy among the population. Will address out of pocket through pre-payment mechanism [Social Health Insurance]
Human Rights Impact	<ul style="list-style-type: none"> Attainment of socio-economic rights on health will be slowed down. 	<ul style="list-style-type: none"> Administrative measures do not have the force of law necessary for guaranteeing human rights 	<ul style="list-style-type: none"> The regulations will assist in the achievement of highest attainable standards of healthcare for citizens as guaranteed in Article 43 of the Constitution of Kenya.
Impact on business	<ul style="list-style-type: none"> Largely no impact 	<ul style="list-style-type: none"> Lack the force of law for full implementation of the Act. 	<ul style="list-style-type: none"> Creates framework for enterprises to contribute to attainment of UHC.
Impact on	<ul style="list-style-type: none"> Will be generally 	<ul style="list-style-type: none"> Generally 	<ul style="list-style-type: none"> Will facilitate investment in

Impact on sectors	Option one: Maintaining the Status quo	Option two: Administrative measures	Option three: Developing Regulations to the Social Health Insurance Act, 2023
environment	unaffected	unaffected since there will be no enforcement and frameworks promoting a better healthcare environment.	health infrastructure leading to a better environment for all.
Impact on taxes	<ul style="list-style-type: none"> Largely no impact 	<ul style="list-style-type: none"> No impact 	<ul style="list-style-type: none"> No impact as the contributions on Social Health Insurance are not taxes.
Impact on existing legal frameworks	<ul style="list-style-type: none"> The existing legal gaps will not be addressed. 	<ul style="list-style-type: none"> Regulatory concerns will remain unaddressed 	<ul style="list-style-type: none"> Addresses all the identified gaps. Provides harmony with related legal frameworks. No further legal amendments or enactments will be required

CHAPTER 9

CONSIDERATION OF ALTERNATIVES FOR THE STATUTORY INSTRUMENTS TO THE SOCIAL HEALTH INSURANCE ACT, 2023

9.1 INTRODUCTION

The Statutory Instruments Act requires a regulation making authority to carry out an informed evaluation of a variety of regulatory and non-regulatory policy measures by considering relevant issues such as costs, benefits, distributional effects and administrative requirements. Regulations or legislation should be the last resort in realising policy objectives. The options considered under this chapter are maintenance of the status quo, administrative measures and developing the Social Insurance Health Regulations, 2024.

9.2 OPTION ONE: MAINTENANCE OF THE STATUS QUO

Maintaining the status quo means that no regulations are developed and therefore the Social Health Insurance Act, 2023 will not be fully implemented. The development of these Regulations is a requirement of the Act which seeks to address the problems and challenges that have faced the sector since inception. As enacted, the Act requires these Regulations for its full implementation.

Effect of non-implementation of the Act will include amongst others-

- i. Non-achievement of the UHC state in Kenya, this means that the Authority will not be able to ensure that all Kenyans from the age of 18 years and above are duly registered as members in order to contribute to the Social Insurance Fund and enjoy accessible, affordable health care.
- ii. The Social Health Insurance Fund will not be financially sustainable, and this brings about concerns on the Fund's sustainability in the future.
- iii. The out-of-pocket expenditure in Kenya as a percentage of the total health expenditure as of 2019 was 24.3%. Although out-of-pocket expenditure has gradually reduced over the years, from 47.1% in the year 2000 to 24.3% in the year 2019, Kenyans are still at risk of being exposed to catastrophic health expenditures. When out-of-pocket payments are required, households with elderly, handicapped, or chronically ill members are generally more likely to be confronted with catastrophic health spending than others.
- iv. Complaints and disputes relating to the decisions made under the Act will not be effectively managed.

The full Implementation of the regulations will address the above highlighted challenges.

9.3 OPTION TWO: ADMINISTRATIVE MEASURES

This is a non-regulatory measure which, if applied, will depend on the good will of public officers to implement the provisions of the new Act. Administrative measures involve issuance of directives and circulars to the various departments hoping that they will be implemented. Administrative measures do not have the force of law and may be challenged in courts of law. These Regulations seek to impose payment of mandatory fees in terms of contribution to the Social Health Insurance Fund and this must be done

in law. This therefore necessitates the need to include all this information in regulations to streamline implementation and achievement of UHC.

Furthermore, changes to the benefits payable cannot be done administratively as the stakeholders have a legitimate right to incorporate their views on the same and to give their recommendations since they will be affected by these changes.

9.4 OPTION THREE: DEVELOPING THE STATUTORY INSTRUMENTS TO THE SOCIAL HEALTH INSURANCE ACT,2023

The development of the regulations on beneficiary identification, member registration, member contributions, empanelment and contracting ,benefits and claims and operationalization of the Dispute Resolution Tribunal shall ensure that the full implementation of the Social Health Insurance Act, 2023. This will affect a much more practicable aspect towards the attainment of Universal Health Coverage.

9.5 PREFERRED OPTION

The preferred option would be the implementation of the regulations with a view to ensure that universal health coverage is fully attained and that all Kenyans receive accessible, affordable, and quality health care without suffering financial constraints as envisioned.

CHAPTER 10

COMPLIANCE AND IMPLEMENTATION

10.1 INSTITUTIONS

It is the duty of the regulation making authority to assess the adequacy of the institutional framework and other incentives through which the regulations will take effect and design responsive implementation strategies that make the best use of them¹⁷.

The implementation and enforcement of the regulations to the Social Health Insurance Act, 2023 will be undertaken through the existing institutional framework at National level (Ministry of Health and the Social Health Authority) and the County level (County Governments).

10.2 CONCLUSION

Based on the analysis in this report, the Social Health Insurance Regulations, 2024 and the Social Health Insurance (Tribunal Procedure) Rules, 2024 are extremely necessary.

10.3 RECOMMENDATION

In view of the above conclusion, it is recommended that the Social Health Insurance Regulations, 2024 and the Social Health Insurance (Tribunal Procedure) Rules, 2024 be adopted.

¹⁷ Source: OECD (1995), the 1995 Recommendation of the Council of the OECD on Improving the Quality of Government Regulation, Paris.

ANNEXURE 1: ANALYSIS ON THE COSTS AND BENEFITS OF THE THREE OPTIONS

Problem	Proposed Reform	Cost	Benefits
Inadequate Financial Sustainability of the Social Health Insurance Fund	Mandatory contributions.	Cost to the Govt <ul style="list-style-type: none"> Indigents Cover – Kshs. 45 billion 	Benefits to the Fund <ul style="list-style-type: none"> Assured premiums/revenue of Kshs. 133 billion from all Kenyan residents
		Cost to the Citizens <ul style="list-style-type: none"> Informal sector Cost – Ksh.56 billion 	Benefits to the Govt <ul style="list-style-type: none"> Reduced cost of hospital bills waivers of 30% – 40% of FIF Achievement of UHC Benefit to Citizens Reduced OOP expenditure by 15% to less than 10% of total health expenditure.
Weak Funding Model	Mandatory contributions for Informal Sector and Indigents with payment of premiums for indigents by the national government. Payments for non-salaried persons to be determined through means testing instrument.	As above	Benefit to the Fund <ul style="list-style-type: none"> Improved retention of informal sector from 24% to 100%
			Benefit to Govt <ul style="list-style-type: none"> All Kenyans insured Reduced health burden in the country
	Compliance	Cost to the Fund	Benefit to the Fund

	<p>mechanism introduced to support mandatory registration.</p> <p>Automation through the Centralized Healthcare Provider Management System (CHPMS)</p>	<ul style="list-style-type: none"> • Reduced collections <p>Cost to the Fund</p> <ul style="list-style-type: none"> • Acquisition and Countrywide roll-out of CHPMS – Kshs. 5 billion • Maintenance – Kshs. <p>Cost to Healthcare Providers</p> <ul style="list-style-type: none"> • ICT Infrastructure acquisition and maintenance 	<ul style="list-style-type: none"> • Increased retention <p>Benefit to the Citizens</p> <p>Reduced expenditure from 500% to 10% of principal amount</p> <p>Benefit to the Fund</p> <ul style="list-style-type: none"> • Reduced losses at approximately 10% – 20% of total pay-out <p>Benefits to Beneficiaries</p> <p>Increased transparency</p>
Adverse Selection in the Informal Sector	Mandatory Contributions by/for all Kenya residents	<p>Cost to the Govt</p> <ul style="list-style-type: none"> • Indigents Cover – Kshs. 45 billion <p>Cost to the Citizens</p> <ul style="list-style-type: none"> • Informal sector Cost – Ksh.56 billion 	<p>Benefits to the Fund</p> <ul style="list-style-type: none"> • Reduced pay-out ratio from the current 280% to at most 85% • Increased Informal Sector Revenue from the current approximately 5.5 billion to approximately 56 billion per annum <p>Benefits to the Government</p> <ul style="list-style-type: none"> • Healthy workforce <p>Benefit to Citizens</p> <p>Reduced OOP expenditure by 15% to less than 10% of total health expenditure.</p>

Low Health Insurance Coverage

Mandatory Registration of all Kenya Residents

Cost to the Govt

- Indigents Cover – Kshs. 45 billion

Cost to the Citizens

- Informal sector Contributions – Kshs. 56 billion

Benefits to the Fund

- Growth in revenue to Kshs. 133 billion from all Kenyan residents

Benefits to the Govt

- Reduced cost of hospital bills waivers of 30% – 40% of FIF
- Healthy workforce
- Achievement of UHC

Benefit to Citizens

Reduced OOP expenditure by 15% to less than 10% of total health expenditure.

High out of the pocket expenditure.

Mandatory registration of all Kenya residents

Cost to the Govt

- Indigents Cover – Kshs. 45 billion

Cost to the Citizens

- Informal sector Contributions – Ksh.56 billion
-

Benefits to the citizens

- Reduced out of pocket payments for health.
- Elimination of the practice of hospital detention due.

Government subsidy of Kshs. 45 billion for indigents.

National government payment of premiums for the indigents and the vulnerable

Limited access to emergency services, and premium chronic and critical illness services.

Expanded Coverage for emergency services by the Emergency, Chronic and Critical illness Fund

Cost to the Govt

- Kshs. 46 billion

Benefits to the citizens

- Assured access to emergency and premium chronic and critical illness health services to all Kenyans.
- Reduced mortality and

Weak health financing models

Improved Health Financing Model.
Mandatory registration for all Kenyans as the key financing mechanism for health services

Cost to the Govt

- Indigents Cover – Kshs. 45 billion
- Reorganization of financial resources for health

Cost to the Citizens

- Informal sector Contributions – Ksh.56 billion

disability-adjusted Life Years arising from medical emergencies, some chronic and critical illnesses.

Benefits to healthcare providers

Assured reimbursements for health emergency, premium chronic and critical illness health services provided to clients who would not have otherwise paid.

Benefit to Government

- Strengthened health financing systems.

Benefits to the Fund

- Growth in revenue to Kshs. 133 billion from all Kenyan residents

Weak primary healthcare services

Primary Healthcare Fund

Cost to the Government

Kshs. 58 billion

Benefits to the citizens

Improved access to primary health care services for free.

Benefits to the Government

Long term reduction in cost of care accrued from gradual decline in diseases through preventive and health

System inefficiencies

Change in the manner used for empanelment of providers.

Increased scope and geographical spread of health care providers engaged including for primary healthcare.

Centralized healthcare providers' management system.

Cost to the Fund

- Acquisition and Countrywide roll-out of CHPMS – Kshs. 5 billion

- Maintenance

Cost to Healthcare Providers

- ICT Infrastructure acquisition and maintenance

promotion services.

Benefits to the facilities and providers

Assured reimbursements for primary healthcare services provided.

Availability of financial resources for facility improvement.

Benefit

Improved transparency for clients, providers, facilities, and the Government.

ANNEXURE 2: ATTENDANCE PER CONSTITUENCY

S/No	REGION	COUNTY NO.	COUNTY NAME	CONSTITUENCY	VENUE
1	COAST	001	MOMBASA	Changamwe	Changamwe Social Hall
2				Mvita	Tononoka Social Hall
3				Kisauni	Kisauni Social Hall
4				Likoni	Likoni Social Hall
5				Jomvu	Mikindani Social Hall
6				Nyali	Kongowea Social Hall (1)
7	COAST	002	KWALE	Kinango	Kinango Youth Hall
8				Matuga	Kwale Cultural Centre
9				Msabweni	Mvideni Social Hall
10				Lunga	Kag Church Lunga
11	COAST	003	KILIFI	Kilifi North	Titanic Hotel
12				Malindi	Cleopatra Cinema Hall
13				Kaloleni	Mariakani Social Hall
14				Magarini	Marafa Social Hall
15				Ganze	Pefa Church
16				Rabai	Rabai Social Hall
17				Kilifi South	Vipingo Cdf Hall
18	COAST	004	TANA RIVER	Garsen	Marjan Resort Ltd
19				Galole	Milelel Guest House
20				Bura	Bcc Hall
21	COAST	005	LAMU	Lamu East	Faza Social Hall
22				Lamu West	Mwanaarafa Hall
23	COAST	006	TAITA - TAVETA	Mwatate	Cdf Hall Mwatate
24				Wundanyi	Cc County Hall
25				Voi	Voi Cdf (Dan Mwanzo Hall)
26				Taveta	Sub County Adm Hall
27	NORTHEAST ERN	007	GARISSA	Garissa Township	Government Guest House
28				Dadaab	Dadaab Primary School
29				Balambala	Balambala Library Hall
30				Lagdera	Modagashe High School
31				Fafi	State Lodge
32				Ijara	Shurie Secondary School
33	NORTHEAST ERN	008	WAJIR	Wajir East	Ict Hall Wajir Town
34				Wajir South	Habaswein National Library
35				Tarbaj	Ict Hall Tarbaj
36				Wajir North	Ict Hall Bute

37				Wajir West	Wajir West Cdf Hall
38				Eldas	Eldas Secondary School
39	NORTHEAST ERN	009	MANDERA	Mandera East	Mandera Social Service Hall
40				Mandera South	Elwak Social Hall
41				Lafey	Sala Public Baraza Park
42				Mandera North	Racida Social Hall- Rhamu
43				Mandera West	Takaba Cdf Social Hall
44				Banissa	Midway Banisa Social Hall
45	EASTERN	010	MARSABIT	Moyale	Holale Hotel and Resort
46				North Horr	North Hor Catholic Mission
47				Saku	Saku Catholic Hall
48				Laisamis	Laisamis Catholic Hall
49	EASTERN	011	ISIOLO	Isiolo	Police Hall
50				Garbatula	Classic Hotel
51				Merti	Mama Tore Hotel
52	EASTERN	012	MERU	Buuri	Muuna Hotel
53				North Imenti	Kamunde Hall
54				Central Imenti	Kamakia Plaza
55				South Imenti	Roots Rest
56				Igembe North	Victoria Hotel
57				Igembe South	Victoria Hotel
58				Igembe Central	Kangeta Multi-P Hall
59				Tigania West	Kirindini Social Hall
60				Tigania East	Dcc Uuru Hall
61	EASTERN	013	THARAKA NITHI	Tharaka	Tharaka Cdf Hall
62				Chuka/Igambangombe	Kathwana Social Hall
63				Maara	Maara Cdf Hall
64	EASTERN	014	EMBU	Manyatta	Talent Hall
65				Runyenjes	Ack Kagari Hall
66				Mbeere North	Mbeere Cdf Hall
67				Mbeere South	Kiritiri Cdf Hall
68	EASTERN	015	KITUI	Mwingi Central	Mwingi Resource Centre
69				Mwingi North	Kyuso Full Gospel Church
70				Mwingi West	Deliv Church Migwani
71				Kitui East	Zombe- Aic Church
72				Kitui Central	Multi-P Hall Kitui Town
73				Kitui Rural	Kwa- Vonza Hall
74				Kitui South	Mutomo Chiefs Office
75				Kitui West	Kabati Catholic Church
76	EASTERN	016	MACHAKOS	Machakos Town	Machakos Social Hall

77				Mwala	Kawayu Stadium-Masii
78				Kangundo	Abc Church Kalimani
79				Matungulu	Abc Church Matungulu
80				Kathiani	Dc Kathiani Office Hall
81				Mavoko	Mavoko Youth Centre
82				Masinga	Cdf Grounds Masinga
83				Yatta	Kithendu Social Hall
84	EASTERN	017	MAKUENI	Mbooni	Tawa Social Hall
85				Makueni	Wote Social Hall
86				Kaiti	Kilungu Aic Nunguni
87				Kibwezi East	Kilome Tangu Catholic Church-Salama
88				Kibwezi West	Kibwezi Makindu County Ha
89				Kilome	Makindu Kambu Deliveranc Church
90	CENTRAL	018	NYANDARUA	Olkalau	Olkalau
91				Oljororok	Oljororok Cdf Hall
92				North Kinangop	Engineer Catholic Hall
93				Kipipiri	PCEA Miharati
94				Nyandarua North	Ndaragwa Dcc Hall
95	CENTRAL	019	NYERI	Mukurweini	Cdf Hall
96				Nyeri Central	Cdf Hall
97				Mathira	Karatina Town Hall
98				Othaya	Dcc Hall
99				Tetu	Cdf Hall
100				Kieni	Cdf Hall
101	CENTRAL	020	KIRINYAGA	Kirinyaga Central	Cdf Offices
102				Mwea	Ccf Hospital
103				Ndia	Ack St Philip
104				Gichugu	Gichugu Social Hall
105	CENTRAL	021	MURANGA	Kangema	Kangema Social Hall
106				Kiharu	Kiharu Mothers Union Hall
107				Maragwa	Kenol DCC Hall
108				Kigumo	Kigumo CDF Hall
109				Gatanga	Gatanga Catholic Hall
110	CENTRAL	022	KIAMBU	Juja	Dccs Hall
111				Thika Town	Community Hall
112				Ruiru	Kahawa Wendani Social Hal
113				Kabete	Kirangari Polytechnic
114				Kikuyu	Kikuyu Market
115				Limuru	Kirathimo Social Hall
116				Lari	Dcc Hall
117				Githunguri	Githunguri Township Prima School
118				Kiambu	St. Peter and Paul Catholic Hall

119				Kiambaa	DCC
120				Gatundu South	Gatundu Education Hall
121				Gatundu North	Kamwangi Dcc Grounds
122	RIFTVALLEY	023	TURKANA	Loima	Logurum Resource Centre
123				Turkana Central	Lodwar Youth Polytechnic (Loyopo)
124				Turkana East	Lokori Church Hall
125				Turkana North	Lokitoung Subcounty Administrator Office
126				Turkana South	Aic Lokichar
127				Turkana West	Kakuma Subcounty Hall
128	RIFTVALLEY	024	WEST POKOT	Kacheliba	Acc Ground Kacheliba
129				Kapenguria	County Commissioner Off Ground
130				Sigor	Acc Ground Sigor
131				Pokot South	Acc Ground Chepareria
132	RIFTVALLEY	025	SAMBURU	Samburu East	Wamba Town Public Bara
133				Samburu North	Samburu North TVET hall
134				Samburu West	Maralal Vocational Training Centre
135				Samburu West	Maralal Cdf Hall
136	RIFTVALLEY	026	TRANSZOIA	Cherangany	Deliverance Church - Kachibora
137				Kwanza	St. Andrews Kagwa Catholic Church
138				Saboti	Kitale Museum Hall - Kitale Town
139				Endebess	Ack Church Hall
140				Kiminini	Kiminini Catholic Church Hall
141	RIFTVALLEY	027	UASIN GISHU	Kesses	Ug Social Hall
142				Kapseret	Kapseret Sub County Office
143				Moiben	Aic Church Hall
144				Ainabkoi	Kipkabus Technical & Vocational College
145				Soy	Ziwa Catholic Church Hall
146				Turbo	Cdf Hall
147	RIFTVALLEY	028	ELGEYO MARAKWET	Marakwet East	Chesoi Cdf Hall
148				Marakwet West	Kapsowar Girls High School
149				Keiyo North	Kmtc Iten
150				Keiyo South	Kamwosor Social Hall
151	RIFTVALLEY	029	NANDI COUNTY	Mosop	Kabiyet Social Hall
152				Emgwen	Kipchoge Complex

153				Aldai	Kobujoi Youth Hall Aldai
154				Tinderet	Dcc Hall
155				Nandi Hills	Catholic Church Hall Nandi Hills
156				Chesumei	Cdf Grounds, Chesumei
157	RIFTVALLEY	030	BARINGO	Koibatek	Taidy'S Restaurant
158				Mogotio	Mogotio Cdf Grounds
159				Baringo South	Mlimani Resort
160				Tiaty	Aic Chemolingot Church
161				Baringo Central	Ksg Hall
162				Baringo North	Youth Empowerment Centr
163	RIFTVALLEY	031	LAIKIPIA	Laikipia West	Nyahururu Social Hall
164				Laikipia North	Doldol Catholic Hall
165				Laikipia East	Nanyuki Social Hall
166				Molo	Social Hall
167				Njoro	Aic Njoro Town
168				Kuresoi South	Keringet- Subcounty Social Hall
169				Kuresoi North	Cdf Hall Sirikwa
170				Rongai	Rongai Social Hall
171	RIFTVALLEY	032	NAKURU	Naivasha	St. Francis Xavier Catholic Hall
172				Gilgil	Clavina Hotel
173				Nakuru Town East	Regional Commissioner Plenary Hall
174				Nakuru Town West	Kapkures Mca Grounds
175				Subukia	Subukia Nys Hall
176				Bahati	Bahati Ng-Cdf Hall
177	RIFTVALLEY	033	NAROK	Narok East	Nairagie Enkare Ng-Cdf Hall
178				Narok West	Lemek Ng-Cdf Hall
179				Narok North	Narok North Youth Centre.
180				Narok South	Ololunga Ng-Cdf Hall
181				Kilgoris	KILGORIS NG-CDF HALL
182				Emurwa Dikirr	EMURUA DIKIRR NG - CDF
183	RIFTVALLEY	034	KAJIADO	Kajiado Central	Maasai Technical
184				Kajiado West	Dc Hall Kisamis
185				Kajiado North	Dc Hall Ngong
186				Kajiado East	Mavoko Subcounty Youth Development
187				KajiadoSouth	Loitoktok Catholic
188	RIFTVALLEY	035	KERICHO	KipkelionEast	Londiani Town Hall
189				Ainamoi	Ack Holy Trinity Hall
190				Soin/Sigowet	Chepkemel Acc'S Office

191				Kipkelion West	Kipkelion Acc'S Office
192				Belgut	Sosiot Accs Office
193				Bureti	Bureti Cdf Office
194	RIFTVALLEY	036	BOMET	Sotik	Sotik Catholic Pastoral Centre
195				Konoin	Mogogosiek Aic, Liberty Hall - Konoin
196				Bomet East	Longisa Agc Hall
197				Bomet Central	Silibwet Agc Hall
198				Chepalungu	Siongiroi Agc Hall
199	WESTERN	037	KAKAMEGA	Ikolomani	Musingu Friends Church
200				Lurambi	Lurambi Magharibi Hall
201				Shinyalu	Shinyalu Dcc Hall
202				Navokholo	Navokholo Social Hall
203				Malava	Malava Cdf Hall
204				Lugari	Lugari Cdf Hall
205				Likuyani	Kongonin Catholic Church
206				Khwisero	Khwisero Politechnic
207				Butere	Butere Cdf Office
208				Mumias West	Mumias Cultural Centre
209				Mumias East	CDF Office
210				Matungu	CDF Office
211	WESTERN	038	VIHIGA	Emuhaya	Emuhaya Cdf Office
212				Luanda	Kim'S Mission Church of G
213				Sabatia	Serve International Church
214				Hamisi	Munzatsi Friends Church
215				Vihiga	Vihiga Friends Resource Centre
216	WESTERN	039	BUNGOMA	Webuye East	Sinoko Vocational Trainin Center
217				Webuye West	Glamour Hotel
218				Mount Elgon	Pema Church
219				Kimilili	St Lukes Kimilili Boys
220				Tongaren	Salvation Army Naitiri
221				Bumula	Bumula Girls
222				Kanduyi	Milimani Hotel
223				Sirisia	St Antony'S High School
224				Kabuchai	Busagala Secondary
225	WESTERN	040	BUSIA	Butula	Sub-County Commissioner'S Hall
226				Nambale	Polytechnic Social Hall
227				Matayos	Busia Town Social Hall
228				Funyula	Youth Social Hall
229				Budalangi	Youth Social Hall
230				Teso North	Sub-County Commissioner'S Hall

231				Teso South	Sub-County Commissioner'S Hall
232	NYANZA	041	SIAYA	Alego Usonga	Siaya Institute Hall
233				Bondo	Jooust Hall
234				Gem	Wagai Resource Centre
235				Rarieda	Ruma Multipurpose Hall
236				Ugenya	Sega Polytechnic
237				Ugunja	Municipal Hall
238	NYANZA	042	KISUMU	Kisumu Central	Cdf Hall
239				Kisumu East	Cdf Hall
240				Kisumu West	Cdf Hall
241				Muhoroni	Cdf Hall
242				Nyakach	Cdf Hall
243				Nyando	Cdf Hall
244				Seme	Cdf Hall
245	NYANZA	043	HOMABAY	Homa Bay Town	Kabunde Cdf Hall
246				Kisipul Kabondo	Kasipul Cdf Hall
247				Karachwonyo	Kamodi Social Hall Kendu B
248				Kasipul	Rawinji Resource Center
249				Suba North (Mbita)	Mbita Cdf Hall
250				Ndhiwa	Ndhiwa Cdf Hall
251				Rangwe	Rangwe Social Hall
252				Suba South	Pag Church
253	NYANZA	044	MIGORI	Awendo	Awendo Social Hall
254				Kuria East	Kegonga Social Hall
255				Kuria West	Kuria West - Kehancha
256				Nyatike	Macalder Social Hall
257				Rongo	Awendo Social Hall
258				Suna East	Ifad Hall Migori Hqs
259				Suna West	Ifad Hall Migori Hqs
260				Uriri	Uriri Social Hall
261	NYANZA	045	KISII	Bobasi	Maya Hotel
262				Bonchari	Cdf Hall
263				Bomachoge Borabu	Cdf Hall
264				Bomachoge Chache	Cdf Hall
265				Kitutu Chace North	Cdf Hall
266				Kitutu Chace South	Nyakoe Hall
267				Nyaribari Chache	Dallas Hotel
268				Nyaribari Masaba	Cdf Hall
269	NYANZA	046	NYAMIRA	South Mugirango	Jokeira Hotel
270				West Mugirango	Cdf Hall
271				Kitutu Masaba	Cdf Hall
272				North Mugirango	Cdf Hall
273				Borabu	Cdf Hall
274	NAIROBI	047	NAIROBI	Dagoretti South	Empowerment Center

275			Dagoretti North	Empowerment Center
276			Kamukunji	Pumwani Social Hall
277			Roysambu	Kasarani Ball Room
278			Kasarani	Kasarani Ball Room
279			Ruaraka	Mathare North Social Hall
280			Embakasi South	Embakasi Social Hall
281			Embakasi East	Embakasi Social Hall
282			Kibra	Kibra Social Hall (Joseph Kangethe)
283			Lang'Ata	Uhuru Gardens Primary C Hall
284			Starehe	Kariokor Social Hall
285			Westlands	Blessings College, Kanger
286			Embakasi North	Dandora Social Hall
287			Makadara	Mbotela Social Hall
288			Mathare	Mathare North Social Hall
289			Embakasi Central	Kayole Social Hall
290			Embakasi West	Embakasi DCC Youth Hall

ANNEXURE 3: SUMMARY ON THE BENEFIT PACKAGE AND TARIFFS UNDER THE SOCIAL HEALTH INSURANCE ACT AND THE SOCIAL HEALTH INSURANCE REGULATIONS, 2024

BACKGROUND

The Social Health Insurance Regulations, 2024 outline the benefit package offered through the three Funds: the Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund. The objectives of the SHA Benefits Package include to:

- (a) increase investment in financing preventive and promotive health, and access to relevant essential services at the primary level.
- (b) progressively expand the population and services covered under the SHA for Kenyans and persons resident in Kenya including the poor and vulnerable groups.
- (c) progressively enhance financial risk protection for all beneficiaries including the poor and vulnerable groups.
- (d) progressively improve the quality of health services for better health outcomes.
- (e) sustainably finance the essential benefit package for all Kenyan residents.

The Social Health Authority, vide the Social Health Insurance Regulations, 2024, had published approved the benefit package for roll out on 1st October 2024. This benefit package is contained in the Second, Third and Fourth Schedules to the Social Health Insurance Regulations, 2024.

Upon publication of the Social Health Insurance Regulations, 2024 and their subsequent approval by the National Assembly and the Senate, the tariffs for the approved benefit package that was subjected to public participation was optimized based on the available funds to reflect the available budget and projected enrolment of Kenyans in the 2024/2025 financial year (nine months). This optimization involved the following aspects:

- (a) analyzing and refining the components of the benefits package to ensure that the resources available are utilized in the most impactful way possible;
- (b) ensuring the limited financial resources are strategically allocated to the most critical areas of need in the benefit package;
- (c) prioritizing services that provide the greatest value to beneficiaries; and

- (d) identifying the cost-effective strategies such as negotiating better rates with service providers.

Optimization basically helps ensure that limited resources are used in the most effective way possible. By carefully selecting and prioritising interventions, focusing on high-impact interventions, SHA can achieve better health outcomes within the available budget.

1. THE PRIMARY HEALTHCARE FUND

The Primary Healthcare (PHC) Fund is primarily tax-funded, and all Kenyans registered as members of the Social Health Authority (SHA) are eligible to benefit from it and therefore SHA had projected KES 61.1 billion for this Fund. However, in as much as the estimated requirement for PHC services for the nine months was KES. 35.15 billion, the available resources from the exchequer was KES. 20.215 billion. This necessitated the prioritization of the allocation of benefits to align with the available budget which led adoption of the following:

- (a) KES. 900 for outpatient care services at the primary health care level where KES 540 would cover consultations, diagnostic services, therapeutic services, preventive services, and administrative services and KES 360 would fund pharmaceutical commodities.
- (b) A per diem rate of KES. 2240 (a 12% increase of the rates payable under the defunct NHIF). The new rate is projected to have a 7% reduction in the estimated cost of delivering the service.
- (c) Optical benefit package for children aged 18 years and below (deferred in the year 1 rollout).
- (d) screening for cancers through PSA, HPV, Stool for occult blood and management of pre-cancerous lesions (this would target 15% of the population in need).
- (e) last office benefit package including storage and embalming targeting all death estimates in the country.

2. THE SOCIAL HEALTH INSURANCE FUND

The SHA benefit package under this Fund covers outpatient, inpatient (admission, critical care and palliative care), dental, mental health, renal care therapies including pre and post-transplant management, maternity (deliveries), radiology, haematology and oncology, surgical and overseas treatment in line with published tariffs. As

regards inpatient care services, a per diem rate was set in accordance with the level of a health facility as well as the section of the health facility (medical admission, HDU, ICU and palliative care) in which the service is being provided.

The surgical benefit package was determined guided by factors such as prevalence and need, equity and access, patient demand, and resource availability and as such a listing of 549 surgical procedures was developed and included in the published Tariffs. The list also sets out the complexity of the surgical procedure in terms of whether it is minor, major or specialized which prevents abuse by indicating the surgical procedures that will require pre-authorization.

The maternity and child health services benefit package was included in the PHC Fund and the SHIF in light of the rising Maternal Mortality Rate (MMR) over the last 10 years. This rate has risen by 46.4% to 530 per 100,000. The SHA therefore considered this rate in adopting the new model of financing which covers mothers from level 1 to level 6. This new funding model guarantees safe deliveries while ensuring that pregnant mothers are well taken care of, pre- and post-partum.

The provision for overseas treatment enables SHIF to finance medical management and surgical procedures that are not locally available and have been cleared for overseas treatment in accordance with the SHI Regulations, 2024 and the guidelines issued by the MOH on treatment outside the country. The latter have made comprehensive provisions which will guarantee patient safety by ensuring that:

- (a) the healthcare service for which the beneficiary is being referred is not available in Kenya;
- (b) the referral is to a healthcare service provider or health facility that is contracted by SHA;
- (c) the referral is medically necessary based on peer review by healthcare professionals;
- (d) the financial implication of the healthcare service sought outside Kenya is within the limits of the published benefits package; and
- (e) the treatment sought is not unproven, experimental or an unconventional therapy.

The mental wellness benefit package under the SHIF is very expansive as it covers aspects including:

- (a) mental health education and counselling
- (b) psychosocial support

- (c) outpatient diagnosis and management of behavioural disorders, neuro-development disorders, neuro-degenerative, affective and psychoactive disorders
- (d) inpatient diagnosis and management of behavioural disorders, neuro-development disorders, neuro-degenerative, affective and psychoactive disorders
- (e) rehabilitation for drugs and substance addictive disorders including inpatient stay
- (f) detoxification and rehabilitation.

3. EMERGENCY, CHRONIC AND CRITICAL ILLNESS FUND

The SHA benefit package under this Fund covers outpatient, inpatient critical care and palliative care, assistive devices, mental wellness including rehab for DSA, affective and other disorders, renal care therapies, haematology and oncology, accident and emergency, ambulance evacuation services and overseas treatment.

The available budget for the roll out of this Fund was KES. 2Billion which was presented a huge financial shortfall necessitating prioritization and optimization of the published package.

CONCLUSION

In light of the budgetary constraints during the roll-out of the aforementioned three Funds, SHA readjusted the costs for delivering the packages under the three Funds for the 9-month period as below:

INITIAL COSTS			
	PHC	SHIF	ECCIF
Total	43,534,400,125	118,608,511,045	76,372,321,301
Total +Admin (5%)	45,825,684,342	124,851,064,258	80,391,917,158
NEW PRIORITIZED COSTS			
	PHC Prioritized	SHIF Prioritized	ECCIF Prioritized
Total	33,393,450,000	94,451,815,233	1,900,000,000
Total +Admin (5%)	35,151,000,000	99,422,963,403	2,000,000,000

From the above costs, the insurance yield of the Social Health Insurance Fund, the contributory Fund, was calculated based on several scenarios that took into account several factors including:

- (a) the projected active membership of households who are registered and paid up or not paid up;
- (b) assumption that SHA shall embark on a rigorous recruitment exercise to enrol 3 million informal sector earner households and ensure that they are fully registered and paid-up members of SHIF;
- (c) assumption that the informal sector earners will contribute the actuarially determined premium of KES. 14,090 per annum;
- (d) assumption that the informal sector earners will contribute a monthly average amount based on the results of proxy means testing tool; and
- (e) assumption that the indigent population (of approximately 1.44m households) will be paid for a premium by the government(Both National and County) or by sponsor.

The optimization and prioritization based on the available and prioritized costs done by the Social Health Authority for the benefits packages provided in the Second, Third and Fourth Schedules to the Social Health Insurance Regulations, 2024 will progressively expand the services covered by SHA and finance healthcare in a sustainable manner.

