
HEALTHCARE FINANCING IN KENYA: CHALLENGES, EQUITY AND POLICY OPTIONS

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ABSTRACT

Financing of healthcare is the policy issue in the center stage in Kenya due to the national progress to Universal Health Coverage (UHC). Even with continued reforms, such as the replacement of the National Hospital insurance fund (NHIF) by the social Health authority (SHA), access to quality and affordable healthcare services has not been equitable across income groups, regions as well as job groups. This is especially true of the poor and informal sector workers, who are susceptible to the financial restrictions to healthcare access. This paper focuses on the healthcare financing structure, equity and effectiveness in Kenya and its focus is the balancing of the public funding, the health insurance arrangements, the donor assistance and the out-of-pocket payment.

Based on secondary sources on national health accounts, government budget reports, and household survey data, the paper employs descriptive analysis and a conceptual framework of association between sources of healthcare financing, access, financial protection, and welfare outcomes. The results show that out of pocket spending still comprises a substantial portion of total health spending subjecting households to catastrophic spending on health and making them vulnerable to poverty. Coverage of insurance is disjointed and biased towards workers in formal sector, and the financing of the health sector is limited by the lack of fiscal strains and resource allocation inefficiencies. The paper holds that the current financing mechanisms are not sufficient to realize viable and fair access to healthcare. Policies suggestions include: enlargement of pooled financing by enforcing mandatory health insurance, increase in public spending on health, enhancing subsidies on the vulnerable groups, and effectiveness and accountability in ensuring healthcare spending. These reforms are essential in the

development of Kenya UHC agenda and the advancement of health and economic results long term.

INTRODUCTION

The financing of healthcare is a lower-level support structure of the economic and social policy, especially in the developing countries, where the health risks are in the synergy with poverty, inequality. The financing of healthcare, besides defining the access to services, defines which group of people bears the financial cost of illness (World Health Organization [WHO], 2010). Under the mechanism of Universal Health Coverage (UHC), it is anticipated that good healthcare financial mechanisms will be in place to provide needed health services to the population without putting the households at a socioeconomic disadvantage (WHO & World Bank, 2017).

Within the last twenty years, Kenya has documented significant changes and gains in health outcomes such as the reduction of child mortality and improvements in life expectancy (World Bank, 2020). Nevertheless, such aggregate gains hide a great deal of inequality in healthcare access among income distribution, geographic area, and occupational groups (Barasa et al., 2018). One of the factors that contribute to these differences is the healthcare financing structure.

The healthcare sector of Kenya is funded in a mixture of publicly funded sources by general taxation, health insurance schemes that were previously mostly controlled by NHIF but are now managed by the Social Health Authority (SHA) and the direct out-of-pocket payments by households (Ministry of Health [MoH], 2020). Although the policy has been committed to UHC, out-of-pocket spending has been elevated, implying that few households are financially insured (Xu et al., 2018). This subjects the vulnerable groups to disastrous health spending which may further fuel poverty and inequality (Wagstaff et al., 2018).

This paper aims to discuss healthcare financing in Kenya through the lens of an economic policy. In particular, it reviews the form of healthcare financing, appraises its drawbacks and advantages to equity, access, and financial protection, and suggests policy alternatives that may improve efficiency, sustainability, and inclusiveness. Its contribution to the policy discussions concerns healthcare financing reforms required to attain UHC in Kenya.

Literature Review and Policy Context

Healthcare is considered laboratory of a merit good that is prone to significant failures in the market according to economic theory. The impact of market-based healthcare systems is constrained by the presence of information asymmetry between patients and providers, uncertainty to the illness and positive externalities linked to disease prevention (Arrow, 1963). It is reasonable to note that these shortcomings, in turn, warrant government intervention in the form of taxation, regulation, and health insurance.

The empirical data of low- and-middle-income countries has also shown that high out-of-pocket payment prevalence is retrogressive and unproductive and, in a disproportionate manner, it impacts the poor households and poses risk to catastrophic health spending and impoverishment (Xu et al., 2007; Wagstaff & van Doorslaer, 2003). Contrary to this, the tax-based financing and social health insurance financing systems encourage the risk pooling, better financial safety, and equity (Kutzin, 2013).

Research in Kenya indicates that out-of-pocket expenditure is still a big proportion of the overall health spending even after the introduction of reforms that are meant to increase insurance cover (Barasa, Maina, & Ravishankar, 2017). Although the NHIF has succeeded in increasing coverage of the formal-sector workers, the coverage of the informal-sector workers is low since they cannot afford it and their incomes are irregular (Kazungu & Barasa, 2017). The introduction of the Social Health Authority (SHA) is aimed at eliminating these coverage gaps, but it is still facing difficulties in implementation. Donor funding has been a long-standing supportive institution of important health programs yet it is increasingly unpredictable and unstable (World Bank, 2019).

Nevertheless, there are still knowledge gap areas despite this body of research that have not yet been covered on how the changing healthcare financing architecture of Kenya impacts on equity, access, and welfare outcomes, especially amongst the low income and informal-sector groups. One of the policy issues that arise in this paper is that the finance structures in health care are related to access, financial security, and general welfare outcomes.

Conceptual Framework

The study conceptual frameworks the relationship that exists between healthcare financing mechanisms and healthcare access, financial protection, and welfare outcomes, based on the WHO health financing framework (WHO, 2010) and on the economic theory used (Kutzin,

2013; Bloom and Canning, 2000). It demonstrates the influence of the sources and form of financing on the utilization of healthcare services as well as socio-economic wellbeing of a household in general.

Financing Mechanisms

The key sources of healthcare financing that were used in the research are:

Public financing: Government funding (via general taxation or earmarked funds), Health insurance Social health insurance (e.g., Social Health Authority) and voluntary insurance schemes, **Out-of-pocket payments:** Household-payments at the point of service and **Donor-funding:** External funds to particular programs or health interventions.

Pathways to Outcomes

A large direct cost of care is weakened by **public financing and insurance initiatives** which enable people to access healthcare more **cheaply**, participate in healthcare services earlier, and have a greater appeal to low-income households, which are overburdened by **out-of-pocket payments** (Xu et al., 2007) and **Donor funding** may allow more individuals to access critical healthcare services, however, its variability makes it harder to plan and sustain over time (Kutzin, 2013) and **Out-of-pocket payments** available increase the financial risk faced by individuals, discourage healthcare.

Link to Welfare Outcomes

Healthcare access has impacts on health outcomes, labor productivity, and household welfare: Low access or excessive financial burden is associated with low health outcomes, less productivity, and increased risk of poverty (Bloom & Canning, 2000) ,Greater pooling of risks boosts equity and financial protection (WHO and World Bank, 2017) and Fragmented financing systems make inequality and inefficiency worse.

Methodology and Data

The research design applied in this study is descriptive and analytical by relying on secondary data sources, as it is quite common in health financing and health policy analysis when the aim of the study is to examine the performance of a system or system component instead of formulating causal conclusions (McIntyre & Kutzin, 2016). Secondary data provides an opportunity to cover the trends of financing at the national level in a comprehensive manner and guarantee alignment of the research with formal policy and planning frameworks.

This analysis uses a variety of data to reflect the form and pattern of healthcare funding in Kenya. To begin with, the National Health Accounts data can disclose the detailed information on the amount of health spending and the internal structure of the funding of this spending by funding source, such as public expenditure, health insurance, out-of-pocket payments, and donor funds (Ministry of Health [MoH], 2020). Second, trends in state financing and fiscal prioritization of public health are evaluated by examining the reports of government budgets and expenditures on the national budget. Third, Kenya National Bureau of Statistics provides nationally representative household survey data that is used to investigate the insurance coverage pattern and household out of pocket spending by income group, region, and employment status (KNBS, 2019).

The empirical method is based on descriptive statistics in order to examine the patterns of changes over a period of time and distribution within population groups. In particular, the research investigates how various sources of financing contribute to the overall health spending, contrasts the insurance coverage rates between the formal and informal sector and determines the level of out-of-pocket payments in measuring the financial protection. This method suitably applies to the current study because the outcomes of policy under means of equity and access and the financial protection of risk are policy-oriented and do not concern causal inference.

The chosen descriptive methodology is also supported by the limitation of data as well as the character of healthcare financing reform in Kenya, which is constant and dynamic. Although econometric tools might be adequate to assess the efficacy of a certain intervention, descriptive analysis will offer a solid base to design any gaps in the system, argue about the policies, and conduct future empirical inquiries. Using evidence-based recommendations provided by various reliable sources of data, the study provides a policy-relevant evaluation of healthcare financing in Kenya.

RESULTS

The findings reveal that out-of-pocket payments continue to be a significant healthcare financing source in Kenya, which means that households are not well financially safeguarded (MoH, 2020). It puts several families at risk of devastating health costs, especially when it comes to severe illnesses or even hospitalization (Xu et al., 2018).

The actual spending on public health has risen in nominal terms but stays insufficient in

comparison with population growth, rising health expenditures and expanding UHC liabilities (World Bank, 2020). The nature of insurance coverage is not even, with the formal-sector and urban population representation is much more probable to have insurance than the informal-sector and rural one (Kazungu & Barasa, 2017). Donor funding remains relevant but is also weakening and damaged, and causes sustainability issues (World Bank, 2019).

Composition of Total Health Expenditure in Kenya (%)

Financing Source	Share of Total Health Expenditure (%)
Out-of-pocket payments	High and persistent share
Public financing	Adequate to average.
Health insurance (NHIF/SHA & private)	Limited and skewed
Donor funding	Decreasing and unstable

Discussion and Policy Implications

The results show that there is an inherent conflict between Universal Health Coverage (UHC) goals in Kenya and the existing healthcare financing system. Although the reforms have been sustained, increased dependency on out-of-pocket payments points to risk pooling and inadequate financial protection. Equity-wise, this funding pattern will heavily burden households with low income and employees in informal sector, which goes against the very principle of UHC, which posits that access to basic healthcare cannot be conditional upon financial means (WHO, 2010).

High levels of out-of-pocket expenditure are the indication of the lack of government investments as well as the absence of insurance. The public health expenditure has recorded a pattern of growing in the real terms, but at a lower rate of growth compared to population growth, ascending costs of healthcare and an expanded service requirements under UHC. This welfare implication of this underinvestment is significant since household with large medical bills might defer care, dispose of productive assets or get into poverty. The results support poverty traps and undermine the economic productivity in the long term, which is consistent with previous studies in the health-growth literature (Bloom et al., 2014).

Healthcare Financing Reform Trade-offs

Expanding pooled financing through public spending or mandatory insurance involves significant trade-offs. On one hand, increased public financing improves equity, financial protection, and population health outcomes. On the other hand, it places pressure on government budgets, particularly in low- and middle-income countries with limited fiscal

space and competing development priorities. Kenya faces a clear trade-off between short-term fiscal constraints and long-term economic and social gains from improved population health.

Another key trade-off relates to mandatory insurance under the Social Health Authority. While mandatory enrollment can significantly expand risk pooling and reduce adverse selection, it may face political resistance, administrative challenges, and affordability concerns among informal-sector workers. Without effective subsidization and enforcement mechanisms, mandatory schemes risk excluding the very populations they are intended to protect. These trade-offs underscore the importance of complementary reforms, including targeted subsidies, flexible contribution mechanisms, and strong governance structures.

International Comparison

The global experience can offer good lessons to Kenya. In nations like Thailand and Rwanda, tax-based financing and compulsory social health insurance have played important roles in ensuring that a substantial progress has been registered regarding UHC in the respective countries. The Universal Coverage Scheme completed in Thailand is based on taxes and has greatly decreased the amount of out-of-pocket expenditure and has enhanced equity without placing too much burden on the administration of the program. The community-based insurance model in Rwanda attained high coverage because it has obligatory enrollment, and the government greatly subsidized poor families (Kutzin et al., 2016).

Contrastingly, countries still depended extensively on out-of-pocket payment like in Nigeria and other sub-Saharan countries are characterized by the continued inequities, low service usage among the poor and high levels of catastrophic expenditure on health. The current financing system in Kenya is situated between these two systems, and it may be inferred that the gradual yet decisive changes toward the pooled financing may have significant welfare-payoff.

Policy Implications

This would suggest that the change of NHIF in Kenya into a Social Health Authority is a chance to utilize healthcare financing redesign according to the global best practice. Nevertheless, it is not enough that the institutional reform takes place. To make any progress meaningful towards UHC, it is necessary to maintain positive increment in the national health investments, enhance efficiency in the allocation of resources and intensify accountability.

Staged growth of pool funded savings, along with a specific hedge of vulnerable populations, can present a viable way to achieve fair and economically viable healthcare insurance (McIntyre & Kutzin, 2016).

In general, there is evidence that the anticipated economic and social interests of investing in pooled healthcare financing are more than the short-term fiscal and political expenses. Any instances of not handling the structural deficiencies of the healthcare financing system in Kenya will continue to increase the possibility of perpetrating inequality, diminishing the objectives of UHC and narrowing down the overall development potential of Kenya.

Policy Recommendations

According to the results, the following recommendations are given:

Increase compulsory health insurance cover in the Social Health Authority in order to enhance risk pooling in both the formal and informal employment (WHO & World Bank, 2017).

Increase the public health expenditure by implementing better domestic revenue mobilization and better budget prioritization (World Bank, 2019).

Cut out of pocket expenses through improving benefit plans and offering benefit subsidies to low-income households (Xu et al., 2007).

Ensure greater efficiency and accountability demanded by enhancing the governance, improved procurement, and performance-based financing (Barasa et al., 2018).

Enforce targeting and enrollment to make vulnerable and marginalized groups gain access to public subsidies.

CONCLUSION

This paper has analyzed healthcare financing in Kenya through the economic policy lens, and the aim of the paper has been to determine the structure, equity and effectiveness of available financing systems in promoting Universal Health coverage (UHC). The study used the secondary data on costs associated with health spending, health insurance coverage, and financing sources to assess how the existing financing policies determine access to health care, financial security, and welfare outcomes (World Health Organization [WHO], 2010;

McIntyre and Kutzin, 2016).

The results indicate that the system of healthcare financing in Kenya is still fragmented and most of it is dependent on out-of-pocket payments, which subjects households, especially low-income households and people in informal sectors, to disastrous spending on health (Xu et al., 2007; Wagstaff et al., 2018). Despite the general rise in the level of the public health spending and introduction of insurance reforms, the coverage is still unequal and pooled funding is not enough to maintain equitable access and sufficient financial support (Barasa et al., 2018; Kazungu and Barasa, 2017). The fact that the donor funding is getting decreasing and uncertain results in the additional doubts regarding the long-term sustainability of the system (World Bank, 2019).

These results possess significant implications of policy. The implementation of UHC in Kenya will necessitate deep financing reforms in focus on increased pooled funds by means of obligated insurance by the Social Health Authority, further government financing of health, and enhancement in efficiency and accountability of healthcare expenditures (WHO and World Bank, 2017; Kutzin et al., 2016). Financial safety of vulnerable populations is also crucial to improving health care outcomes as well as helping to lower poverty and preventing economic development in the long run (Bloom et al., 2014).

The further study should be aimed at the evaluation of the fiscal sustainability of other healthcare financing strategies that are the long-term viability of the system of mandatory insurance and tax-based financing (McIntyre and Kutzin, 2016). It may also be studied later how current reforms in the Social Health Authority affected the distribution effects, the efficiency of informal-sector worker-specific subsidies, and the contribution of efficiency gains to fiscal constraints (Barasa et al., 2017; World Bank, 2020). This kind of research would give useful evidences to inform the policy making and help Kenya to achieve equitable and sustainable Universal Health Coverage.

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