THINK WELL
HERU HEALTH ECONOMICS RESEARCH UNIT
KEMRI | Wellcome
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Who Is Poor? Lessons from Kenya's UHC Indigent Program on Targeting Health Insurance Subsidies

Summary Findings

1. In 2020/21, Kenya rolled out a Health Insurance Subsidy Program under the National Hospital Insurance Fund (NHIF)as part of the Universal Health Coverage (UHC) scale-up following the UHC pilot. The program aimed to expand healthcare access for poor households.
2. Counties relied on community health volunteers (CHVs)and village elders to identify poor households and compiled household lists using paper records. This paper-based process introduced delays and reduced the accuracy of household verification and eligibility assessment.
3. Many indigent households were unaware of their enrolment in the scheme due to inadequate communication about their entitlements. Similarly, health facilities were not adequately sensitized about the program or the benefits due to them.
4. Although the program enrolled 882,291 households, only 48% completed biometric registration, which limited effective coverage. In many cases, household dependents (spouses and children) were not added to the household cover.
5. Weak operational capacity and political interference led to inclusion and exclusion errors in beneficiary identification. This led to mistrust within communities.
6. Considerations for strengthening the identification of indigents include strengthening intergovernmental collaboration, enhancing data harmonization between the ministry of labour and social protection, the Social Health Authority (SHA), and County governments, building operational capacity at the local level.

Introduction

Kenya is implementing significant social health insurance reforms following the passing of the Social Health Insurance (SHI) Act of 2023 (Social Health Insurance Act, 2023). The Act establishes the Social Health Authority (SHA), as the body responsible for managing SHI in Kenya and whose mandate includes overseeing enrolment, claims, and administration of premium subsidies to ensure access to healthcare for all Kenyans. Under this new framework, the government finances premiums for indigent households and could receive external support from funders.

Indigents are defined as those who are poor and needy, identified through eligibility assessments that rely on proxy-means testing (PMT). PMT is a method used to estimate a household's economic status by assessing observable characteristics—such as housing type, asset ownership, and household demographics—rather than direct household income or expenditure data. It's commonly used in contexts where formal income data is unavailable or unreliable, helping to identify individuals eligible for assistance(Coady,Grosh, et al., 2003).

Program Overview

The UHC indigent program in Kenya was developed to address financial barriers to healthcare for the poorest households.Implemented through the national social health insurer, NHIF, the program aimed to provide subsidized health insurance coverage to 5.2 million poor households.

The program was designed in phases, seeking to cover one million households in its first roll out in 2020/21, scaling to 1.5 million households in phase II in 2021/22, and with a long-term goal to cover five million indigent households (Republic of Kenya, 2023). The national government allocated 6 billion shilling to NHIF for the cost of premiums on behalf of the households in phase I of the program.

The program was designed to utilize a standardized approach using a PMT tool but the decentralization of the beneficiary identification to the counties led to variations in eligibility criteria with some counties using a PMT tool and others relying solely on community-based approaches. While the PMT tool uses a standard questionnaire to assess household socio-economic status data, the community-based approaches rely on knowledge of household socio-economic status by community leaders (Table 1).

This policy brief is based on findings from a qualitative study conducted by KEMRI-Wellcome Trust and ThinkWell between June and October 2024, designed to assess the implementation process and experience of the UHC indigent program. The study included primary data collection with key informant interviews (national and county stakeholders) and secondary data analysis of published and grey literature.

Key Findings

Program development rationale

The UHC indigent program was designed as a national, targeted SHI initiative and was considered a part of broader efforts to scale up UHC following the implementation of the UHC pilots in four counties in Kenya. The shift from an input-based financing model to an insurance-based model was informed by lessons from the implementation of the pilots, aiming to create a more sustainable and scalable approach. Legislative support through the NHIF Amendment Act (2022) established NHIF's role in managing indigent health coverage, laying a foundation for SHA's future mandate(The NHIF Amendment Act, 2022).

Implementation fidelity and challenges

- **Operational capacity**: The reliance on paper-based processes and limited technological resources such as electronic tablets for capturing household information and verification, introduced delays and reduced accuracy in identifying eligible households. Registration was also incomplete for dependents of indigents, limiting coverage. This was owing to the urgency to fill the slots allocated with the counties that initially only required household head information with plans to enrol dependents at a later stage. Additionally, service availability in facilities was contingent upon the availability of essential commodities and human resources, affecting the consistency of service delivery.
- **Communication and awareness**: Many indigent households were unaware they had been enrolled in the scheme due to inadequate communication about their entitlements. It was unclear which actor—NHIF, the county, or the national government—was responsible for informing households after the beneficiary lists were cleaned. Counties reported that after submitting their lists, they were not informed about which households had been successfully enrolled and which had not. Furthermore, healthcare facilities were not sufficiently sensitized on the scheme, leading to gaps in service provision and a lack of clear understanding regarding patient coverage and benefits.
- **Political capacity**: Decentralization allowed for local political influence in beneficiary selection, which led to inequities and deviations from the program's original equity goals. Some of these actors included area chiefs, ward representatives, county officials and members of parliament. impacting the program's quality and alignment with its objectives.

In some cases, political expediency and local political considerations—such as appeasing supporters, targeting electoral strongholds, or rewarding community members aligned with local leaders—shaped beneficiary selection impacting the program's quality and alignment with its objectives. This focus on quick implementation at the expense of rigorous standards compromised the program's effectiveness, as decisions were sometimes driven by political interests rather than by the need to reach the most vulnerable populations.

Program outcomes

While the program enrolled 882,291 households, only 48% completed biometric registration, limiting coverage of households. There were challenges in data harmonization between the county, NHIF, and the lists of poor households managed by Ministry of Labour and Social Protection (MOLSP). Delays in disbursement from the national treasury to NHIF as well as delays in capitation and reimbursements from NHIF to health facilities serving indigent households affected service delivery. Further challenges were experienced in counties without financial autonomy because funds from NHIF to the facilities were directed to the county revenue fund within which health funds are not ringfenced from other county revenue. As a result, facilities were deprived of the resources required for service delivery.

Unintended consequences

Weak operational capacity and political interference led to inclusion and exclusion errors in beneficiary identification. Some eligible households were left out, while others that did not meet the criteria were mistakenly included, undermining program credibility and limiting its reach among the most vulnerable populations. This led to mistrust within communities.

Best practices from health insurance subsidy programs (HISP) from literature

- Using broad eligibility criteria to expand coverage—such as geographical targeting (e.g., residents of drought-prone or underserved areas), demographic characteristics (e.g., children under five, elderly above 70), or social status (e.g., persons with disabilities, female-headed households)—can help expand subsidized health insurance coverage to populations often missed by narrow, income-based assessments. These criteria differ from the PMT tool, which relies on household asset and consumption indicators, and from community-based targeting, where local leaders identify the poor (Table 1).

Table 1: Comparison of Targeting Mechanisms

	Targeting Method	Criteria Used	Strengths	Limitations
Indirect targeting	Universal Targeting	Entire population or defined group (e.g., all elderly, all children under five)	Simple, inclusive, avoids exclusion errors	May not prioritize those most in need
	Geographical or universal approach	Area of residence (e.g., arid regions, informal settlements)	Easy to implement; targets underserved areas	May include non-poor in targeted areas
	Community-Based Targeting	Local leader identification of the poor	Leverages local knowledge	Subjective; prone to elite capture
Direct targeting	Proxy Means Testing (PMT)	Household asset and consumption data	Objective and standardized	May exclude some poor households

- Combining targeting approaches for effective enrolment: There are various targeting mechanisms each with their own strengths and shortcomings. These include 1) Indirect targeting uses observable characteristics like location or employment status to infer vulnerability e.g. informal sector households; 2) Direct targeting, such as PMT or means testing, evaluates household income or consumption directly. Combining these approaches increases the likelihood of including the most vulnerable, mitigating exclusion and inclusion errors(Kidd et al., 2020).
- Defining a pro-poor benefit package that responds to the health needs of vulnerable populations—such as maternal care, immunization, treatment for chronic diseases, and mental health services—can improve health outcomes. Prioritizing primary healthcare (PHC) within this package enhances equity, as PHC services are more accessible and affordable, particularly in rural and low-income areas(Watson et al., 2021).
- Facilitating enrolment mechanisms: Active enrolment requires outreach and mobilization—such as door-to-door campaigns, use of community health promoters, and mobile registration clinics—to inform and register eligible individuals. Automatic enrolment, where individuals are enrolled based on existing social registries or eligibility criteria (e.g., inclusion in national social protection programs), reduces administrative burdens and ensures timely access to benefits(Kidd et al., 2020).
- Financing subsidies primarily through general government revenues ensures predictable funding as opposed to relying on donor funding. Additionally, earmarked taxes, such as sin taxes on tobacco, alcohol, or sugary drinks, provide supplemental funds while also promoting healthier behaviours. These strategies enhance sustainability of subsidy programs(Fenny et al., 2021).

Policy implications for SHA implementation

1. Strengthening intergovernmental collaboration: The SHI Act 2023 mandates county financial contributions for indigent care, emphasizing the need for harmonized roles between MOLSP and county governments. A standardized electronic PMT tool, complemented by community-based verifications, can ensure national standards while considering local autonomy.
2. Enhancing data harmonization: Current implementations should prioritize a unified digital registry accessible to MOLSP, Ministry of Health, SHA, and county governments. A standardized registry can streamline data collection, improve enrolment accuracy, and enhance service access, addressing previous challenges with disparate data sources.
3. Building operational capacity at the local level: Counties need enhanced operational capacity, including digital tools andtraining for Community Health Promoters, to manage beneficiary identification accurately. Improving resources for household data collection, analysis, and verification will strengthen program effectiveness.

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About the brief

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