HERU
HEALTH ECONOMICS RESEARCH UNIT

KEMRI | Wellcome Trust

POLICY BRIEF
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Identifying the Poor for Health Insurance Subsidies: Lessons from the Kenya UHC Indigent Program

Summary Findings

1. The reliance on paper-based processes for data collection and verification introduced delays and reduced accuracy in identifying eligible households
2. Many indigent households were unaware they had been enrolled in the scheme due to inadequate or lacking communication about their entitlements
3. While the program enrolled 882,291 households, only a fraction completed biometric registration, limiting coverage of households
4. Weak operational capacity and political interference led to inclusion and exclusion errors in beneficiary identification. This led to mistrust within communities
5. Considerations for strengthening the identification of indigents include the Strengthening intergovernmental collaboration, enhancing data harmonization between the ministry of labor and social protection, and the Social Health Insurance agency (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), a body responsible for managing Social health insurance in Kenya and whose mandate includes overseeing enrolment, claims, and administration of premium subsidies to ensure access to healthcare for Kenya's most vulnerable populations. Under this new framework, the government will finance 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. Given SHA's recent establishment, this policy brief draws on the lessons from the implementation of the UHC indigent program, which was managed through the National Health Insurance Fund (NHIF), to inform effective beneficiary identification practices for SHA.

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 indigent 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, and with a long-term goal to cover five million indigent households(GOK, 2023). The national government allocated 6 billion shilling to NHIF for the cost of premiums on behalf of the households in phase I.

The program was designed to utilize a standardized approach using a proxy - means testing (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.

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 social health insurance 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.

Implementation fidelity and challenges

- **Operational capacity**: The reliance on paper-based processes and limited technological resources for data collection and verification introduced delays and reduced accuracy in identifying eligible households. Registration was also incomplete for dependents of indigents, limiting coverage. 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 or lacking communication about their entitlements. 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. In some cases, political expediency and local political considerations influenced the selection of beneficiaries and facilities, 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 a fraction completed biometric registration, limiting coverage of households. Challenges in data harmonization and funding disbursement further affected service delivery, particularly in counties without financial autonomy.

Unintended consequences

Weak operational capacity and political interference led to inclusion and exclusion errors in beneficiary identification. This led to mistrust within communities. 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.

Best practices from health insurance subsidy programs (HISP)

1. Using broad eligibility criteria to expand eligibility to cover a wider range of vulnerable groups can enhance population coverage, ensuring more individuals benefit from subsidized health insurance. This approach can reduce inequities in access and financial protection.
2. Utilizing a combination of targeting methods—universal, indirect, and direct—helps identify and enrol the most vulnerable populations effectively, ensuring that subsidies reach those in greatest need.
3. Offering a well-defined, comprehensive benefit package that addresses the health needs of vulnerable populations can improve health outcomes and encourage healthcare utilization.
4. Facilitating active enrolment by beneficiaries, along with automatic enrolment options, can enhance access and ensure that eligible individuals are not left out of the system. This approach prevents administrative delays and maximizes access.
5. Utilizing general government revenues as the primary source of funding for subsidies can ensure a stable and predictable financing mechanism. Exploring multiple funding sources, such as earmarked taxes (e.g., sin taxes on tobacco and alcohol), can also provide additional revenue streams.

Policy implications for SHA implementation

1. **Strengthening intergovernmental collaboration**: The SHI Act mandates county financial contributions for indigent care, emphasizing the need for harmonized roles between MOLSP and county governments. A standardized electronic Proxy Means Testing (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, MOH, 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 and training for Community Health Volunteers (CHVs), to manage beneficiary identification accurately. Improving resources for data collection, analysis, and verification will strengthen program effectiveness.

Conclusion

The implementation experience of the UHC indigent program in Kenya provides valuable insights into the complexities of implementing a national health insurance subsidy for vulnerable populations. By integrating best practices from successful Health Insurance Subsidy Programs (HISP), such as broad eligibility criteria, integrated pooling, and comprehensive benefit packages, SHA can enhance the UHC indigent program. With improvements in intergovernmental coordination, standardized financial flows, and data harmonization, SHA can align current implementation of the program with Kenya's UHC goals, ensuring equitable and accessible healthcare for the most vulnerable citizens.

About the brief

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Beryl Maritim, Jacinta Nzinga, Benjamin Tsofa, Peter Mugo, Rahab Mbau, Anne Musuva, Felix Murira, Ethan Wong, Caitlin Mazzilli, Wangari Ng'ang'a, Brittany Hagedorn, Nirmala Ravishankar, Edwine Barasa. **Examining the Implementation Process and Experience of UHC indigent program in Kenya. 2025. (Forthcoming)**

For more information, email **bmaritim@kemri-wellcome.org**

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