REPUBLIC OF KENYA

THE NATIONAL ASSEMBLY

THIRTEENTH PARLIAMENT – FOURTH SESSION – 2025

DIRECTORATE OF DEPARTMENTAL COMMITTEES

DEPARTMENTAL COMMITTEE ON HEALTH

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REPORT ON THE ASSESSMENT OF SOCIAL HEALTH AUTHORITY (SHA) UTILIZATION OF FUNDS DISBURSED SINCE INCEPTION AND CHALLENGES FACED BY FACILITIES

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CHAIRPERSON'S FOREWORD

The Departmental Committee on Health of the National Assembly is guided by its constitutional and parliamentary mandate to safeguard the health and well-being of the people of Kenya. Through its oversight role, the Committee continues to ensure that public resources allocated to the health sector are effectively utilized, that service delivery meets the required standards, and that Kenyans have access to affordable and quality healthcare in line with the objectives of Universal Health Coverage (UHC).

This fact-finding visit report is a product of the Committee's commitment to accountability, transparency, and responsiveness to issues of concern raised by the public. It reflects the Committee's observations, engagements, and findings from selected health facilities across Nairobi, Homa Bay, Kakamega, Laikipia, and Nyeri Counties. The Committee acknowledges the cooperation extended by the respective county governments, health facility management teams, and other stakeholders during the visits.

We hope that the findings and recommendations herein will inform policy, strengthen health systems, and contribute towards building a resilient healthcare sector that meets the aspirations of the Kenyan people.

HON. DR. NYIKAL JAMES WAMBURA, CBS, MP.
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

CHAPTER ONE

1.0 PREFACE

1.1 Establishment and Mandate of the Committee

1. The Departmental Committee on Health is one of the Departmental Committees of the National Assembly established under Standing Order 216 whose mandates pursuant to the Standing Order 216 (5) are as follows:

   i. **To investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned ministries and departments;**

   ii. To study the programme and policy objectives of ministries and departments and the effectiveness of the implementation;

   iii. on a quarterly basis, monitor and report on the implementation of the national budget in respect of its mandate;

   iv. To study and review all legislation referred to it;

   v. To study, assess and analyse the relative success of the ministries and departments as measured by the results obtained as compared with their stated objectives;

   vi. To investigate and inquire into all matters relating to the assigned ministries and departments as they may deem necessary, and as may be referred to them by the House;

   vii. To vet and report on all appointments where the Constitution or any law requires the National Assembly to approve, except those under Standing Order 204 (Committee on Appointments);

   viii. To examine treaties, agreements and conventions;

   ix. To make reports and recommendations to the House as often as possible, including recommendations of proposed legislation;

   x. To consider reports of Commissions and Independent Offices submitted to the House pursuant to the provisions of Article 254 of the Constitution; and

   xi. To examine any questions raised by Members on a matter within its mandate.

1.2 Subjects under the Committee

2. In accordance with the Second Schedule of the Standing Orders, the Committee is mandated to consider matters related to health, medical care and health insurance, including universal health coverage.

1.3 Oversight

3. In executing its mandate, the Committee on Health oversees the:
   i. State Department for Medical Services
   ii. State Department for Public Health and Professional Standards.

1.4 Committee Membership

4. The Departmental Committee on Health was constituted by the House on 27th October 2022 and comprises the following Members:

Chairperson
Hon. Dr. Nyikal James Wambura, CBS, MP
Seme Constituency
ODM Party

Vice-Chairperson
Hon. Ntwiga, Patrick Munene MP
Chuka/Igambang'ombe Constituency
UDA Party

Hon. (Dr) Robert Pukose,CBS MP
Endebess Constituency
UDA Party

Hon. Maingi Mary, MP
Mwea Constituency
UDA Party

Hon. Owino Martin Peters, MP
Ndhiwa Constituency
ODM Party

Hon. Muge Cynthia Jepkosgei, MP
Nandi (CWR)
UDA Party

Hon. Mathenge Duncan Maina, MP
Nyeri Town Constituency
UDA Party

Hon. Wanyonyi Martin Pepela, MP
Webuye East Constituency
Ford Kenya Party

Hon. Lenguris Pauline, MP
Samburu (CWR)
UDA Party

Hon. Kipng'ok Reuben Kiborek , MP
Mogotio Constituency
UDA Party

Hon. Oron Joshua Odongo, MP
Kisumu Central Constituency
ODM Party

Hon. (Prof.) Jaldesa Guyo Waqo, MP
Moyale Constituency
UPIA Party

Hon. Mukhwana Titus Khamala, MP
Lurambi Constituency
ODM Party

Hon. Kibagendi Antoney, MP
Kitutu Chache South Constituency
ODM Party

Hon. Julius Ole Sunkuli Lekakeny, MP
Kilgoris Constituency
KANU

1.5 Committee Secretariat

5. The Committee is facilitated by the following staff secretariat:

Mr. Hassan Abdullahi Arale
Clerk Assistant I/Head of Secretariat

Mr. Timothy Kimathi Samson
Clerk Assistant III

Ms. Gladys Jepkoech Kiprotich
Clerk Assistant III

Ms. Marlene Ayiro
Principal Legal Counsel I

Ms. Sheila Chebotibin
Senior Serjeant-At-Arms

Ms. Faith Chepkemoi
Legal Counsel II

Ms. Abigel Muinde
Research Officer III

Mr. Hiram Kimuhu
Fiscal Analyst III

Ms. Rahab Chepkilim
Audio Recording Officer II

Mr Eric Lungai
Hansard Reporter II

Mr. Hillary Mageka
Media Relations Officer III

CHAPTER TWO

2.0 INTRODUCTION AND BACKGROUND

2.1 Background on the Social Health Authority (SHA)

6. The Social Health Insurance Act, No. 16 of 2023, was enacted to provide a legislative framework for social health insurance, promote Universal Health Coverage (UHC), and guarantee all Kenyans access to affordable and comprehensive quality healthcare. The Act establishes the Social Health Authority (SHA), mandated to manage three public funds:
    1. **Primary Healthcare Fund** – finances services in Level 2 and 3 facilities. It is exchequer-funded, removing direct financial burden from Kenyans and strengthening preventive healthcare as a sustainable financing model.
    2. **Social Health Insurance Fund** – covers services in Levels 4, 5, and 6 facilities, financed by mandatory contributions of 2.75% of income from Kenyans.
    3. **Emergency, Chronic, and Critical Illness Fund** – finances emergency care, 24-hour stabilization, and treatment of chronic or critical illnesses once insurance benefits are depleted. It is exchequer-funded and provides critical financial protection, particularly against illnesses like cancer.
7. The SHA is responsible for registering beneficiaries, collecting contributions, contracting accredited healthcare providers, making payments, and advising the Cabinet Secretary on policy matters. The Act also provides for a Claims Management Office to process claims and a Dispute Resolution Tribunal to handle appeals and complaints.
8. By design, SHA supports national development priorities, including Kenya Vision 2030, the Bottom-up Economic Transformation Agenda (BETA), and the UHC Policy (2020–2030). Its mandate aligns with the constitutional principle of Leaving No One Behind by ensuring healthcare access for vulnerable groups, including the elderly, indigents, and persons in lawful custody.
9. The Act further introduces mandatory registration of all members and digitization of claims and service processes to enhance efficiency, transparency, and fraud prevention. Healthcare providers are empanelled and contracted in consultation with accreditation bodies responsible for the quality of care.

2.2 The Digital Health Act, 2023

10. The Digital Health Act, No. 15 of 2023, establishes a regulatory framework for digital health services and creates the Digital Health Agency to oversee implementation. Its mandate includes developing and maintaining a Comprehensive Integrated Health Information System (CIHIS), ensuring data governance, and safeguarding patient privacy.
11. Key functions include:
    (i) Establishing registries as a single source of truth for health information.
    (ii) Certifying digital health solutions in line with global standards.

(iii) Facilitating collection, analysis, and sharing of health data for policy, research, and service delivery

(iv) Supporting innovations such as telemedicine, health tourism, and e-waste management.

2.3 Context of the Fact-Finding Visits

12. The Departmental Committee on Health is established under Standing Order 216(5) of the National Assembly with the mandate to investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operation, and estimates of the Ministries and State Departments assigned to it.
13. In addition, Article 95 of the Constitution of Kenya empowers the National Assembly to deliberate and resolve issues of concern to the people. In line with this mandate, the Committee, during its sitting held on Tuesday, 26th August 2025, resolved to undertake a fact-finding visit to selected health facilities in Nairobi, Homa Bay, Laikipia, and Nyeri Counties.
14. The objective of the visits was to;

(i) Assess the utilization of SHA funds since the inception of the scheme.

(ii) Examine the impact of SHA financing on service delivery particular focus on the timeliness of reimbursements and efficiency of fund management.

(iii) identify challenges faced by health facilities in the implementation of UHC programs and;

(iv) To provide recommendations for improving SHA's efficiency and effectiveness.

15. The facilities visited were as follows:

a) **Nairobi County:** Ladnan Hospital Ltd and Mbagathi County Hospital,
b) **Homa Bay County:** Matata Nursing Hospital, Nyandiwa Level 4 Hospital, St. Elizabeth Swindon, Rachuonyo County Hospital and Nyandiwa Health Centre.
c) **Kakamega County:** St. Mary's Hospital, Mumias,
d) **Laikipia County:** Nyahururu County Referral Hospital and Sipili Hospital
e) **Nyeri County:** PCEA Tumutumu Hospital and Nyeri County Referral Hospital

16. The visits were undertaken from Tuesday, 2nd September 2025, to Friday, 5th September 2025. This report presents the Committee's findings, observations, and recommendations arising from the engagements during the visits.

2.4 Methodology

17. The Committee adopted a multi-pronged methodological approach to generate reliable insights on the implementation of the Social Health Insurance (SHI) scheme and the utilization of payments from the Social Health Authority (SHA), particularly within the framework of the Facility Improvement Financing Act, 2023. The methodology involved the following:

(i) Document Review: The Committee undertook a review of the legal and regulatory documents, including the Social Health Insurance Act, the Facility Improvement Financing Act, 2023, SHA guidelines, and facility-level financial reports.

(ii) Selection of Facilities: A purposive sampling approach was applied for diverse perspectives across health service providers. The sample included: County referral hospitals representing government health facilities, Mission (faith-based) hospitals providing essential healthcare services under SHA accreditation and Private health facilities contracted by SHA.

(iii) Site Visits: The Committee conducted visits to the selected facilities to observe first-hand the implementation of SHI and the Facility Improvement Financing framework. The visits allowed members to assess infrastructure, service delivery processes, claims management, and financial flow systems.

(iv) Stakeholder Engagements: During the visits, the Committee held consultative meetings with a range of stakeholders, including:

a. Facility administrators and finance officers,
b. Health workers across cadres,
c. County health officials, and
d. Representatives of faith-based and private sector health providers.

18. This methodology provided qualitative insights into operational challenges, successes, and gaps in the implementation of SHI and facility financing mechanisms. The Committee triangulated data from reviewed documents, site observations, and stakeholder inputs to develop the recommendations.

CHAPTER THREE

3.0 THE ASSESSMENT OF SHA UTILIZATION OF FUNDS IN SELECTED HEALTH FACILITIES

3.1 LADNAN HOSPITAL, PANGANI

a) Facility Overview

19. Ladan Hospital, located in Pangani, Nairobi County, is a private health facility accredited under the Social Health Authority (SHA). The hospital provides both outpatient and inpatient services. The facility operates with a 50-bed capacity and is equipped with a maternity unit, two operating theatres, an intensive care/high dependency unit (ICU/HDU), a radiology department, a laboratory, and various specialized clinics.

20. The hospital was previously contracted and empaneled under NHIF, with continuity carried forward into SHA since its inception in October 2024. Ladnan Hospital continues to provide uninterrupted services, including outpatient, inpatient, maternity, and emergency care, despite facing financial challenges with the new system. The facility is owned and managed by Ladnan Hospital Limited, which is fully under Metro Group PLC, a now unlisted public company with over 500 shareholders and a corporate governance structure governed by established protocols and oversight mechanisms.

b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	**Percentage**
Total Claims Submitted	325,609,818	100%
Total Claims Received	192,583,146	59%
Outstanding Claims	133,026,672	41%

Summary of SHA Funding and Reimbursements Disbursed to Ladnan Hospital (October 2024 – August 31st 2025)

21. Since SHA's inception, Ladnan Hospital Limited has received Ksh 192,583,146 in reimbursements, representing only 59% of the total amount claimed for the period October 2024 to August 2025. The hospital reports that this recovery ratio is not sustainable because SHA packages were priced in advance with quite low margins. There have been months when the facility received no payments at all, severely affecting cash flow and operational planning.

1Members of the Health Committee on a visit at Ladnan Hospital in Pangani

22. The facility faces significant challenges with SHA's reimbursement system, which provides lump sum payments without breakdown by fund type, unlike the previous NHIF system that automatically provided remittance schedules per invoice. This makes reconciliation difficult and affects timely allocation to private doctors.

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	360,000,000
SHA Outstanding Debt	133,026,672
Total Debt Burden	493,026,672

The facility reports a total debt burden of Ksh 493 million, with NHIF owing Ksh 360 million (ready for verification) and SHA owing Ksh 133 million as at 31st August 2025.

c) Key Findings

23. The following key findings were identified:

i. **Ownership and Governance;** The Committee confirmed, in line with hospital management and Metro Group's filings, that Ladnan Hospital Limited fell wholly under Metro Group PLC, now an unlisted public company with over 500 shareholders and strict governance protocols.

ii. **Delayed and Inconsistent Reimbursements from SHA;** the hospital has only received approximately 59% of claims, with no predictable payment schedule. The absence of detailed remittance advice creates difficulties in reconciliation and financial planning.

iii. **High Debt Burden;** The facility carries a substantial debt burden totaling Ksh 493 million, with significant amounts owed by both NHIF and SHA, affecting operational sustainability.

iv. **Lack of Transparency in Payment Systems;** SHA provides lump sum reimbursements without breakdown by fund type (SHIF, PHCF, and ECCIF), making it impossible to track payments by fund category and affecting accurate financial reconciliation.

v. **Consultant-Driven Referrals;** as a subsidiary of the Metro Group, Ladnan benefits from access to a wide pool of consultants. These specialists frequently refer patients to the facility for inpatient care, especially for surgical interventions, thereby boosting patient volumes and strengthening Ladnan's position in surgical service delivery.

vi. **Empanelment Process;** the facility has reported no challenges, since the facility was previously contracted and empaneled under NHIF, with continuity carried into SHA.

vii. **Geofencing Requirement for Doctors and System Challenges;** the current system requires doctors to be within a 1km radius for the One-Time Password (OTP) to be generated and sent. This geofencing restriction often creates delays and inconveniences, limiting flexibility for doctors and affecting timely service delivery. Occasional system downtimes affecting claim submissions

viii. **Patient Understanding and Enrollment Barriers;** Patients struggle to understand the outpatient model and what is covered vs. excluded, creating dissatisfaction. The requirement for annual lump-sum contributions for self-employed members has been a barrier to enrolment and continuity of care.

ix. **Limited Coverage for Multiple Injuries;** Patients are only allowed to benefit from coverage for a single case. In situations where a patient sustains two fractures, only one is covered, while the second must be paid for in cash. This creates financial hardship for patients and undermines the principle of comprehensive health coverage.

x. **Strong Performance in Surgical Cases;** Ladnan has consistently attracted surgical clients both during the NHIF period and under SHA. This is largely driven by referrals from its network of consultants. Additionally, when NHIF clients were received under the national capitation scheme, many patients became aware of the inpatient benefits, particularly for surgical procedures.

xi. **Alignment with SHA Tariffs;** for surgical cases, Ladnan operates effectively within the approved SHA reimbursement rates without requiring co-payments from clients. This approach has icreased affordability and made the facility more attractive to SHA beneficiaries seeking surgical services.

d) Request by Hospital to the Committee

24. The hospital respectfully submitted the following requests to the Committee for policy interventions and engagement with the Social Health Authority (SHA):

i. Reinstate the practice of issuing remittance advice before payments (as practiced under NHIF) to improve transparency, reconciliation, and financial planning.

ii. Address payment inequities across county, faith-based, and private facilities.

iii. Facilitate structured negotiations for clearance of outstanding debts totaling Ksh 493 million from both NHIF and SHA.

iv. Strengthen SHA civic education programs to improve patient awareness of entitlements and covered services, particularly regarding outpatient care models.

v. Review authorization protocols to reduce treatment delays without increasing risk of abuse

vi. Consider implementing more flexible contribution models for self-employed members to reduce enrolment barriers and improve continuity of care.

vii. Increase transparency by requiring SHA to publish full claim information including total claims for each fund, returns, rejections, and payments to improve accountability and oversight.

viii. Establish a comprehensive accountability framework that holds all stakeholders (members, SHA, hospitals, and doctors) accountable without discrimination, while addressing fraud concerns across the entire system.

3.2 MBAGATHI COUNTY HOSPITAL

a) Facility Overview

25. Mbagathi County Referral Hospital is a Level 5 public health facility serving Nairobi and its neighboring counties. It is accredited by the Kenya Medical Practitioners and Dentists Council (KMPDC) with a bed capacity of 416 beds. The hospital offers a wide range of inpatient and outpatient services, including surgery, maternity care, renal dialysis, management of chronic and critical illnesses, and emergency care. It also serves as a training site with medical interns posted regularly.

26. The hospital is currently contracted with the Social Health Authority (SHA) under the Social Health Insurance Fund (SHIF) since SHA's inception in October 2024. Despite this engagement, it has not received any reimbursements under the Emergency, Chronic, and Critical Illness Fund. All claims are submitted through SHA's designated digital platform.

b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	Percentage
Total Claims Submitted	383018857	100%
Total Claims Received	194,097,910.5	51%
Outstanding Claims	188920946.5	49%

Summary of SHA Funding and Reimbursements Disbursed to Mbagathi County Hospital (October 2024 – Present)

27. Since SHA's inception, Mbagathi County Hospital has submitted claims totaling Ksh 383,018,857 and received Ksh 194,097,910.5 in reimbursements, representing 51% of total claims submitted. Outstanding claims total Ksh 188,920,946.5, representing 49% of submitted claims. Only a portion of reimbursements are disbursed within expected timelines, with the remainder released in staggered, delayed, and fragmented payments. Reimbursement processing typically takes 60 to 120 days,

severely constraining the hospital's cash flow and undermining effective budget execution and service delivery planning.

2Hon. Cynthia Muge, seeking clarification, when the Committee held a meeting at Mbagathi County Hospital.

28. Claim rejections due to documentation gaps remain a concern. To date, approximately 500 claims worth Ksh 6 million and 39 claims worth Ksh 4 million have been returned for incomplete patient records (such as missing theatre notes and claim forms). In total, rejected claims amount to Ksh 18.3 million.

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	279,576,802.00
SHA Outstanding Debt	188,920,946.50
Total Debt Burden	468,497,748.50

29. The facility claims to have experienced persistent challenges in recovering outstanding debts from the Social Health Authority (SHA). It reports that there is no structured or transparent process for following up on these debts, which continues to impede financial planning and service delivery.

c) Key Findings

30. The following key findings were identified:

i. **Delayed and Partial Reimbursements from SHA;** the hospital continues to experience delayed and fragmented disbursements from the Social Health

Authority (SHA), with only 57.2% of reimbursements made on time. This significantly affects cash flow, financial planning, and timely implementation of hospital activities.

ii. **High Debt Burden;** The facility carries a substantial debt burden totalling Ksh453.5 million, inherited from NHIF and accumulated under SHA. The lack of a structured follow-up mechanism on outstanding reimbursements has further worsened the situation.

iii. **Inadequate Service Coverage;** Outpatient services are not covered at Level 5 hospitals under SHIF. Additionally, the withdrawal of the Linda Mama program has negatively impacted maternal and neonatal care services, particularly within the Neonatal Intensive Care Unit (NICU).

iv. **Weak Referral System;** Patients face challenges in accessing referred services due to their inability to afford SHA premiums. This undermines the efficiency of the referral system and limits access to higher-level care within the health network.

v. **System Downtime and Capacity Building Challenges;** SHA's digital systems experience frequent downtimes, which disrupt claim submissions and processing. In addition, online training related to empanelment and system usage are poorly structured, reducing staff efficiency and increasing the risk of rejected claims.

vi. **Service Delivery;** Outpatient services are not covered at Level 5 hospitals. Withdrawal of Linda Mama has negatively affected maternal and neonatal care, especially in the NICU.

vii. **Referral System;** Patients experience difficulties due to their inability to pay SHA premiums, limiting seamless transfers across facilities.

viii. **Infrastructure & Projects;** Several projects have stalled, including the Dental Unit, Critical Care Unit, and expansion of the Renal Unit.

ix. **Supply Chain;** KEMSA supplies are inadequate, with only a 30% fill rate on essential commodities. The hospital supplements supply through private vendors. Suppliers are also not honoring LPOs due to non-payment of their invoices.

d) Request by Hospital to the Committee

31. The hospital respectfully submits the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Streamline SHA reimbursement processes to ensure timely and adequate disbursements.

ii. Facilitate the clearance of outstanding debts through structured negotiations involving SHA, NHIF, and the hospital.

iii. Reintroduce or establish a replacement for the Linda Mama program to support maternal and neonatal care services, particularly in the NICU.

iv. Fast-track the completion of stalled infrastructure projects, including the Dental Unit, Critical Care Unit, and Renal Unit expansion to improve service capacity.

v. Strengthen the referral system by subsidizing patient transfers and ensuring full functionality of lower-level facilities within the referral network.

vi. Improve the efficiency of the KEMSA supply chain, with a focus on increasing the fill rate for essential medical commodities.

vii. Upgrade SHA digital systems and provide well-structured, in-person training to improve staff capacity and reduce claim rejections.

3.3 ST ELIZABETH SWINDON

a) Facility Overview

32. St Elizabeth Swindon is a faith-based hospital founded by missionaries with the primary mission of providing affordable private healthcare for vulnerable populations, especially those affected by HIV/AIDS.
33. The hospital partnered with government and development agencies to expand services and infrastructure, growing to a 34-bed facility. Initially accredited as a Level 3 facility by NHIF, the hospital has undergone several inspections and capacity reviews.
34. However, the hospital currently faces a critical operational challenge following systemic changes within the healthcare regulatory framework. The KMPDC system suddenly reduced all Level 3B facilities, including St Elizabeth Swindon, to zero beds without prior notice or inspection, despite the facility maintaining its physical 34-bed license and infrastructure. As a result, the Social Health Authority (SHA) will not pay for admissions.
35. The hospital can only admit cash-paying patients, excluding the vulnerable population it was designed to serve. Patients requiring admission are being redirected to Level 4 facilities such as Evans Healthcare and Matata, leading to increased strain on those hospitals and hardship for patients.

b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	6,992,903.50	100%
Total Claims Received	4,604,304.00	65%
Outstanding Claims	1,228,439.25	35%

Summary of SHA Funding and Reimbursements Disbursed to St. Elizabth Swindon since its inception.

36. Since SHA's inception, St. Elizabeth Swindon has submitted claims totalling Ksh 6,992,903.50 and received Ksh 4,604,304.00 in reimbursements, representing 65% of total claims submitted. Outstanding claims total Ksh 1,228,439.25, representing 18% of submitted claims. Rejected claims amount to Ksh 1,160,160.25. The facility experiences payment delays that affect its ability to maintain consistent service delivery and meet operational obligations.

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	2,600,000.00
SHA Outstanding Debt	2,388,599.25
Total Debt Burden	4,988,599.25

37. The facility faces a total debt burden of Ksh 4,988,599.25, comprising SHA outstanding debt (Ksh 2,388,599.25) and inherited NHIF debt (Ksh 2,600,000.00).

c) Key Findings

38. The following key findings were identified:
    i. **Systemic Contradictions**; There is poor coordination between KMPDC, SHA, and DHA, with facilities receiving conflicting directives and no clear written communication. This lack of alignment creates confusion at the facility level and hinders smooth service delivery.
    ii. **Bed Capacity Conflict**: The facility is licensed for 34 beds, yet the SHA portal reflects zero beds, effectively locking out patients dependent on SHA from accessing inpatient care. This discrepancy denies services to vulnerable populations.
    iii. **Payment Model Barriers**: The shift from NHIF's monthly or quarterly contributions to SHA's annual lump-sum payments has excluded many poor households that cannot afford upfront payments. This change has already reduced patient access to essential health services.
    iv. **Inspection Gaps**; though recent joint inspections confirmed compliance, facilities were not issued written reports. Regional inspection officers also cite directives from the Cabinet Secretary halting inspections, leaving facilities without guidance on compliance or improvement.
    v. **Impact on Patients**; Patients are increasingly denied inpatient care, with many resorting to self-medication, alternative treatments, or traveling long distances to higher-level facilities. As a result, the hospital is unable to fulfil its founding mission of serving vulnerable populations.

d) Request by Hospital to the Committee

39. The hospital respectfully submitted the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:
    i. SHA Insurance should be able to effectively address the issue of bed capacity at the point of empanelment since all the required licenses and documents from relevant bodies are usually submitted at that stage before contracting the facility. The different levels should operate as licensed by KMPDC to ease congestion of patients in few facilities.
    ii. SHA must be able to communicate effectively with all stakeholders and governing bodies to quickly address raised concerns aimed at improving services.
    iii. SHA should streamline their communication and support system for seamless operations.
    iv. SHA should sensitize the public about PHC tariffs to mitigate conflicts at billing stage.
    v. SHA should explain to the facilities how the Global Budget Allocation operates to allow facilities plan on service delivery according to contractual terms.

vi. SHA should send back claims and allow facilities to address medical review concerns before rejecting claims, the resubmission tab for rejected claims should be added in the dashboard.

vii. The dashboard should display all SHA payments: SHIF, PHC and Outpatient (Public Officers Medical Scheme) to allow easy reconciliation for the facilities.

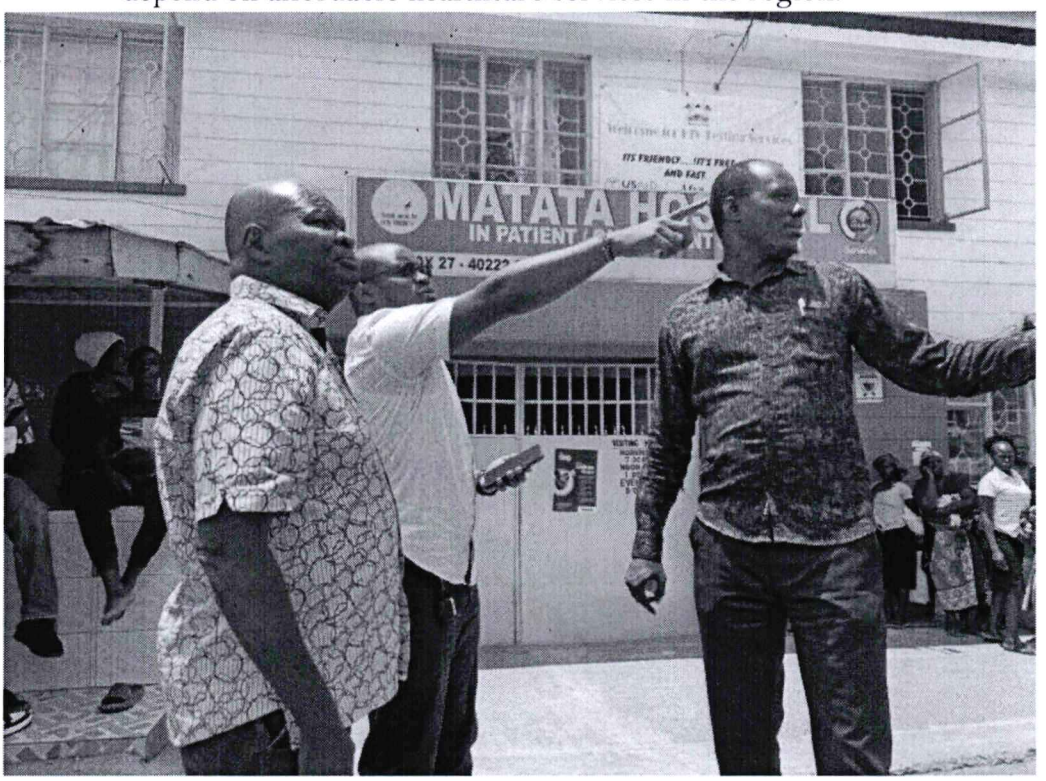
3.4 MATATA NURSING HOME

a) Facility Overview

40. Matata Nursing Home is a faith-based healthcare facility operating as a Level 4 hospital mandated to offer both primary health care services and inpatient care. The facility has a bed capacity of 150 beds, which is generally adequate to meet patient demand except during health crises or disease outbreaks such as malaria epidemics.

41. The hospital was previously accredited under NHIF and transitioned to SHA when the Social Health Authority was established. The facility underwent both manual contracting initially and later adopted the e-contracting system developed by SHA. The hospital is currently fully accredited and continues to serve patients despite facing significant operational and financial challenges under the new system.

42. As a faith-based organization, Matata Nursing Home plays a crucial role in sustaining healthcare provision to patients, particularly vulnerable populations who depend on affordable healthcare services in the region.



3Hon. Joshua Oron (left) is shown around Matata Hospital when the Committee visited the facility.

b) Funding and Reimbursements

i. **Claims**

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	118,277,076	100%
Total Claims Received	63,801,537	54%
Outstanding Claims	54,475,539	46%

Summary of SHA Funding and Reimbursements Disbursed to Matata Nursing Home since its inception.

43. Since SHA's inception, Matata Nursing Home has submitted claims totalling Ksh 118,277,076 and received Ksh 63,801,537 in reimbursements, representing 53.9% of total claims submitted. The amount received comprises Primary Health Care Fund payments of Ksh 12,140,098 and Social Health Insurance Fund payments of Ksh 51,661,439. Outstanding claims total Ksh 54,475,539, consisting of unpaid SHIF claims worth Ksh 50,675,539 and unpaid PHC claims worth Ksh 3,800,000. Only 30% of reimbursements are disbursed on time, with 70% experiencing significant delays. The facility's payments have been on hold since June 2025, and letters of inquiry to SHA remain unanswered.

iii. **Debt Position:**

Debt	Amount (Ksh)
NHIF Outstanding Debt	53,000,000
SHA Outstanding Debt	54,475,539
Total Debt Burden	107,475,439

44. The facility faces a total debt burden of Ksh 107,475,539, comprising unpaid SHIF claims (Ksh 50,675,539), unpaid PHC claims (Ksh 3,800,000), and inherited NHIF debt (Ksh 53,000,000).

ii. **Key Findings**

45. The following key findings were identified:

i. **Delayed and Withheld Payments**; The Facility continues to face delays in receiving reimbursements, with some payments being withheld without clear explanations. Despite verification of details, funds remain blocked due to issues such as mismatched facility codes, where wrong facility numbers are linked to claims, creating unnecessary financial strain on hospitals.

ii. **Claims Rejections**; There is a persistently high rate of claim rejections even when proper documentation including patient IDs, discharge summaries, and passports has been provided. The AI-driven system frequently flags legitimate claims as fraudulent, while some rejections are communicated months later, far beyond the legally stipulated 90-day period, leaving facilities unable to resubmit claims in time.

iii. **Systemic Issues with SHA**; SHA's heavy reliance on automation without adequate human oversight results in frequent errors. System downtimes often trigger fraud flags when patients are admitted during outages. Pre-authorization processes are impractical, requiring all doctors to log in simultaneously. Network issues and geocoding affect authorizations, especially in emergencies. Some doctors cannot

approve surgeries, and reimbursement favors public over private facilities. Allocation methods under capitation and global budgets lack transparency.

iv. **Empanelment and Authorization**; the transition from manual to e-contracting improved the empanelment process, but significant challenges remain. Claims often take over six months to be reimbursed, with minimal communication on claim status. Many are eventually rejected without clear justification. Surgical claims in particular remain stuck at the review stage, delaying payments to consultants and affecting service delivery.

v. **Contractual and Policy Limitations**; Rigid package rates, such as Ksh 30,000 for caesarean sections, fail to cover extended hospital stays or complications. There are no provisions for additional claims when newborns or mothers develop further conditions. Outpatient claims remain poorly structured and inconsistently handled.

vi. **Governance and Accountability Gaps**; Local SHA offices lack adequate authority to resolve pressing facility-level issues, forcing facilities to escalate matters unnecessarily. Senior officials in Nairobi often dismiss or redirect complaints without offering solutions, while internal disorganization within SHA results in departments—finance, claims, and compliance—passing responsibility back and forth, leaving problems unresolved.

vii. **Service Delivery Impact on Vulnerable Populations; Quality** services to patients have been paralyzed due to inadequate drug stocking. Expecting mothers cannot access medical treatment or maternity services without SHA registration and premium payment. Upfront annual premium payments have made it impossible for most patients to access medical services.

viii. **Operational and Financial Constraints;** As a service delivery gap, the facility reported that the statutory remittances including HELB, PAYE, NSSF, and Housing Levy cannot be made, leading to accumulating penalties. The facility cannot meet obligations to patients and creditors, and staff payments are consistently delayed.

ix. **Referral System Inefficiencies;** Referrals are not seamless because the facility cannot claim ambulance costs at Level 4, and ambulance services are not covered under SHA benefits packages.

x. **UHC Implementation Barriers**; Barriers include the requirement for annual premium payments, unclear contribution rates, lack of coverage for critical services (e.g., ambulance services), monthly claim reimbursement cycles, and perceived discrimination in disbursement across different facilities.

iii. Request by the Hospital to the Committee

46. The hospital respectfully submitted the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Human oversight should be reinstated alongside AI systems to reduce wrongful rejections, while the 90-day payment rule must be strictly enforced for all approved claims. Additionally, pre-authorization processes should be improved by allowing asynchronous approvals, eliminating the impractical requirement for simultaneous doctor log-ins.

ii. Facility coding errors must be corrected to prevent misallocation of claims, and SHA should increase transparency in how capitation and global budgets are

calculated. Fixed package payments should also be reviewed to better reflect the actual costs of extended care and medical complications.

iii. Rigid package rates should be reviewed to reflect actual costs of care, including provisions for complications and extended stays. Comprehensive coverage for ambulance services and outpatient chronic illness care should be implemented.

iv. Local SHA offices should be empowered with the authority to resolve issues without constant referrals to Nairobi. A clear escalation pathway must be established for unresolved payment matters, supported by improved customer care and stronger accountability mechanisms at SHA headquarters.

v. The apparent favoritism toward public facilities over private and faith-based facilities in allocation and disbursement should be eliminated. Transparent criteria for fund allocation should be established and consistently applied.

vi. Contracts inherited from NHIF should be reviewed to ensure payment structures align with actual service delivery costs. Flexibility must be introduced for claims involving maternal and newborn complications, while counties should be required to remit contributions on time to avoid disruptions in service delivery.

vii. The annual lump-sum premium payment model should be reviewed to include flexible monthly or quarterly options for low-income households to improve access to healthcare services.

3.5 RACHUONYO COUNTY HOSPITAL

a) Facility Overview

47. Rachuonyo County Hospital operates as a public healthcare facility serving the local community. The hospital faces significant operational challenges due to bed capacity discrepancies in official records, with some facilities licensed for 100 beds being incorrectly listed as 200 beds in SHA and KMPDC systems. These data inconsistencies have led to misreporting and unfair payment patterns, with attempts to correct these errors at the national level having stalled.

48. The facility provides both inpatient and outpatient services, with additional operational costs including oxygen supply services costing approximately Ksh 1.1 million. The hospital continues to serve patients despite facing significant systemic challenges with SHA operations and funding mechanisms.

b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	121,967,597	100%
Total Claims Received	90,363,892.95	74%
Outstanding Claims	31,603,704.05	26%

Summary of SHA Funding and Reimbursements Disbursed to Rachuonyo County Hospital since its inception.

49. Since SHA's inception, Rachuonyo County Hospital has submitted claims totaling Ksh 121,967,597 and received Ksh 90,363,892.95 in reimbursements, representing 74% of total claims submitted. Outstanding claims total Ksh 31,603,704.05, representing 26% of submitted claims. The facility has also experienced rejected

claims amounting to Ksh 21,583,998. The facility experiences delayed disbursements that force the hospital into debt with suppliers for food, drugs, and consumables. Additional operational expenses include oxygen supply (approximately Ksh 1.1 million) and other costs for inpatient and outpatient services.

4Health Committee Chairman (Centre) Hon. (Dr) James Nyikal, chairing a meeting at Rachuonyo County Hospital.

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	22,430,880
SHA Outstanding Debt	25,862,558
Total Debt Burden	48,293,438

c) Key Findings

50. The following key findings were identified:

i. **System Downtime**; Frequent SHA system outages delay patient admissions and claims processing. Patients are often admitted physically but entered the system later, creating audit and compliance issues.

ii. **Claims and Compliance**; Facilities face slow authorisation procedures and cumbersome compliance requirements. Local SHA officers lack system access to

resolve disputes, while claims surveillance for verifying admitted patients is no longer functional.

iii. **Primary Health Care (PHC) Funding**; Although PHC is meant to be free for all registered members, facilities lack clarity on the per-patient reimbursement rate and how allocations are calculated. Payments are pooled globally and disbursed without transparent communication.

iv. **Bed Capacity Discrepancies**; Official SHA and KMPDC records often misstate bed capacities, with some facilities licensed for 100 beds being listed as 200. Attempts to correct these errors at the national level have stalled, leading to misreporting and unfair payment patterns.

v. **Delayed Disbursements**; Late fund releases force hospitals into debt with suppliers for food, drugs, and consumables, while stalling development projects such as toilets, generators, and equipment upgrades.

vi. **Tariff Misalignment**; Contradictions exist between county service tariffs and SHA reimbursements—for example, county rates for deliveries are far below SHA packages. This creates inconsistencies between SHA guidelines, county finance bills, and the true cost of care.

vii. **Access to Care**; Patients not registered with SHA must pay cash, and many poor households still struggle to afford services despite PHC being nominally free.

d) Request by the Hospital to the Committee

51. The hospital respectfully submitted the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Improve System Reliability by investing in ICT to reduce downtime and ensure real-time patient admissions.

ii. Increase Transparency in PHC Funding by disclosing per-patient reimbursement rates and allocation formulas.

iii. Correct Bed Capacity Records through urgent alignment of digital records with physical verification by KMPDC and SHA.

iv. Streamline Claims and Compliance by restoring local verification capacity, granting regional officers' system access, and ensuring written feedback on compliance issues.

v. Address Tariff Discrepancies by aligning SHA reimbursement rates with county finance bills and regularly reviewing tariffs against inflation and actual costs.

vi. Ensure Timely Disbursements with predictable fund release schedules to prevent service disruptions and supplier debts.

vii. Support Facility Development by ringfencing part of reimbursements for infrastructure and equipment upgrades.

viii. Strengthen Data and Research by requiring facilities to track service disruptions, patient outcomes, and maternal health indicators during funding delays.

3.6 NYANDIWA LEVEL 4 HOSPITAL

a) Facility Overview

52. Nyandiwa Level 4 Hospital is a public healthcare facility operating as a Level 4 hospital mandated to offer both primary health care services and inpatient care. The facility has a bed capacity of 60 beds according to SHA records, though only 46 beds are currently in use due to ward space limitations, with fourteen additional beds remaining in storage. The average daily occupancy is about 80%.
53. SHA reimbursements have financed construction, procurement of equipment, a modern kitchen, a septic tank, and other infrastructure.

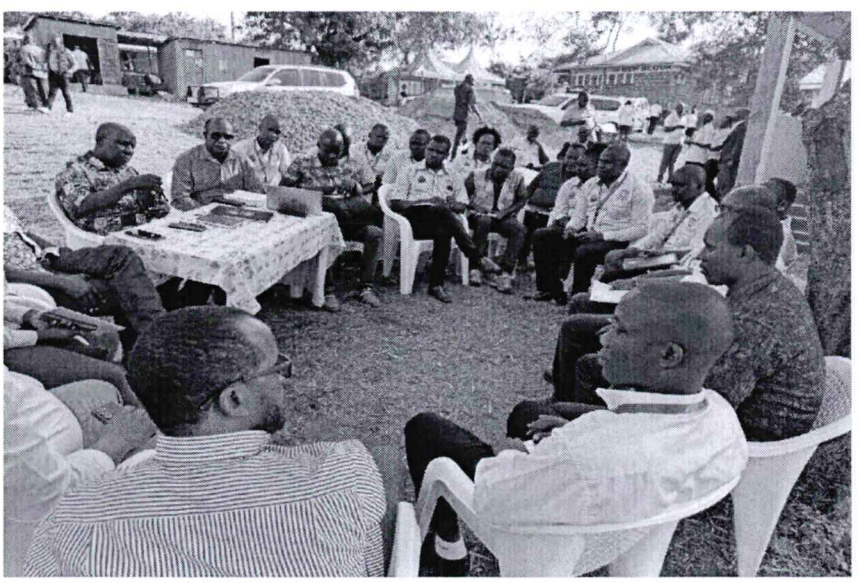
b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	Percentage
Total Claims Submitted	98,879,873.00	100%
Total Claims Received	81,996,706.00	83%
Outstanding Claims	16,869,067.00	17.%
Rejected Claims	14,100.00	0.0143%

Summary of SHA Funding and Reimbursements Disbursed to Nyandiwa Level 4 County Hospital since its inception – 31/08/2025.

54. Since SHA's inception, Nyandiwa Level 4 Hospital has submitted claims totaling Ksh 98,879,873 and received Ksh 81,996,706 in reimbursements, representing 83% of total claims submitted. Outstanding claims total Ksh 16,869,067, representing 17% of submitted claims. Rejected claims are minimal at Ksh 14,100, representing only 0.0143% of total submissions. SHA payments have been received, though delays were noted between April and June before clearance in August. Claims for outpatient services often reimburse less than the actual cost of drugs, lab work, and imaging. Preventive health allocations under PHC are unclear, with most funds going to curative services



5Members of the Departmental Committee on Health in a meeting with healthcare staff at Nyandiwa Level 4 Hospital

ii. **Debt Position:**

Debt	Amount (Ksh)
NHIF Outstanding Debt	5,653,500.00
SHA Outstanding Debt	16,869,067.00
Total Debt Burden	22,522,567.00

55. The facility faces a total debt burden of Ksh 22,522,567, comprising SHA outstanding debt (Ksh 16,869,067) and inherited NHIF debt (Ksh 5,653,500). The outstanding SHA debt represents approved but unpaid claims that create operational challenges for the facility.

c) Key Findings;

56. The following key findings were identified:

i. **Governance and Financial Management Challenges;** All SHA and FIF funds are remitted to the county, which returns 80% to the facility. However, delays occur, and policies differ across counties, creating inconsistency. 80/20 split varies by county, leading to delays and inefficiencies. The Health Management Team (HMT) and the Board review budgets before approval and expenditure. KEMSA supplies some commodities, but facilities must supplement from other suppliers using FIF. The adequacy of KEMSA allocations remains a concern.

ii. **Mismatch in Bed Capacity Records;** SHA lists 60 beds, but only 46 are in use, creating a risk of accusations of overbilling or fraud despite the facility operating within its actual physical constraints.

iii. **Weak Branch Support;** The SHA branch offices lack adequate capacity and often refer cases to Nairobi headquarters, creating delays in dispute resolution and limiting local problem-solving capabilities.

iv. **Teenage Mothers and Unique Identifiers;** The current system for registering underage mothers is not functioning effectively, limiting their access to essential maternal health services and creating bureaucratic barriers for vulnerable populations.

v. **Preventive Care Gap;** PHC funds are not clearly directed to preventive services like health education and community health workers, with most allocations going to curative rather than preventive care initiatives.

vi. **Delayed or inadequate reimbursements;** especially for outpatient services and preventive care. The facility experiences particular challenges with outpatient services and preventive care reimbursements, which often fail to cover actual service delivery costs.

d) Request by Hospital to the Committee

The hospital respectfully submits the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Improvement of claims and payment process through strict enforcement of the 90-day payment rule to ensure all claims are settled within stipulated timelines. Transparency in PHC fund allocation should be enhanced by clearly distinguishing between preventive and curative components, while outpatient reimbursement rates should be reviewed and adjusted to reflect actual care costs.

ii. Facility capacity data to be corrected by SHA to align with actual physical infrastructure on the ground. Bed capacity records should accurately reflect the 46 beds currently in use rather than the listed 60 beds to prevent fraud allegations and improve planning accuracy.

iii. Governance and financial management should be strengthened through harmonization of Facility Improvement Fund policies across counties to eliminate inconsistencies. County governments should streamline remittances to health facilities, while hospital boards and Health Management Teams should be empowered with greater budget autonomy.

iv. Special population access should be improved through establishment of a functional and decentralized system for registering teenage mothers using unique identifiers at facility level, rather than limiting registration to branch or national offices, to improve healthcare access for vulnerable groups.

v. Request for branch office to provide adequate local support and reduce dependency on Nairobi headquarters for routine operational issues. Regional offices should be empowered with decision-making authority to resolve facility-level challenges promptly.

3.7 NYANDIWA HEALTH CENTRE

a) Facility Overview

57. The Health Centre, located in Kasipul constituency, Homa Bay County, is currently non-operational. It has not been registered under the Social Health Authority (SHA) and, consequently, does not receive any payments or reimbursements from the scheme.

3.8 ST MARY'S HOSPITAL MUMIAS

a) Facility Overview

58. St. Mary's Mission Hospital Mumias is a Level 4 faith-based healthcare facility located in Kakamega County, Mumias West Sub-County, along the Bungoma-Kakamega Road. The hospital has a bed capacity of 255 beds and serves as a critical referral centre for maternity services, including care for underage mothers and vulnerable populations in the region.

59. The facility was previously accredited under NHIF and transitioned to SHA when the Social Health Authority was established in October 2024. The hospital underwent empanelment through SHA's e-contracting online platform, though initially faced challenges with incorrect facility allocation that was later corrected.

60. St. Mary's operations were severely disrupted and suspended after June 2025 due to staff walkouts caused by non-payment of salaries, with staff arrears exceeding 3 months. The hospital currently operates at only 40% bed occupancy despite its 255-bed capacity, with monthly operating costs of approximately Ksh 17 million, including Ksh 6.2 million for salaries, Ksh 1 million for consultants, and Ksh 233,800 for cleaning services.

6Members of the Departmental Committee on Health at St. Mary's Mission Hospital in Mumias, which closed recently due to alleged unpaid dues from the Social Health Authority (SHA).

b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	128,542,541	100%
Total Claims Received	98,671,567	77%
Outstanding Claims	29,870,974	23%

Summary of SHA Funding and Reimbursements Disbursed to St. Mary's Hospital Mumias since its inception.

61. Since SHA's inception, St. Mary's Mission Hospital has submitted claims totaling Ksh 128,542,541 and received Ksh 98,671,567 in reimbursements, representing 76.7% of total claims submitted. The amount received comprises Primary Health Care Fund payments of Ksh 5,687,425 and Social Health Insurance Fund payments of Ksh 92,984,142. However, significant delays in payments began from May 2025, with reimbursements falling far below monthly claims submitted, creating severe cash flow challenges.

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	143,021,036
SHA Outstanding Debt	35,558,400
Total Debt Burden	178,579,436

62. The facility faces a substantial total debt burden of Ksh 178,579,436, comprising inherited NHIF debt of Ksh 143,021,036 and SHA outstanding debt of Ksh 35,558,400 as at September 1, 2025.

c) Key Findings

The following key findings were identified:

i. **Financial Crisis and Operational Suspension;** the hospital suspended operations after June 2025 due to staff walkouts caused by non-payment of salaries for over 3 months. SHA began reimbursements late (December instead of October 2024), creating an immediate financial gap that has persisted.

ii. **Maternity and Neonatal Care;** St. Mary's is a key referral centre for maternity services, including underage mothers. The lack of newborn ICU and equipment undermines the quality of care. There are currently issues with registering teenage mothers due to a lack of IDs. Temporary ID system in place, but inconsistent.

iii. **Debt Burden:** NHIF debt (Ksh143m+), irregular SHA reimbursements, rejected claims, and low income from private insurance.

iv. Staffing: Strikes due to delayed salaries; need for Ksh19.2m to settle arrears. Reliance on interns and volunteers.

v. **System Reliability Issues;** SHA's digital platform experiences downtime approximately 4 times per month, disrupting admissions, discharges, and claims processing. System glitches create biometric access barriers for patients, particularly those with faint fingerprints.

vi. **Service Delivery and Infrastructure Gaps;** Lack of NICU, shortages of drugs and oxygen during funding delays, reduced patient flow due to upfront payments.

vii. **Referrals and Equity**; The referral system faces discrimination against faith-based facilities, with services like Red Cross ambulances refusing to transport patients from mission hospitals, undermining equitable healthcare access.

viii. **Community Health Integration Gaps;** the hospital struggles to effectively link its community health workers with government-funded community health promoters, leading to potential underutilization of Primary Healthcare Fund resources.

ix. **Teenage Mothers;** Difficulty in registering patients without IDs, delays in service access.

d) Request by the Hospital to the Committee

63. The hospital respectfully submits the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. The National Treasury urgently settle the outstanding NHIF debts or, alternatively, establish a clear repayment framework to ease the financial burden on hospitals. SHA should enhance its reimbursement mechanisms by improving efficiency, transparency, and timelines to reduce delays and cash-flow challenges. In addition, hospitals should be supported to review and strengthen their business

models, with a focus on diversifying income streams, cutting operational costs, and exploring public-private partnerships to enhance financial sustainability.

ii. To stabilize operations and restore staff morale, the release of Ksh19.2 million in outstanding staff arrears. Further, a sustainable framework for salaries and consultant payments should be developed to prevent recurrent wage crises and ensure hospitals can retain qualified personnel.

iii. Strengthen SHA's ICT platforms to enhance reliability and user-friendliness. Adequate digital support should be provided to health facilities, or alternatively, regional SHA offices should be reintroduced to handle claims-related issues. Rejected claims should be reopened for resubmission with clear feedback provided to facilities on the reasons for rejection. Additionally, SHA should establish fallback protocols to ensure system continuity during downtime, thereby preventing disruption of services.

iv. Establishment of a newborn intensive care unit (NICU) and the overall strengthening of maternity and neonatal services. Ambulance and referral systems should be standardized nationally to prevent discrimination against faith-based and mission hospitals. Furthermore, hospitals should enhance disease prevention efforts by strengthening collaboration between hospital-based community health workers and government health promoters, ensuring broader reach and better health outcomes at the community level.

v. Claims with issues should be flagged and returned at the early stages of processing, not after approval for payment. Rejected claims should be reopened promptly to allow correction and resubmission.

vi. All system updates should be communicated in advance, with clear information on what changes are being implemented and how they affect facility operations.

vii. Level 4 faith-based hospitals should be allowed to offer Emergency, Critical, and Chronic (ECC) illness services and benefit from the associated fund. Additional guidance is requested on the cost structuring for newborns in NBU requiring continuous oxygen or CPAP support.

viii. Facilities should be permitted to treat teenage mothers once issued with a Unique Identifier Number. In cases where documentation is unavailable, a waiver process should be clearly outlined in line with SHA provisions. Sample cases are attached.

ix. The maternity reimbursement package should be reviewed and increased to reflect the actual cost of care for both normal and caesarean deliveries. A breakdown of average facility expenditures is attached.

x. Referral policies should be revised to allow patients to be referred beyond public-to-public facilities. Patients should be able to choose a referral destination based on need and preference.

xi. Review of existing laws and policies to align SHA processes with practical realities at the facility level, eliminating bureaucratic inefficiencies. Special emphasis should be placed on ensuring that teenage mothers have equitable access to health services without discrimination or unnecessary barriers, in line with national commitments to universal health coverage and equity

3.9 NYERI COUNTY REFERRAL HOSPITAL

a) Facility Overview

64. Nyeri County Referral Hospital is a Level 5 public healthcare facility serving as a major referral center providing specialized services to the region. The hospital has a comprehensive bed capacity of 335 beds, comprising 294 normal ward beds, 6 ICU beds, 3 HDU beds, and 32 baby cots. However, the facility reports that this capacity is inadequate as the hospital frequently runs out of beds due to high patient demand.
65. The hospital underwent empanelment under SHA through a structured process involving declaration of care levels and services offered, obtaining KMPDC licensing, and signing both hard copy and soft copy contracts. Initially, the facility faced limitations in offering emergency services due to restricted SHA portal access, though full access was granted recently.
66. The facility operates under the oversight of the Nyeri Health Services Fund Board, established under the Nyeri Health Services Fund Act, which manages the Facility Improvement Fund (FIF) with transparency and accountability measures including annual audits by the Auditor General.

b) Funding and Reimbursements

i. Claims

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	339,649,692	100%
Total Claims Received	197,112,640	58%
Outstanding Claims	142,537,052	42%

Summary of SHA Funding and Reimbursements Disbursed to Nyeri County Referral Hospital since its inception.

67. Since SHA's inception Nyeri County Referral Hospital has submitted claims totaling Ksh 339,649,692 and received Ksh 197,112,640 in reimbursements from February 2025, representing only 58% of total claims submitted. The facility experiences significant delays in reimbursements, with payments not made on time as stipulated in contracts.
68. The facility reports that between the months of February 2025 and May 2025 an amount of Ksh 56,121,150 was erroneously paid to another facility which luckily was within Nyeri County. The facility had already spent Ksh 16,756,200 by the time it realised that the money was meant for Nyeri hospital.
69. In addition, as at 24th August 2025, the total number of claims that reflected in the SHA system as rejected were worth Ksh 106,800 but by the morning of the following day 25th August 2025 that figure had risen to Ksh 34,838,720. The reasons that were given for rejection were failure to attach documents such as invoices and discharge summaries. However, these documents are duly attached to the claims.

7Hon. Duncan Mathenge (left) interacts with patients at Nyeri County Referral Hospital.

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	156,615,121
SHA Outstanding Debt	142,537,052
Britam Outstanding Debt	950,055
Medical Administrators Kenya (MAKL) Outstanding Debt	2,601,569
Total Debt Burden	302,703,797

70. The facility faces a massive total debt burden of Ksh 302,703,797, with the largest portion being inherited NHIF debt (51.7%) and SHA outstanding claims (47.1%). With additional smaller debts to intermediaries (e.g., MAK Ltd – Ksh3.2 million).

Medical Administrators Kenya Limited (MAKL) Context

71. Medical Administrators Kenya Limited (MAKL) is a private health insurance administrator in Kenya that manages medical schemes for specific groups, particularly government-employed groups such as teachers, police officers, and prison wardens. MAKL has historically been contracted to oversee and disburse medical benefits for these groups through a health scheme management.
72. While not a primary insurer itself, MAKL operates as a third-party administrator (TPA), liaising between healthcare providers and funding institutions to process claims, authorize treatment, and facilitate reimbursements.

73. PCEA Tumutumu has reported delays and non-payment of claims by MAKL, resulting in significant debt accumulation. These challenges have affected service continuity and strained relations between providers and the administration.

c) **Key Findings**

74. The following key findings were identified:

i. **Delayed Reimbursements:** The hospital has submitted claims worth Ksh339.6 million, but only 58% (Ksh197.1 million) has been reimbursed. Pending claims (approx. Ksh142.5 million) have affected service delivery, equipment maintenance, and supplier payments. The now-defunct NHIF also owes the hospital Sh156 million, exacerbating cash flow challenges.

ii. **Rejected Claims Due to Technicalities;** Facility reported instances where claims were rejected due to minor errors, such as mismatched identification numbers, missing attachments, or data inconsistencies. While these errors are often clerical, their impact is significant: rejected claims translate into lost revenue for facilities and delays in care for patients. The rejection system is also seen as rigid, with limited avenues for quick correction and resubmission.

iii. **Erroneous Payments by SHA;** Nyeri County Referral Hospital lost over Sh16 million to a neighbouring private hospital due to SHA's payment processing errors. The affected hospital has been unable to recover the funds despite efforts.

iv. **Limited Benefits Package**; Oncology patients were highlighted as being particularly disadvantaged under the SHA. Certain essential diagnostic and follow-up tests are not covered, forcing patients to shoulder high out-of-pocket costs. Considering the long-term and expensive nature of cancer care, this gap increases the risk of treatment discontinuation, poor outcomes, and inequity in access. Laboratory tests are limited to 5 tests for outpatients. ICU 12-day package limits are impractical for longer stays.

v. **Ambulance Services Unfunded despite Legal Provisions;** The SHA Act provides for ambulance services reimbursement, yet facilities reported they are not receiving funds for these services. Patients often complain about the high cost of ambulance transfers, particularly when being referred from lower-level to higher-level facilities for specialized treatment. Lack of ambulance funding undermines the referral system, a critical pillar of healthcare delivery.

vi. **System Inefficiencies in Digital Health Platforms;** the biometric and digital claim authorization systems, though innovative, have experienced frequent downtime and errors. Examples include: Doctors physically present in a facility being marked as "out of station" by the system. Internet downtime halts biometric verification, delaying admissions or surgical interventions. The new Practice 360 app is causing authorization backlogs. These inefficiencies result in delayed care for patients and frustration among providers.

vii. **Inadequate Coverage for Prisoners and Vulnerable Groups;** Correctional facilities have not fully aligned their budgets with SHA requirements, leaving prisoners unable to access services consistently. Similarly, other vulnerable populations often lack the financial means to cover gaps left by SHA, pushing them into healthcare exclusion.

viii. **Limited Access for Infants of Underage Mothers;** Infants born to underage mothers are unable to access health services as they are not covered under their mothers' temporary benefits.

ix. **Emergency Services;** The facility was unable to offer emergency services until May 2025 due to limited access to the SHA portal, which was only recently granted.

x. **Unrealistic ICU Package Limits**; The current 12-day package limit for ICU care is impractical, as many critically ill patients require extended stays.

xi. **Service Denial for Public Servants Due to Delayed Premium Remittances;** Public servants are unable to access services when their premiums are not remitted to SHA by the 9th of every month, forcing them to pay out of pocket and causing widespread outcry.

xii. **Non-Functional Referral System;** the referral portal is unavailable, preventing patients from being traced through the system as referral cases from primary facilities, undermining the continuum of care.

xiii. **Transparency and Accountability in FIF (Facility Improvement Fund);** at the facility level, there has been notable transparency and accountability in the use of FIF. There is an established health services funds board which oversees the management of the FIF as per the Nyeri Health Services Fund Act. Decision-making follows structured governance channels: Health Management Team (HMT), Finance sub-committee, and Hospital Board oversight.

xiv. **Expansion in Membership Coverage;** The implementation of SHA has led to a substantial increase in registered beneficiaries within Nyeri County, with membership growing from approximately 4,000 to over 38,000. This reflects improved access to health coverage and increased population enrollment under the new health financing model.

xv. **Supply Chain and Commodity Availability;** until two months ago, essential drugs and supplies for ICU, renal, and theatre services were not stocked by KEMSA, posing challenges to uninterrupted service delivery. However, the situation has since improved in the current financial year.

c) Request by the Hospital to the Committee

75. The hospital respectfully submitted the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Conduct an independent forensic audit of SHA payment systems to identify loopholes leading to errors and introduce pre-payment verification protocols to prevent wrongful disbursement of claims.

ii. Enforce strict timelines for claim settlement (e.g., 30–45 days), with penalties for non-compliance by SHA. Establish a real-time claim tracking system accessible to hospitals for transparency.

iii. Activation of the referral portal to enable seamless patient transitions and review policies to allow Level 5 facilities to provide SHA-covered outpatient services.

iv. Develop a structured repayment plan for outstanding NHIF debts, ensuring facilities are progressively cleared of arrears.

v. Policies enabling access for patients without national IDs, infants from underage mothers, indigents, prisoners, and other vulnerable groups to ensure equity in healthcare access.

vi. Civic education programs about SHA operations, fund functions, and referral systems to improve public understanding and appropriate service utilization.

vii. Expansion of benefits package to meet medical requirements, laboratory test limits beyond 5 tests for outpatients, activation of the ECCIF fund for oncology and critical care, and review of impractical package limitations like 12-day ICU limits.

viii. Resolution of SHA system downtimes and Practice 360 App authorization conflicts that delay patient care. Ensure robust IT infrastructure supporting continuous service delivery.

ix. Inclusion of rehabilitation services (speech therapy, occupational therapy, hearing aids, wheelchairs, crutches) in SHA portal to prevent out-of-pocket payments.

x. Train hospital finance officers and SHA staff on claims processing standards, documentation, and error prevention.

xi. Institutionalize regular consultative forums between SHA, hospitals, and county health departments to address emerging challenges and review performance.

xii. SHA should establish an alternative verification mechanism to guarantee service continuity for public servants, even when remittances are delayed, with subsequent reconciliation once funds are received.

3.10 SIPILI MATERNITY AND NURSING HOME LTD

a) Facility Overview

76. The hospital is a private facility empanelled under the Social Health Authority (SHA) following a smooth transition from the defunct NHIF. It has a bed capacity of 46 and provides both outpatient and inpatient services, including consultations, diagnostics, immunizations, procedures, maternity care, emergency services, and admissions. The facility emphasizes quality, timely, and affordable healthcare and operates on a 24/7 basis.

77. Since SHA's rollout, the hospital has maintained stable operations with uninterrupted service delivery, supported by financial management strategies including bank loans and overdrafts during any reimbursement delays to ensure that service quality remains at optimal levels.

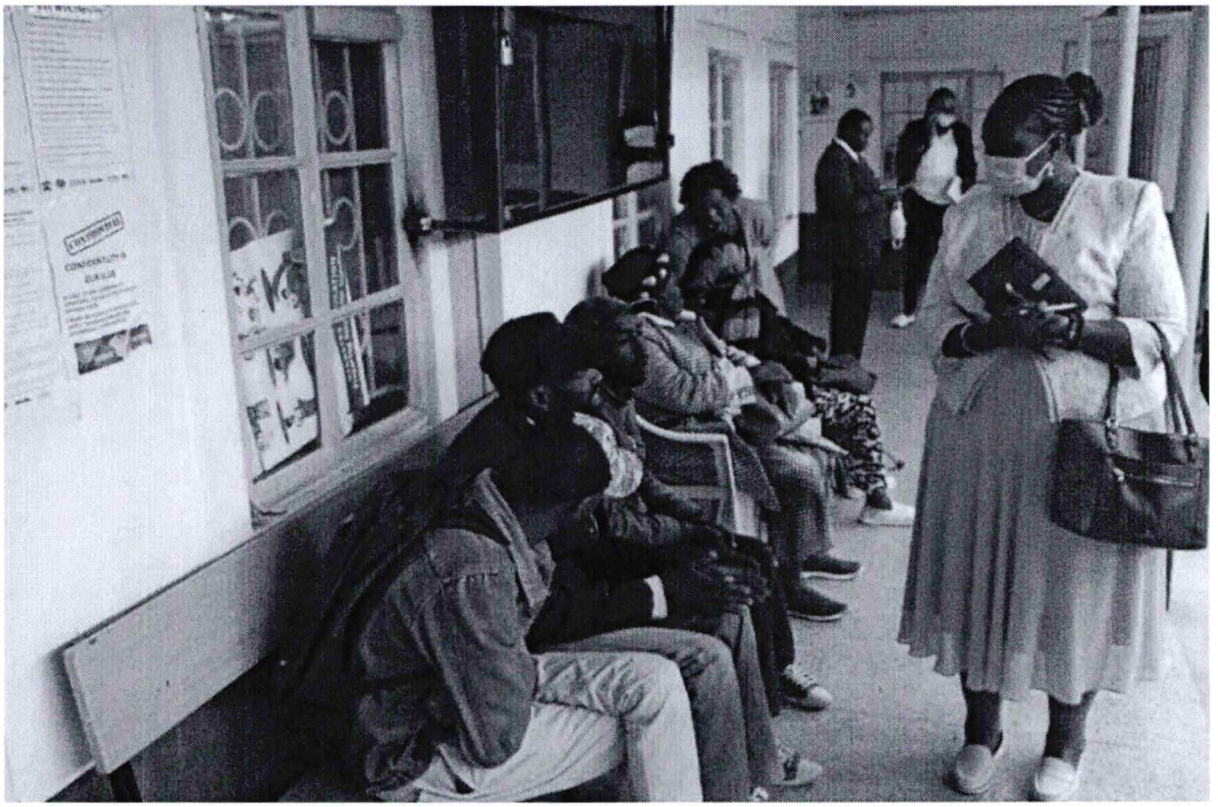
b) Funding and Reimbursement

i. Claims

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	25,617,075	100%
Total Claims Received	18,966,580	74%
Outstanding Claims	6,650,495	26%

Summary of SHA Funding and Reimbursements Disbursed to Sipili Maternity and Nursing Home Ltd since its inception.

78. Since the rollout of SHA, the hospital has received Ksh18, 966,580, representing 74% of submitted claims (Ksh25, 617,075). The facility reported that the SHA reimbursements are now more predictable and timelier, largely due to reforms introduced by the Ministry of Health that ensure payments are disbursed on the 14th of every month, with occasional additional disbursements on the 21st. The referral system for patients is functional, especially for outbound referrals to higher-level facilities. The facility's operations remain stable, with uninterrupted service delivery supported by financial adjustments such as bank loans during delays.



8Hon. Pauline Lenguris interacts with patients at Sipili Maternity and Nursing Home

ii. Debt Position:

Debt	Amount (Ksh)
NHIF Outstanding Debt	9,078,310
SHA Outstanding Debt	6,650,495
Total Debt Burden	15,728,805

79. The facility carries a total debt burden of Ksh 15,728,805, comprising inherited NHIF debt of Ksh 9,078,310 which the facility expressed that they are hoping will be paid soon to enable them clear our supplier and doctors' debts.

c) Key Findings

80. The following key findings were identified:

i. **Financing and Debt;** the facility still carries a debt burden of Ksh6.65M under SHA and Ksh9.07M inherited from NHIF, affecting suppliers and doctors.

ii. **System Limitations:** The hospital faces system challenges in accessing remittances for amounts paid by SHA. This ICT limitation has been reported to SHA's ICT department, though resolution timelines remain unclear, affecting financial reconciliation processes.

iii. **Referral Inefficiencies;** while outbound referrals to higher-level facilities work effectively, the hospital experiences challenges with inbound referrals from peripheral facilities (Levels 2 and 3) that are unable to effectively utilize the SHA referral system, limiting patient flow optimization.

iv. **Public Awareness;** the facility identifies significant gaps in civic education about UHC benefits, particularly in rural communities, which affects patient enrollment and service utilization rates.

v. **Human Resource Gaps;** There is a shortage of specialists in county and sub-county hospitals, limiting access to specialized care.

vi. **Empanelment & Training;** The hospital experienced challenges during SHA's initial rollout, including insufficient system training, access to system login credentials, and system downtimes that affected early operations.

vii. **Standardization of Payment Systems and Transparency;** Ensure consistent payment mechanisms across all facility types while maintaining transparency in payment schedules and amounts to build confidence in the SHA system among healthcare providers.

viii. **Continuous Capacity Building and Training Support;** Facilitate provision of ongoing system training and mentorship programs for health workers in empaneled facilities to improve system utilization and operational efficiency.

ix. **Patient Premium Burden;** Clients have raised concerns about high annual premium payments and issues with the means testing questionnaire producing unaffordable premium amounts for some beneficiaries.

d) Request by Hospital to the Committee

81. The hospital respectfully submitted the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Advocate for SHA to expedite ICT system upgrades to allow facilities seamless access to payment remittances and minimize system downtimes that disrupt operations and financial reconciliation processes.

ii. Support county-level initiatives to provide comprehensive training to lower-level facilities (Levels 2 and 3) on SHA referral protocols to ensure smoother patient flow and optimize the referral network efficiency.

iii. Strengthen UHC civic education campaigns, particularly targeting rural communities, to improve public understanding of benefits, boost enrollment rates, and increase appropriate service utilization.

iv. Advocate for the Ministry of Health to deploy more specialists to county and sub-county hospitals to bridge critical staffing gaps and improve access to specialized healthcare services.

v. Support SHA's review of the means testing tool to ensure fairer and more affordable premium assessments and consider implementing flexible payment schedules beyond the current annual contribution requirement.

vi. Facilitate provision of ongoing system training and mentorship programs for health workers in empanelled facilities to improve system utilization and operational efficiency.

vii. Ensure consistent payment mechanisms across all facility types while maintaining transparency in payment schedules and amounts to build confidence in the SHA system among healthcare providers.

3.10 PCEA TUMUTUMU HOSPITAL

a) Facility Overview

82. PCEA Tumutumu Hospital is a faith-based Level 5 healthcare facility serving as a major referral hospital. The hospital has a comprehensive bed capacity of 209 beds, comprising 6 ICU beds, 8 HDU beds, 28 pediatric beds, and 167 adult beds. The facility provides specialized services including intensive care, high dependency care, surgical services, imaging, laboratory services, and comprehensive inpatient and outpatient care.
83. The hospital was empaneled under the Social Health Authority (SHA) through a reasonable process with no extraordinary challenges encountered during the transition from NHIF. The facility provides various SHA benefit packages including ICU/HDU services, surgical procedures, and rebates, imaging services, and selected laboratory services, though reimbursements for some services have been problematic.
84. The hospital faces significant operational challenges due to inconsistent SHA reimbursements, with payment proportions oscillating between 15% and 40% of submitted claims, creating severe cash flow constraints and affecting service delivery capacity.

b) Funding and Reimbursement

i. **Claims**

	Amount (Ksh)	Percentage (%)
Total Claims Submitted	273,190,142	100%
Total Claims Received	144,816,550	53%
Outstanding Claims	128,373,592	47%

Summary of SHA Funding and Reimbursements Disbursed to PCEA Tumutumu Hospital since its inception.

85. Since SHA's inception in October 2024, PCEA Tumutumu Hospital has submitted claims totaling Ksh 273.19 million, of which only Ksh 144.8 million (53%) has been reimbursed. The facility notes that monthly disbursement rates fluctuate between 15% and 40%, and delays are persistent and disruptive to operations.

ii. **Debt Position:**

Debt	Amount (Ksh)
NHIF Outstanding Debt	89,825,672
SHA Outstanding Debt	128,373,592
MAKL Outstanding Debt	27,000,000
Total Debt Burden	245,199,264

86. The total outstanding debt is estimated at Ksh 245 million, attributed to pending reimbursements from NHIF, SHA, and MAKL (serving teachers and police). These unpaid amounts have strained the hospital's ability to maintain essential services and meet supplier and payroll obligations.

9Members of the Health Committee with the staff at Tumutumu Hospital, when they visited the facility,

c) Key Findings

87. The following key findings were identified:

i. **Reimbursement Delays**; The hospital receives only 15-40% of submitted claims, with payment delays being persistent and severe. This inconsistency creates unpredictable cash flows and threatens operational sustainability.

ii. **Debt Accumulation**; The facility carries a total debt burden exceeding Ksh 245 million, including Ksh 89.8 million inherited from defunct NHIF, Ksh 128.4 million under SHA, and over Ksh 27 million in MAKL debts for teachers and police personnel.

iii. **Patient Access Barriers**; Patients cannot access OPD services at level 5 facilities without direct payment, effectively undermining universal healthcare principles. Nuclear clients, including staff and students are also excluded from services without cash payment.

iv. **Supply Chain Gaps**; the facility has faced persistent stockouts of essential drugs and commodities from the Kenya Medical Supplies Authority. As a result, the facility has resorted to sourcing from the Mission for Essential Drugs and Supplies, which has since suspended further supplies. Additional suppliers have already withdrawn their services, compounding the situation. Orders through KEMSA are no longer relevant as the facility no longer relies on this supply line. In response to these challenges, the facility has resorted to borrowing from financial institutions, negotiating with banks for invoice discounting arrangements, requesting extended credit periods, and has recently approved copayments to support continued service provision

v. **Impact on Patients**; Patients are increasingly denied inpatient care, with many resorting to self-medication, alternative treatments, or traveling long distances to higher-level facilities. The opportunity cost of failed reimbursements translates directly into adverse patient outcomes, including preventable deaths. Stock shortages force patients to purchase medications directly, compromising treatment adherence and increasing financial burden. As a result, the hospital is unable to fulfil its founding mission of serving vulnerable populations.

vi. **Punitive Claims Management System;** The facility reports groundless rejection of claims and punitive rejection processes. Claims remain unprocessed for unreasonably long periods, with some remaining under surveillance without clear justification or timelines.

vii. **Staff Retention and Morale Crisis**; SHA funding has not improved staffing levels. Instead, resignations have increased as staff cite uncertain salary payments. This creates a negative cycle affecting service quality and institutional stability.

viii. **Unsustainable Operational Model;** The hospital faces an uneven playing field with the same benefit packages applying to government and faith-based facilities despite different operational realities. The reimbursement model is unsustainable for specialized Level 5 services.

ix. **Limited Stakeholder Engagement;** The facility reports that their views are not adequately incorporated during stakeholder engagement processes, limiting their ability to influence policy decisions that affect their operations.

d) Requests by the Hospital to the Committee

88. The hospital respectfully submits the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. Advocate for SHA to establish sustainable and consistent reimbursement rates that reflect the true cost of specialized Level 5 services, moving beyond the current 15-40% payment range to ensure operational viability.

ii. KMPDC, SHA, and DHA should establish a joint coordination framework with a designated county or regional contact person to streamline communication and avoid contradictory directives.

iii. Flexible monthly or quarterly contributions should be reinstated for low-income households to prevent exclusion and improve patient access.

iv. Resolution of the Ksh 245 million debt burden across NHIF, SHA, and MAKL schemes through structured negotiation and payment plans that prevent further operational deterioration.

v. Elimination of punitive claims, rejection practices and establishment of clear timelines for claims processing. Claims should not remain under surveillance for unreasonable periods without clear justification and resolution pathways.

vi. Policy changes to ensure Level 5 facilities can provide SHA-covered outpatient services, eliminating the current restriction that forces patients to pay directly and contradicts universal health coverage principles.

vii. Interventions to restore supplier confidence through guaranteed payment mechanisms and explore invoice discounting arrangements to maintain essential medical supplies and equipment.

viii. Development of differentiated benefit packages that recognize the higher operational costs and specialized services provided by Level 5 facilities compared to lower-level government facilities.

ix. Meaningful participation of faith-based and specialized facilities in policy development processes, particularly regarding benefit package reviews and operational policy changes.

x. Immediate emergency funding or guaranteed credit facilities to prevent complete operational collapse while longer-term systematic reforms are implemented.

3.11 NYAHURURU COUNTY REFERRAL HOSPITAL

a) Facility Overview

89. Nyahururu County Referral Hospital NCRH is a Laikipia County Government's hospital located in Laikipia West, Nyahururu town. Initially accredited as a Level 4 facility by NHIF and has transitioned to SHA funding mechanisms while maintaining its role as a key referral center.

90. The facility has a capacity of 243 authorized beds and 26 authorized cots, maintaining an average bed occupancy rate of approximately 90%.

b) Funding and Reimbursement

i. **Claims**

	Amount (Ksh)	**Percentage (%)**
Total Claims Submitted	238,375,728	100%
Total Claims Received	176,929,678.85	74%
Outstanding Claims	128,373,592	26%

Summary of SHA Funding and Reimbursements Disbursed to Nyahururu County Referral Hospital since its inception.

91. Since the inception of the Social Health Authority (SHA) in October 2024, Nyahururu County Referral Hospital has submitted claims amounting to Ksh 238,375,728. Of this total, the hospital has received Ksh 176,929,678.85, representing 74% of all claims submitted. The remaining Ksh 61,446,049.15, or 26%, remains outstanding as of August 2025.The hospital management reports that payments remain delayed and unpredictable, impacting cash flow and procurement planning. In particular, surgical claims are subjected to medical reviews, contributing to further reimbursement delays.

92. The hospital receives SHA funding from two key sources: the Primary Health Care Fund, from which it has received Ksh 6.569, 574.35 million, and the Social Health Insurance Fund, with Ksh 170.360, 104.50 million disbursed to date. Notably, the Emergency, Chronic and Critical Illness Fund (ECCIF) remains completely non-operational, with zero disbursements made to the hospital under this stream. This lack of ECCIF funding significantly undermines the hospital's ability to provide emergency care and cover critical illness cases.]

ii. **Debt Position:**

Debt	Amount (Ksh)
NHIF Outstanding Debt	36,753,246
SHA Outstanding Debt	61,446,049.15
Total Debt Burden	98,199,295.15

c) Key Issues Identified

93. The following key findings were identified:

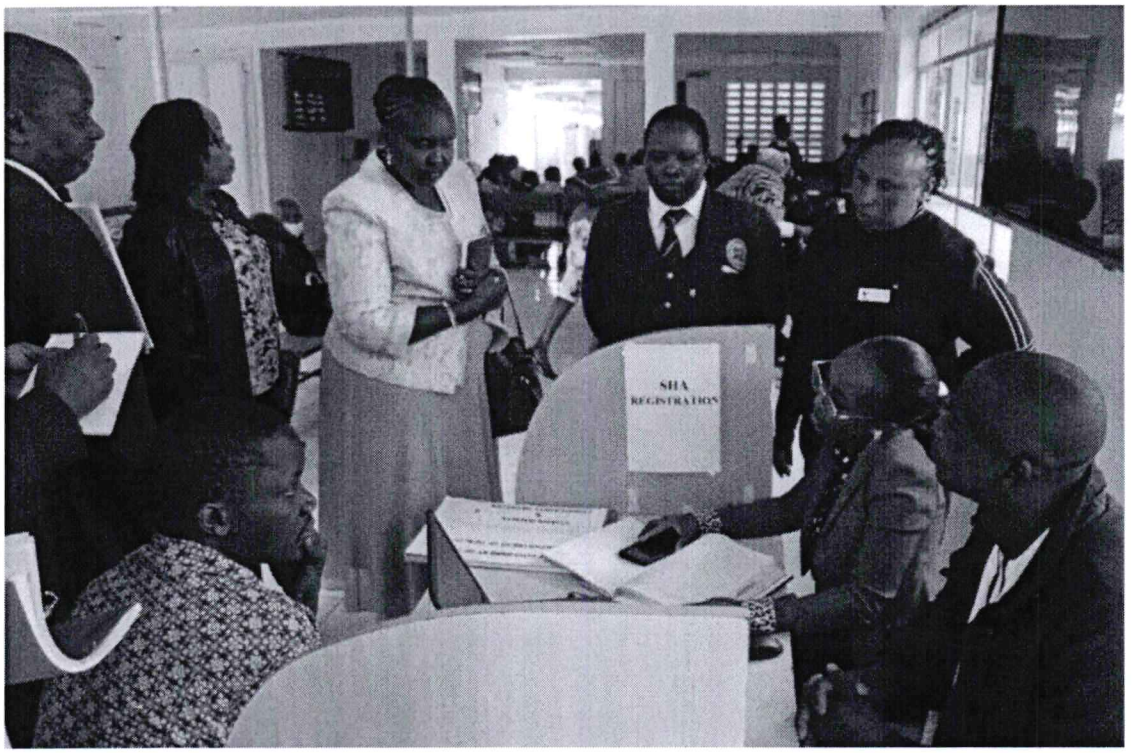
i. **Incomplete Fund Operationalization;** The Emergency, Chronic and Critical Illness Fund remains completely non-operational with zero disbursements, creating significant gaps in coverage for critical health services and emergency care.

ii. **Contractual Clarity Issues;** Primary Health Care contracts for Level 4 facilities lack clarity, particularly regarding the modified capitation rate of Ksh 225 per quarter, with hospitals receiving no detailed information about capitated beneficiaries.

iii. **Vulnerable Population Exclusions;** Teenage mothers without identification documents cannot enroll with SHA, effectively excluding vulnerable populations from essential maternal health services and contradicting equity principles.

iv. **System Abuse and Administrative Burden;** The means testing instrument is subject to widespread abuse by citizens seeking minimum premium payments, while biometric registration delays exceed 16 minutes, creating operational inefficiencies.

v. **Emergency Services Gaps;** Ambulance referral services continue requiring cash payments as they are not covered under SHA benefits, creating barriers to emergency care access and undermining comprehensive coverage.



10Health Committee Members at the SHA registration desk at Nyahururu County Hospital.

d) Request by the Hospital to the Committee

94. The hospital respectfully submits the following requests to the Committee, with the aim of guiding policy interventions and engaging the Social Health Authority (SHA) on identified operational and systemic gaps:

i. SHA should ensure the activation of the Emergency, Chronic and Critical Illness Fund to provide comprehensive coverage for critical health services and eliminate existing coverage gaps.

ii. Provide clear guidance on Primary Health Care contracts for Level 4 facilities, including detailed capitation arrangements and beneficiary information to improve operational clarity.

iii. Include ambulance and emergency transport services within SHA benefit packages to ensure comprehensive emergency care coverage without cash payment barriers.

iv. Flexible monthly or quarterly contributions should be reinstated for low-income households to prevent exclusion and improve patient access.

v. Facilities should collect data on referred patients, including abandonment and self-medication, to better assess the real impact of current policies on vulnerable populations.

CHAPTER FOUR
4.0 COMMITTEE OBSERVATIONS

95. The Committee's assessment of the ten (10) health facilities reveals a series of recurrent, systemic challenges that transcend individual institutions and point to fundamental operational and policy gaps within the implementation of the functions of the Social Health Authority (SHA). The Committee made the following observations:

1) Financial Management and Payments

i. **Delayed and Withheld Payments;** The Committee observed that reimbursements to health facilities under the Social Health Authority (SHA) have been inconsistent, with some months recording no disbursements at all. A substantial backlog of arrears inherited from the defunct National Health Insurance Fund (NHIF) remains unresolved. Approved but unpaid claims continue to accumulate across facilities, further straining the financial stability of hospitals. The Committee also noted a lack of transparency in SHA's payment systems as reimbursements are often issued as lump sums without clear disaggregation based on the type of Funds.

ii. **Erroneous Payments by SHA;** The Committee noted that erroneous payments by SHA have occasioned significant financial strain on health facilities as noted in Nyeri County Referral Hospital which lost over KSh 16 million to a neighbouring private hospital due to payment processing errors, with recovery efforts proving unsuccessful.

iii. **Rejected and Unclear Claims and Lack of Framework for Resolution of Complaints;** The Committee observed that there is a high rate of claim rejections even in cases where health facilities had provided adequate supporting documentation. Hospitals reported the absence of a clear and transparent mechanism for claim resubmission, with feedback on rejected claims often delayed well beyond the 90-day statutory period. Furthermore, the increasing reliance on AI-driven claim processing and approvals without sufficient human oversight has led to unjust denials, causing significant financial strain on facilities. The Committee further noted the absence of an effective framework for resolving disputes and complaints related to claim rejections, leaving facilities without a clear avenue for redress or appeal.

iv. **Medical Administrators Kenya Limited (MAKL);** other challenges observed by the Committee during its visit included persistent delays and non-payment of claims by Medical Administrators Kenya Limited (MAKL) to hospitals such as PCEA Tumutumu Hospital and Nyeri County Referral Hospital. These delays have led to a significant accumulation of debt, disrupted service delivery, strained cash flow, and limited the hospitals' operational capacity.

2) Systemic and Operational Challenges

i. **System and ICT Failures;** The Committee noted frequent SHA system downtimes occurring up to four times a month, which disrupt hospital operations and delay service delivery. Biometric verification challenges were also highlighted, particularly for patients without national IDs or

those with faint fingerprints. Further, there were discrepancies between SHA and KMPDC records including mismatched bed capacities and facility codes leading to administrative bottlenecks.

ii. **Lack of Clarity on the Establishment and Operationalisation of the Claims Management Office;** The Committee observed that the Social Health Authority (SHA) has not clearly established or operationalized the Claims Management Office as required under section 35(1) of the Social Health Insurance Act, No. 16 of 2023. This gap has led to inconsistencies in the utilization of primary healthcare funds disbursed by SHA, inefficiencies in the processing and management of claims, limited accountability, and irregular communication with health facilities.

3) **Governance and Coordination**

i. **Governance and Coordination Gaps**; The Committee noted significant governance and coordination gaps among key regulatory and oversight bodies, including the Kenya Medical Practitioners and Dentists Council (KMPDC), the Social Health Authority (SHA), the Digital Health Agency (DHA), and county governments. There is weak coordination between SHA, KMPDC, DHA and county governments which produces contradictory directives. There is also absence of written compliance guidelines and fragmented regulation.

ii. **Facility Improvement Fund (FIF)**; The Committee observed that Facility Improvement Fund (FIF) policies vary significantly across counties, resulting in inconsistencies in governance, financial management and accountability frameworks. For example, in Homabay County, these variations have created confusion in the collection, retention and utilization of facility-generated revenues thereby hindering the uniform implementation of health financing reforms.

iii. **Failure to Operationalise the Dispute Resolution Tribunal;** Despite the legal provisions under the Social Health Insurance Act, No. 16 of 2023, the Dispute Resolution Tribunal has not been established or operationalised, leaving healthcare providers and beneficiaries without a structured mechanism to address grievances and resolve disputes.

4) **Service Coverage and Equity**

i. **Exclusion of Vulnerable Populations;** The Committee observed that several vulnerable groups remain marginalized in accessing SHA benefits. Teenage mothers without national identification cards face registration barriers that deny them and their infants access to essential maternal and child health services. Similarly, prisoners, indigent persons and individuals living with chronic conditions experience inconsistent coverage across facilities. The requirement for lump-sum annual premium payments has further excluded many poor households, undermining the principles of equity and Universal Health Coverage (UHC). The Committee also noted the absence of a clear national framework for identifying and enrolling vulnerable populations, particularly teenage mothers and their infants, resulting in their continued exclusion from critical health services.

ii. **Primary Health Care (PHC) and Preventive Services**; The Committee noted that allocations for PHC remain unclear, with funding skewed heavily

towards curative services at the expense of preventive care. Weak linkages were also evident between hospital-based community health workers and government-funded community health promoters, undermining the outcomes of preventive health strategies.

5) **Service Delivery and Access**

i. **Service Delivery Gaps**; The Committee noted that some hospitals have been forced to suspend admissions due to the SHA system misclassifications, as in the case of St. Elizabeth Swindon Hospital, which was listed as having "zero beds." Critical service gaps were also noted including the absence of Neonatal Intensive Care Units (NICUs) in level 5 hospitals, coupled with shortages of oxygen, essential drugs and utilities during periods of delayed reimbursements.

ii. **Referral and Ambulance Barriers;** The Committee noted that there is no clear national policy governing the provision of accident and emergency services, including ambulance operations. Although the Social Health Insurance Act, No. 16 of 2023 provides for reimbursement of ambulance services, many health facilities reported that they have not received any funds for such services. The absence of adequate ambulance funding undermines the effectiveness of the referral system, which is a critical component of healthcare delivery. Additionally, reported discrimination in patient transfers for instance refusal by the Kenya Red Cross to transport patients from mission hospitals, undermines the referral continuum.

iii. **Tariff Misalignments and Benefit Package Gaps;** The Committee noted contradictions between the actual cost of care and SHA reimbursement rates, with some packages failing to meet the true cost of care (e.g., Ksh 30,000 for caesarean deliveries, 12-day ICU limits, laboratory tests are limited to five (5) tests for outpatients, and restricted outpatient benefits at Level 5 facilities). These benefit packages and tariffs undermine comprehensive and quality service delivery, discouraging providers from offering specialized care. Oncology patients, in particular, are disadvantaged as some essential diagnostic and follow-up tests are not covered, forcing patients to incur high out-of-pocket costs.

6) **Workforce and Capacity Building**

i. **Financial Strain and Staffing:** Due to delayed and withheld payments, many hospitals have been unable to pay staff salaries for several months. This has triggered strikes, reduced morale and over-reliance on volunteer workers to sustain essential services.

ii. **Capacity Building**: The Committee observed that inadequate training on SHA systems for the health facility staff has contributed to inefficiencies in claims processing and service delivery.

7) **Supply Chain Management**

i. **Supplier and Commodity Shortages:** The Committee noted that the Kenya Medical Supplies Authority (KEMSA) continues to provide inadequate and delayed supplies, with fill rates as low as 30% in some facilities. This has resulted in stockouts of critical drugs, oxygen and consumables, compromising patient care and contributing to preventable deaths.

CHAPTER FIVE
5.0 COMMITTEE RECOMMENDATIONS

96. Based on the Committee's findings and observations, the following are recommended to strengthen the functioning of the Social Health Authority (SHA), advance service delivery, and improve patient outcomes. Following the adoption of this Report by the National Assembly, the Cabinet Secretary for Health shall submit to the House a detailed implementation status report within six (6) months.

1) Claims and Payment;

i. NHIF Arrears Settlement

a. The Principal Secretary for the National Treasury, together with the Principal Secretary for the State Department for Medical Services, should urgently settle all verified NHIF arrears or develop a clear, time-bound repayment framework within three (3) months to ease the financial strain on hospitals. The National Treasury should invoke Article 223 of the Constitution to facilitate the settlement of outstanding NHIF debts of up to Ksh. 10 billion, thereby ensuring the financial stability of health facilities and restoring confidence in the transition to the Social Health Authority (SHA).

ii. Enforcement of the 90-Day Claims Payment Rule

a. The Chief Executive Officer (CEO) SHA shall enforce the 90-day claims settlement rule and issue standardized remittance advice detailing paid, pending, and rejected claims with documented reasons. Rejected claims shall include clear justification and allow for resubmission through the digital portal. The CEO to submit a compliance and implementation report including a comprehensive financial statement of all SHA Revenues and Expenditures within three (3) months.

iii. Disbursement of Pending SHA Bills

a. As verification of the defunct NHIF debt continues, the Chief Executive Officer (CEO) SHA should immediately disburse all pending SHA reimbursements to prevent service disruptions.

b. The Chief Executive Officer (CEO) SHA should submit a report detailing the status of paid and outstanding SHA claims to the Committee within three (3) months.

iv. Full operationalization of PHCF and ECCIF

a. The Principal Secretary for the State Department for Medical Services and the Chief Executive Officer (CEO) of the Social Health Authority (SHA), should fast-track the disbursement of PHCF and ECCIF funds and fully operationalize the PHCF and ECCIF benefit packages within sixty (60) days, ensuring that these Funds become functional in all facilities where they are currently non-operational.

v. To improve efficiency and fairness in claims processing, the CEO, SHA should reinstate mandatory human verification for AI-flagged claims within forty-five (45) days, to reduce allegations of wrongful rejections.

vi. Where fraud or non-compliance is detected, the CEO SHA should initiate investigations and ensure that any identified fraud is prosecuted at individual level while ensuring that no health facility is closed unless patient care continuity is guaranteed.

vii. The Cabinet Secretary, Ministry of Health, within 90 days, should engage the Medical Administrators Kenya Limited (MAKL) to resolve and settle all verified debts owed to their accredited health facilities.

2) Registration and Premium Payment;

(i) Full Operationalization of Benefits Package for the three SHA Funds

a. The Cabinet Secretary, Ministry of Health should operationalize full benefit access for SHIF, PHCF and ECCIF in all Level 2–5 facilities, within ninety (90) days.

(ii) Standardization of Proxy Means Testing:

a. The Cabinet Secretary, Ministry of Health should standardize the proxy means testing framework for the informal sector and establish a standard premium amount for indigents and publish the standardized framework and standard rate for indigents within sixty (60) days.

(iii) Public Communication on Premium Financing

a. The CEO, SHA should implement a national communication campaign within forty-five (45) days to clarify the premium financing obligations including the four-month initial payment rule and SHA *Lipa Pole Pole* scheme terms.

3) Empanelment and Bed Capacity;

i. Correction of Digital Record Errors

a. The CEO, SHA, in collaboration with the Kenya Medical Practitioners and Dentists Council (KMPDC), should audit and correct all errors in digital records including bed capacity and facility names, within sixty (60) days to prevent wrongful claim rejections and misdirected payments.

b. The CEO, SHA should ensure the establishment of the Unique Facility Identifier System within six (6) months to avoid confusion during reimbursement to facilities.

ii. Investigation of Unilateral Bed Removal

a. The CEO, SHA should complete investigations on the removal of beds from the database of some facilities and implement corrective action within sixty (60) days.

4) Pre-Authorization for Admissions and Procedures;

i. Improve Reliability of Approval Systems

a. Within ninety (90) days, the CEO, DHA and CEO, SHA should upgrade approval systems to reduce downtime delays and ensure reliability of approval systems for both admission and other medical procedures by addressing frequent downtimes and delays.

ii. Harmonization of Procedure Approval Processes

a. The CEO, DHA and CEO, SHA should review and harmonize approval workflows within sixty (60) days to allow for timely revision of diagnoses and authorizations when a patient's clinical condition changes or a new diagnosis is made during admission.
b. The CEO, DHA and CEO, SHA should within sixty (60) days simplify pre-authorization protocols to remove unnecessary barriers to urgent admissions and surgical interventions, such as in cases involving multiple fractures

iii. Removal of Geofencing Restriction for pre-authorizations
a. The CEO, DHA and CEO, SHA should remove the one-kilometre radius for a One-Time Password (OTP) for pre-authorizations for admission and procedures of patients.

5) **Indigent Identification and Inclusion of Vulnerable Populations;**
i. National Indigent Identification Framework
a. The Cabinet Secretary, Ministry of Health should within six (6) months, develop a clear national framework for the identification of indigents and vulnerable populations, ensuring their automatic registration and guaranteed coverage to prevent exclusion from essential health services.

ii. Registration of Teenage Mothers and Infants
a. The Cabinet Secretary, Ministry of Health should, within ninety (90) days, implement a unique identifier-based registration system for registering teenage mothers and their infants for uninterrupted access to maternal and child health services.

6) **IT Support Systems;**
i. Data-Sharing Framework across Regulatory Bodies
a. The Cabinet Secretary, Ministry of Health should establish a data-sharing framework and the integration of ICT systems between the Kenya Medical Practitioners and Dentists Council (KMPDC), the Digital Health Agency (DHA), and the Social Health Authority (SHA) within three (3) Months so as to improve interoperability, streamline regulatory processes and improve verification procedures to provide efficient service delivery.

ii. Establishment of Regional SHA Offices
a. The Board of the Social Health Agency should establish fully functional SHA regional offices within nine (9) months to provide real-time technical support for all SHA functions including enrolment, beneficiary identification, claims processing, payments and pre-authorizations, so as to reduce over-reliance on the Nairobi headquarters office.

iii. Strengthening ICT Platforms
a. The CEO, SHA to strengthen ICT platforms within ninety (90) days should reduce biometric/OTP errors and enhance system stability.

7) **Capacity Building;**
i. The Cabinet Secretary, Ministry of Health should support the Social Health Authority in rolling out national training programs for all public, private, and faith-based facilities on the digital systems, claims, pre-authorizations, and the benefit package within four (4) months.

8) **Dispute Resolution;**
i. Adoption of SHI Dispute Resolution Mechanism

a. The Board of the Social Health Authority should, within three (3) months, establish an administrative mechanism in the interim to handle complaints, and disputes including on claim rejections, billing disagreements and facility closure.

ii. Establishment of the SHA Claims Management Office

a. The Board of the Social Health Authority within three (3) Months should establish and fully operationalise the Claims Management Office within the Social Health Authority (SHA), in accordance with Section 35(1) of the Social Health Insurance Act, No.16 of 2023.

b. The Board of the Social Health Authority within the next six (6) months should ensure that the Claims Management Office develops clear guidelines, standard operating procedures and digital systems to ensure transparent, efficient and timely processing of claims.

9) Facility Improvement Fund (FIF) Harmonization;

i. Within six (6) months, the Cabinet Secretary, Ministry of Health should engage with the Council of Governors (COG) on the harmonization of the national and county FIF laws to eliminate inconsistencies particularly on remittance requirements to county accounts, and to ensure uniform accountability frameworks.

10)Ambulance and Referral Services;

i. Reimbursement for Ambulance Services

a. Within three (3) months, the CEO, SHA should operationalize the reimbursement for ambulance and referral services as provided under the Social Health Insurance Act, No.16 of 2023, ensuring that all facilities including faith-based and private facilities are treated equitably.

ii. Standardized Referral Protocol and Expand Ambulance Coverage

a. Within six (6) months, the Cabinet Secretary, Ministry of Health should standardize referral protocols to eliminate discrimination against certain facilities and guarantee the timely transfers of patients during emergencies.

b. Within six (6) months, the Cabinet Secretary, Ministry of Health in collaboration with the county governments, should expand ambulance coverage to rural and underserved areas so as to reduce preventable deaths and improve overall health outcomes.

11)Civic Education and Public Trust;

i. National Civic Education Programme and Community-Level Engagement

a. Within three (3) months, the Cabinet Secretary, Ministry of Health and the CEO, SHA should undertake community engagement programmes through the Community Health Promoters, media and local forums so as to build trust and counter misinformation.

b. The Cabinet Secretary, Ministry of Health should roll out continuous civic education programs to empower citizens with knowledge on their rights, responsibilities and benefits under SHA for informed participation and accountability.

12)Governance and Oversight;

i. Transparency of the SHA Board

a. The Board of the Social Health Authority within the next six (6) months should improve its visibility across the country and be accountable to stakeholders by undertaking routine public reporting on inflows of funds, claim processing and disbursements.
b. The Cabinet Secretary, Ministry of Health, should convene a national multi-stakeholder dialogue within six (6) months to address systemic weaknesses, audit the laws where necessary, and promote a collaborative approach to implementation.

13) Expand Coverage of Essential Health Services;

i. Review of Benefit Package and Tariffs
   a. The Cabinet Secretary, Ministry of Health should engage the Benefits Package and Tariffs Advisory Panel to conduct a comprehensive actuarial review of the current benefits package within six (6) months to align the tariffs with real treatment costs and expand coverage to diagnostics, dialysis, emergency, ambulance care, ICU/HDU/NICU and maternal and neonatal services.
   b. The Cabinet Secretary, Ministry of Health should engage the Benefits Package and Tariffs Advisory Panel to remove the existing ICU day limit, extend coverage to High Dependency Units (HDU) and Neonatal Intensive Care Units (NICU) and increase the reimbursement rate for ICU and HDU from Ksh. 28,000 to a minimum of Ksh. 44,000, subject to actuarial evaluation.

ii. National Transplant Programme
   a. The Cabinet Secretary, Ministry of Health should, within nine (9) months, establish a national transplant programme for kidney, bone marrow and other critical organ transplants.

14) Strengthen Stakeholder Collaboration:

i. Strengthen Multi-Level Coordination and Promote Public Private Partnerships
   a. The Cabinet Secretary, Ministry of Health should implement stronger collaboration between SHA, the Ministry of Health, county governments, and health facility management to improve policy alignment and optimize resource utilization.
   b. The Cabinet Secretary, Ministry of Health should encourage public-private partnerships to draw on innovation, expand infrastructure, and increase access to specialized healthcare services.

SIGNED..... **DATE**.....26/11/2025

HON. DR. JAMES NYIKAL WAMBURA, CBS, M.P
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH

THE NATIONAL ASSEMBLY
PAPERS LAID
DATE: 27 NOV 2025 DAY: Thursday
TABLED BY: Hon. James Nyikal, MP
Chairperson
CLERK AT THE TABLE: A. Shibuka

THE NATIONAL ASSEMBLY
13TH PARLIAMENT – FOURTH SESSION (2025)
DIRECTORATE OF DEPARTMENTAL COMMITTEES
DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ON THE ASSESEMENT OF THE SOCIAL HEALTH AUTHORITY (SHA) UTILIZATION OF FUNDS DISBURSED SINCE INCEPTION AND CHALLENGES FACED BY FACILITIES

We, the undersigned Members of the Departmental Committee on Health do hereby append our signatures to adopt this Report

Date: 22/11/2025 VENUE..... Four points Sheraton Hotel

NO	NAME	SIGNATURE
1.	The Hon. Dr. Nyikal James Wambura, M.P, CBS - **Chairperson**	
2.	The Hon. Ntwiga Patrick Munene, M.P **-Vice-Chairperson**.	
3.	The Hon. Dr. Pukose Robert,**CBS**, M.P	
4.	The Hon. Titus Khamala, M.P	
5.	The Hon. Sunkuli Julius Lekakeny Ole, **EGH, EBS**, M.P.	
6.	The Hon. Prof. Jaldesa Guyo Waqo, M.P.	
7.	The Hon. Owino Martin Peters, M.P.	
8.	The Hon. Wanyonyi Martin Pepela, M.P	
9.	The Hon. Lenguris Pauline, M.P	
10.	The Hon. Mary Maingi, MP	
11.	The Hon. Muge Cynthia Jepkosgei, M.P	
12.	The Hon. Oron Joshua Odongo, M.P.	
13.	The Hon. Kibagendi Antony, M.P.	
14.	The Hon. Mathenge Duncan Maina, M.P	
15.	The Hon. Kipngor Reuben Kiborek, M.P	

MINUTES OF THE 82ND SITTING OF THE DEPARTMENTAL COMMITTEE ON HEALTH HELD IN FOUR POINTS SHERATON HOTEL ON SATURDAY, 22ND NOVEMBER 2025, AT 9.00 AM

PRESENT

1.	The. Hon. Dr. Nyikal James Wambura, MP	**-Chairperson**
2.	The Hon. Dr. Pukose Robert, MP	-Member
3.	The Hon. Prof. Jaldesa Guyo Waqo, MP	-Member
4.	The Hon. Lenguris Pauline, MP	-Member
5.	The Hon. Oron Joshua Odongo, MP	-Member
6.	The Hon. Titus Khamala, MP	-Member
7.	The Hon. Sunkuli Julius Lekakeny Ole, EGH, EBS, MP	-Member
8.	The Hon. Kipngor Reuben Kiborek, MP	-Member

ABSENT WITH APOLOGY

1.	The Hon. Ntwiga Patrick Munene, MP	**-Vice Chairperson**
2.	The Hon Wanyonyi Martin Pepela, MP	-Member
3.	The Hon. Owino Martin Peters, MP	-Member
4.	The Hon. Cynthia Muge, MP	-Member
5.	The Hon. Mathenge Duncan Maina, MP	- Member
6.	The Hon. Mary Maingi, MP	-Member
7.	Hon Kibagendi Antoney, MP	-Member

COMMITTEE SECRETARIAT

1.	Mr. Hassan A. Arale	- Clerk Assistant I
2.	Ms. Gladys Kiprotich	- Clerk Assistant I
3.	Mr. Timothy Kimathi	- Clerk Assistant I
4.	Mr. Faith Chepkemoi	- Legal Counsel II
5.	Ms. Angela Musau	- Legal Counsel II
6.	Ms. Abigael Muinde	- Research Officer III
7.	Ms. Fatma Mohamed	- Intern

IN ATTENDANCE-THE LIST ATTACHED

AGENDA

1. Prayers;
2. Preliminaries;
3. Adoption of the Agenda;
4. Confirmation of Previous Minutes;
5. Matters arising;

6. **CONSIDERATION AND ADOPTION OF REPORTS**
7. Pending Business (enclosed)
8. Any Other Business; and
9. Adjournment

NO. NA/DC-H/2025/551: PRELIMINARIES/INTRODUCTION

The Chairperson called the meeting to order at twenty minutes past twelve o'clock, followed by the Prayer and self-introductions.

MIN. NO. NA/DC-H/2025/552: ADOPTION OF AGENDA

The agenda of the meeting was adopted, having been proposed by the Hon. Pauline Lenguris, MP, and seconded by the Hon Prof. Guyo Jaldesa, MP.

MIN. NO. NA/DC-H/2025/553: CONFIRMATION OF PREVIOUS MINUTES.
This Agenda item was deferred to a later date for consideration.

MIN. NO. NA/DC-H/2025/554: MATTERS ARISING

There were no matters arising.

MIN. NO. NA/DC-H/2025/555: CONSIDERATION AND ADOPTION OF THE REPORT OF THE HEALTH (AMENDMENT) BILL (NATIONAL ASSEMBLY) BILL BY HON. JANE NJERI MAINA, MP

Adoption of the report of the Health (Amendment) Bill (National Assembly) Bill by Hon. Jane Njeri, MP as the true reflection of the Committee deliberation which was proposed by Hon. Pauline Lenguris, MP, and seconded by Hon. Dr. Robert Pukose, CBS, MP as the true reflection of the Committee deliberations.

MIN. NO. NA/DC-H/2025/556: CONSIDERATION AND ADOPTION OF THE REPORT ON THE ASSESEMENT OF THE HEALTH AUTHORITY (SHA) UTILIZATION OF FUNDS DISBURSED SINCE INCEPTION AND CHALLENGES FACED BY FACILITIES

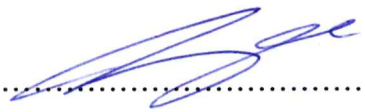
Adoption of the report on the assessment of the Social Health Authority (Sha) Utilization of Funds disbursed since inception and challenges faced by facilities which was proposed by Hon. Pauline Lenguris, MP, and seconded by Hon. Prof. Jaldesa Guyo Waqo, MP as the true reflection of the Committee deliberations.

MIN. NO. NA/DC-H/2025/557: ANY OTHER BUSINESS

There was no any other business.

MIN. NO. NA/DC-H/2025/558: ADJOURNMENT

There being no other business, the meeting was adjourned at 1.15 p.m. The next meeting will be held on notice.

Sign.....  **Date**.....22/11/2025.....

HON. DR. NYIKAL JAMES WAMBURA, CBS, MP
CHAIRPERSON, DEPARTMENTAL COMMITTEE ON HEALTH