AFRICAN RENAISSANCE

Comprehensive legal reform redefines pooling, purchasing, digital systems, and facility financing

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Kenya's exemplar examines the legislative overhaul that created the Social Health Authority and introduced a new architecture for mandatory universal health insurance. It considers both the ambition of the reform and the operational pressures that have emerged during implementation.

Core exemplar

Legislative overhaul for mandatory universal health insurance through the Social Health Authority, backed by the Social Health Insurance Act and related reform laws.

Why it matters for ALM: It shows how comprehensive legal reform can redefine pooling, purchasing, digital systems, and facility financing in one coordinated transition.

Primary ALM contribution: More money for health, equity and financial protection, and governance and accountability through legal and institutional redesign.

Replicability potential: High for countries seeking to replace fragmented insurance arrangements with a mandatory national architecture.

1. Context: From NHIF to Mandatory Universal Health Insurance

Kenya's health-financing reform is one of the most sweeping legislative overhauls seen recently in sub-Saharan Africa. For more than 50 years, the National Health Insurance Fund (NHIF), created in 1966, served as the country's main public insurance platform. By 2023, however, only about a quarter of Kenya's 52.4 million people had any form of health insurance, out-of-pocket spending remained high, and NHIF faced persistent concerns over inefficiency, limited coverage, and governance. President Uhuru Kenyatta's 2018 UHC pilot opened the door, but the decisive break came under President William Ruto, whose administration enacted the legal package that replaced NHIF altogether.

2. Mechanism: Legal Reform, SHA and Digital Health Systems

In October 2023, President Ruto signed four healthcare acts into law, fundamentally restructuring Kenya's health system:

- Social Health Insurance Act (2023): Established the Social Health Authority (SHA) to replace NHIF, creating mandatory social health insurance with premiums set at 2.75 % of gross income for salaried workers (minimum KES 300/month). SHA manages three funds: the Primary Healthcare Fund (publicly financed preventive/community care, accessed free), the Social Health Insurance Fund (SHIF, for inpatient/outpatient treatment at levels 4–6), and the Emergency, Chronic and Critical Illness Fund (ECCI).
- Primary Health Care Act: Formalized Primary Care Networks (PCNs) and community health delivery through community health promoters, with a global budget capitation of KES 900 per person annually.
- Digital Health Act: Established the Digital Health Agency to create a Comprehensive Integrated Health Information System for the entire population.
- Facility Improvement Financing Act: Provided the legal framework for public facilities to retain and reinvest SHA reimbursements, user fees, and grants locally.

For self-employed and informal-sector workers, contributions are determined through an AI-enabled means test accessible through USSD and the national online platform, with a monthly floor of KES 300. Kenya also introduced an interest-free lending mechanism to help informal workers keep up with premium payments.

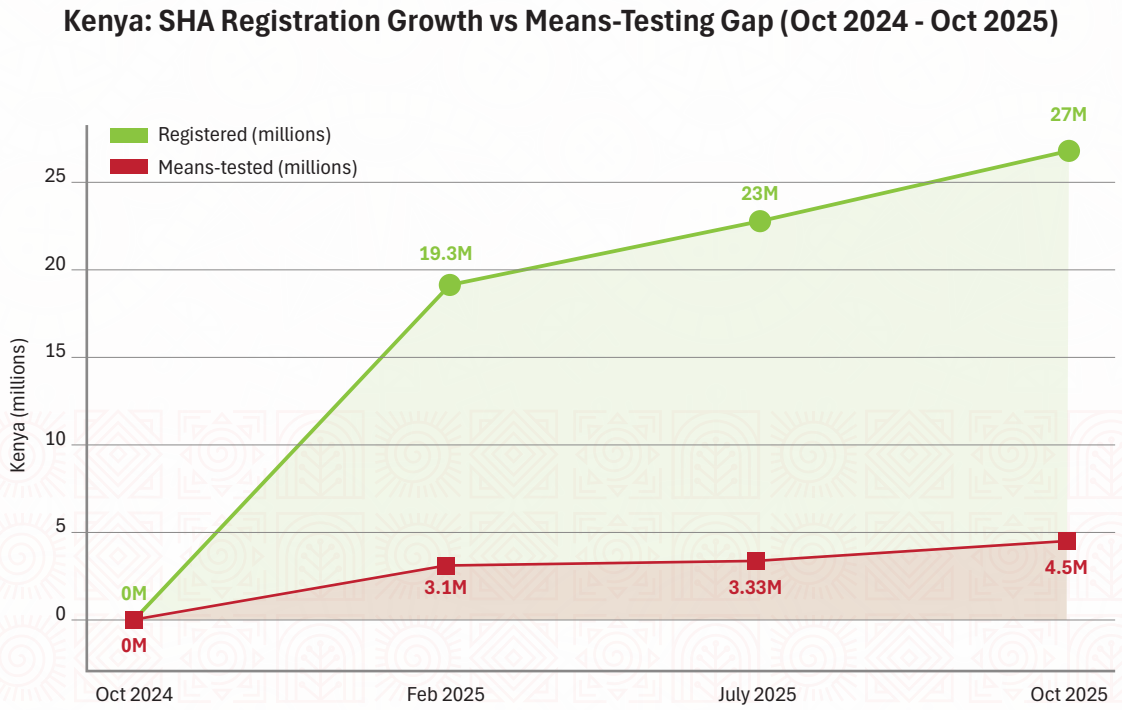

Figure K-1. Kenya: SHA Registration vs Means-Testing (Oct 2024 – Oct 2025). SHA registrations grew from zero to 27 million in 12 months, but means-testing (which determines informal-sector contribution) reached only 3.3M — a critical gap in revenue generation.

3. Outcomes: Rapid Registration and System Expansion

SHA was officially launched on 1 October 2024. By February 2025, more than 19.3 million Kenyans had registered, and 8,813 of the country's 17,755 active health facilities had enrolled, with most of them already using the system. More than one million people accessed primary health care services under SHA between October 2024 and February 2025. By October 2025, total registration had climbed to about 27 million. The benefit package also changed materially from the NHIF era, with higher ceilings for oncology and cardiology care and new coverage for transplant-related services.

At the Tokyo UHC High-Level Forum in December 2025, Kenya signed a National Health Compact with the World Bank that committed the country to doubling public health spending over five years to reach 5% of GDP and to expanding social health insurance coverage from 26% to 85%, with full subsidies for vulnerable groups. It is one of the most ambitious UHC financing commitments made by an East African state and aligns closely with the ALM agenda on domestic resource mobilization and national insurance.

Key Vulnerability

- **What is at risk:** Revenue collection and provider confidence during rapid scale-up of SHA.

- **Why it matters (evidence):** Registration has moved faster than the systems that make insurance financially viable. Only 3.1 million people had completed means testing by February 2025 (and ~3.33 million by mid-2025), and less than 5 million were regular contributors; limiting informal-sector contribution collection. Provider reimbursement has been the sharper crisis: only 20% of PHC-accredited facilities received monthly payments in Q1 2025, and SHIF claims settlement averaged 34%. Governance and dispute-resolution structures are also incomplete: the Dispute Resolution Tribunal has only recently been established, and the National Assembly Health Committee has flagged "inconsistent reimbursements" and "governance gaps." KMPDU threatened and carried out strike actions throughout 2025 and part of 2026.

- **What would reduce the risk:** Further reform may be needed to reduce fragmentation across insurance pools and clarify the roles of the public sector, private sector, and civil society in the SHA value chain so that each contributes where it adds the most value and lowers costs. For example, Kenya's AI-enabled community health information system could help improve means testing, identify vulnerable households more accurately, and support the development of a stronger social register for government subsidies. SMEs and research organizations could also help clear the means-testing backlog, while more stable contribution channels and transparent payment reporting could improve financial performance. Other priorities include fully operationalizing purchaser governance, including the dispute-resolution tribunal, so facilities can plan and trust the system.

4. Kenya on the ALM Scorecard

Kenya's ALM scorecard reflects bold reform momentum, with eight commitments rated On Track and two rated Partial. The strong ratings are driven by the October 2023 four-law package, rapid institutional rollout under the Social Health Authority, and substantial progress in political leadership, partner alignment, domestic mobilization, private-sector engagement, operational undertakings, monitoring, hosting visibility, and AU-linked reform momentum. The two Partial ratings relate to PMPA harmonization and the accountability framework, where implementation is advancing but regulatory alignment, payment governance, and formal accountability structures are still maturing. Overall, the scorecard is consistent with a country that has moved quickly on reform design and is now consolidating the institutions needed for long-term delivery.

ALM Scorecard Heat-Map	
Country	**Kenya**
1. Political Agenda	
2. Leverage Partners	
3. Domestic Mobilization	
4. Private Sector	
5. PMPA Harmonization	
6. Operational Undertakings	
7. Monitoring & Reporting	
8. Accountability Framework	
9. Hosting Role	
10. Leveraging AU Support	

Legend: Green = On Track; Amber = Partial; Red = Off Track

5. Key Lessons and Policy Implications

- Passing four linked laws at once gave Kenya a more coherent reform base than piecemeal changes would have provided. Financing, service delivery, digital infrastructure, and facility autonomy moved together.
- Means testing can improve equity, but only if it works reliably at scale. Kenya's model is promising, though it still needs stronger operational performance to fully support subsidy design and contribution setting.
- Kenya is also a reminder that legislation does not deliver UHC on its own. If payment systems, contracts, and dispute-resolution mechanisms lag behind enrolment, registration numbers quickly lose meaning.
- The National Health Compact may serve as a course-correction tool if its financing and coverage commitments are tracked transparently. Used well, that kind of compact can strengthen accountability rather than simply add another declaration.
- Allowing facilities to retain and reinvest revenue helps preserve frontline autonomy inside a centralized financing system. That may prove one of the reform's most durable design choices.

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ALM score card sources: Egypt (9/10 On Track, 1 Partial)
C1: Political agenda — On Track Indicators: BETA Five Pillars; SHA launch Oct 2024; WB Compact Dec 2025 (5% GDP, 85% coverage); PIFAH co-launch Sources: BETA documentation; SHA Act 2023 (kenyalaw.org); WB Kenya Compact Dec 2025; PIFAH
C2: Leverage partners — On Track Indicators: WB IDA $200M+; Global Fund; Gavi; USAID; AFD; EU; KEMRI-CDC Sources: WB Kenya Health projects; Kenya MoH partner architecture
C3: Domestic mobilisation — On Track Indicators: SHA mandatory; SHIF 2.75% income; ~4.2% budget; ~$57 per capita; 4-law package Sources: SHA Act 2023; PHC/Digital Health/FIF Acts (kenyalaw.org/kl/index.php?id=13035)
C4: Private sector — On Track Indicators: 200+ private hospitals SHA-accredited; Safaricom M-PESA SHA integration; KAPI Sources: SHA Accredited Providers (sha.go.ke); Safaricom announcements
C5: PMPA — Partial Indicators: PPB regulator; PIFAH co-launch 2025; KEMRI vaccine R&D; limited manufacturing scale Sources: PPB Kenya (pharmacyboardkenya.org); PIFAH (nepad.org/pifah)
C6: Operational — On Track Indicators: SHA 19.3M (Feb 2025)→27M (Oct 2025); four-law package; Cabinet SHA Steering Committee Sources: MoH SHA briefings Feb 2025; SHA data (sha.go.ke/news)
C7: Monitoring — On Track Indicators: SHA digital registration + biometric; MoH press briefings; National Assembly Health Committee Sources: MoH Feb 2025 briefings; SHA dashboard (sha.go.ke)
C8: Accountability — Partial Indicators: Parliamentary oversight; Dispute Resolution Tribunal not established; 20% provider payment rate Q1 2025 Sources: KMPDU Mar 2025 communiqué (kmpdu.org); National Assembly Health Committee
C9: Hosting role — On Track Indicators: East African Pharmaceutical Forum Mar 2026 Nairobi; Nairobi Communiqué; PIFAH launch Sources: EA Pharma Forum 2026; EAC Secretariat
C10: Leveraging AU — On Track Indicators: Ruto co-launched PIFAH; took over AU Reform from Kagame 2024; AU Champions architecture Sources: PIFAH launch; AU Assembly/AU/Dec.903-941(XXXVIII)

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