

# Early Experience With Global Budget Capitation for Primary Health Care in Kenya

What Nairobi's first year under SHA's PHC Fund means for MOH, SHA, the Counties, and the rollout of Universal Health Coverage



## KEY MESSAGES

- 1 GBC substantially increased PHC funding reaching Nairobi's public facilities, with the largest gains at level 4 compared to level 2 and 3 facilities: median monthly disbursements rose 178% at level 2 dispensaries, 101% at level 3 health centres, and 515% at level 4 hospitals during 2025 – a shift that has materially changed what facilities can afford to do.
- 2 Facility managers strongly preferred GBC to the previous NHIF capitation model (84% of respondents), citing larger and more predictable payments as the main reason, even in facilities where timeliness itself remained inconsistent.
- 3 Facility-level autonomy to retain and directly manage PHC funds, rather than routing them through the County Revenue Fund, was a critical enabler of effective fund use, letting facilities respond quickly to stock-outs and service gaps rather than waiting on county approval cycles.
- 4 Active, sustained county-SHA troubleshooting – not national policy design alone – was critical to ensuring facilities actually received funds: a joint facility-by-facility effort in Nairobi raised the share of facilities receiving any payment at all from about 10% to over 90%.
- 5 Effective use of GBC funds requires both training facility staff in public financial management and deploying procurement officers at the cluster level.
- 6 Reported improvements in medicines, diagnostics, outreach and service utilisation are based on facility managers' perceptions. Further work is needed to link these reported improvements to routine performance data.
- 7 Payment timeliness remains the model's weakest attribute: only 7% of facilities were paid within 30 days of claim submission, and 26% waited more than 121 days, with the longest delays concentrated at level 2 dispensaries – the facilities with the least capacity to absorb cash-flow gaps.

## About This Brief

Kenya's 2023 health financing reforms replaced NHIF outpatient capitation with global budget capitation (GBC) for primary health care, financed through the PHC Fund and administered by the Social Health Authority (SHA). This brief shares findings from a mixed-methods study combining SHA disbursement data (Jan–Dec 2025) for 111 public PHC facilities in Nairobi, a facility survey, and key informant interviews with SHA, county, sub-county and facility respondents.

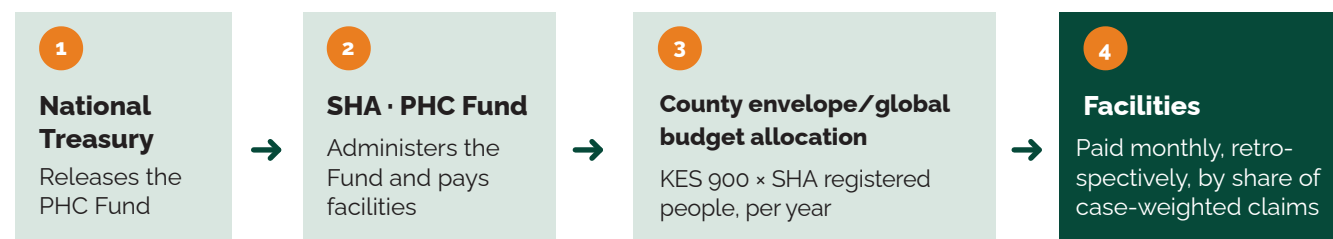
## What is GBC, in practice?

Under GBC, SHA finances public PHC facilities in each county through a fixed budget envelope referred to as 'global budget', sized using a population-based rate of KES 900 per SHA-registered person per year. That rate determines how large the county's overall pool of money is, it is not an amount paid to any individual facility. Facilities are then reimbursed monthly, and retrospectively, from within that envelope: each is paid according to its share of that month's case-weighted outpatient claims – the visits it recorded, adjusted for the complexity and cost of the care provided, relative to every other facility drawing on the same pool. Funds flow from National Treasury to SHA, into the county-level envelope, and out to facilities based on claims already submitted. (Fig 1)

This distinction matters because GBC does not behave like traditional facility-level capitation, where a facility gets a fixed amount per registered patient regardless of how many visits occur. Under GBC, a facility's revenue depends on the volume and complexity of the claims it submits relative to other facilities – which is central to several of the findings below.



**Figure 1: How PHC Fund money reaches facilities under GBC**



**KES 900 (USD 6.9) sizes the county pool.** It is not an amount paid to any individual facility per person.

## The overall picture

The findings below point to a common thread. GBC has brought facilities more money, but it has also brought new demands: facilities must register clients, submit claims, manage reimbursements that sometimes arrives late, and handle more financial planning and reporting than they did under NHIF. How a facility handles these demands – its capacity, autonomy and support – shapes whether the extra funding actually reaches patients as better services.

### AT A GLANCE

**111**

Public PHC facilities in the study

**+515%**

Rise in median level-4 monthly disbursement, 2025

**84%**

Of managers prefer SHA GBC to NHIF

**7%**

Of facilities reported being paid within 30 days of claiming at the time survey was conducted

**>90%**

Of facilities paid after county-SHA troubleshooting, up from ~10%

**≈34%**

National shortfall against the KES 900 design



#### SHA disbursement data

PHC Fund payments to 111 public facilities, January–December 2025



#### Facility survey

Self-administered survey of facility in-charges



#### Key informant interviews

SHA, county, sub-county and facility respondents

## Key Findings

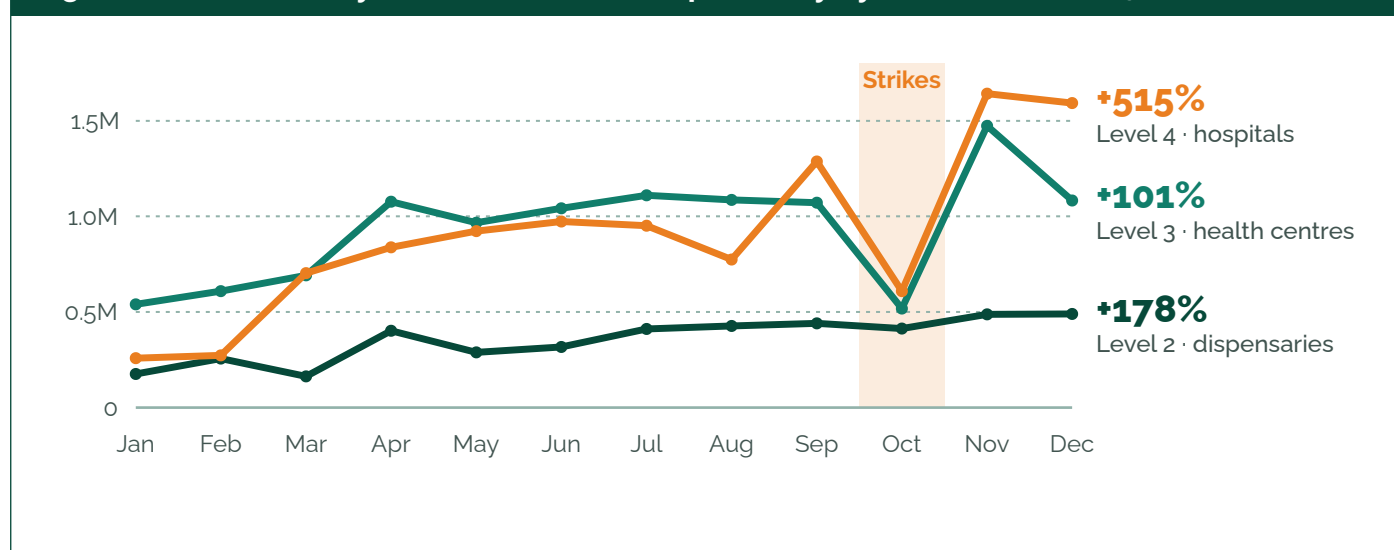
### 1 Facilities receive more funding under SHA's GBC model, but delayed and unpredictable payments continue to affect operations

Median PHC Fund disbursements increased substantially across all facility levels during 2025: +178% at level 2, +101% at level 3, and +515% at level 4 (Figure 2). Facility managers linked this increase directly to their ability to hire casual staff, keep laboratory and pharmacy services running, and sustain outreach.

Timeliness remains the model's most significant weakness. Just 7% of facilities received payment within 30 days of claim submission, whereas 26% waited more than 121 days, with the longest delays concentrated among level 2 dispensaries. (Fig 3)

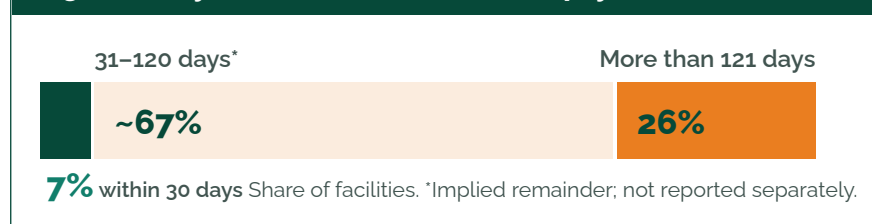
Respondents identified two principal causes: irregular fund releases from the National Treasury to SHA and facility-level onboarding issues, particularly bank detail and facility identifier mismatches. While the latter can be addressed through county-SHA coordination and have improved over time, treasury-related funding delays persist. The occasional practice of combining two months' payments into a single disbursement appears to be a knock-on effect of these upstream financing bottlenecks

**Figure 2: Median monthly SHA PHC disbursement per facility, by level, Jan–Dec 2025 (KES)**



**Data source:** SHA PHC Fund disbursement data, 111 public PHC facilities, Nairobi. October's dip coincided with health-worker strikes that reduced claim volumes.

**Figure 3: Days from claim submission to payment**



*“Treasury hasn’t been sending exactly what our projections are.”*

— SHA official

Despite ongoing delays, managers generally regarded SHA GBC payments as more predictable than NHIF payments once early implementation issues had been resolved. Indeed, more than half described SHA payments as faster, while relatively few viewed them as slower. This increased predictability was attributed to the shift from quarterly to monthly disbursements and to county-level interventions that cleared backlogs of unresolved claims. Importantly, respondents distinguished predictability from timeliness: while payments became more regular and easier to anticipate, many were still not received on time, as evidenced by the figures presented above.

## 2 Coordinated county-SHA action resolved onboarding bottlenecks and achieved over 90% facility coverage

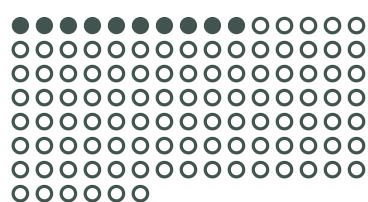
Early implementation was hampered by incomplete or inconsistent bank details, mismatches between facility names and codes, and unresolved issues carried over from the NHIF-to-SHA transition. As a result, only around 10 facilities, primarily level 4 hospitals, were initially receiving PHC Fund payments. Nairobi County responded with a targeted and sustained intervention rather than relying on passive coordination. The county health financing team conducted a joint facility-by-facility audit with SHA and its digital vendor to reconcile the Master Facility List with SHA's registry, established a dedicated escalation pathway through which facility in-charges could channel unresolved

claims to the county team, and systematically tracked each case until payment was confirmed. Over several months, these efforts increased the proportion of facilities receiving PHC Fund payments to more than 90%.

The Nairobi experience shows that early implementation bottlenecks can be addressed. Through active collaboration between counties and SHA, targeted troubleshooting can rapidly expand facility participation, resolve administrative barriers, and restore the flow of funds.

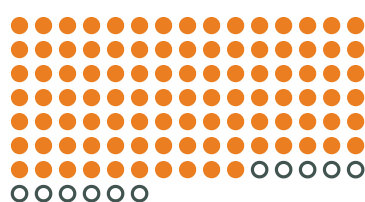
**Figure 4: Facilities receiving PHC Fund payments, before and after joint troubleshooting**

### AT LAUNCH



~10 facilities, mostly level 4

### AFTER



>90% of 111 facilities

1

### Joint audit

Reconcile the Master Facility List with SHA's registry, facility by facility

2

### Escalation pathway

In-charges route unresolved claims to the county team

3

### Tracking payment

Each case followed until payment is confirmed

**Data source:** SHA PHC Fund disbursement data and key informant interviews. Each dot is one of the 111 study facilities.

## 3 Facility revenue is shaped by claiming capacity as well as underlying population need

As described above, facilities are reimbursed according to their share of case-weighted claims within the county, not a fixed amount per registered patient. This means facility revenue is influenced by how many patients a facility sees and how complex or costly those patients' conditions typically are to treat. During 2025, level 4 facilities' median disbursements grew substantially faster (515%) than level 2 (178%) or level 3 (101%) - (Fig 5). This pattern is consistent with – though this study cannot confirm – higher-level facilities having greater capacity to generate and document higher-value claims. Whether this reflects the fact that higher-level facilities genuinely treat more complex cases, a greater capacity to claim, or another cause warrants further examination using claims-level; this study's facility-level disbursement data cannot distinguish between these explanations.

**Figure 5: Growth in median monthly disbursement by facility level, January to December 2025**

Level 2 · dispensaries



+178%

Level 3 · health centres



+101%

Level 4 · hospitals



+515%

**Data source:** SHA PHC Fund disbursement data, 111 public PHC facilities, Nairobi.



#### 4 Increased funding was associated with reported service delivery improvements but should be assessed against routine health information system data

Facility and county respondents reported improvements in service readiness and utilisation following the introduction of GBC, including better availability of medicines and diagnostics, increased outreach activity, and perceived increases in outpatient visits, NCD clinic attendance and uptake of preventive services.

The findings presented here are based on provider and manager accounts and were not independently verified using routine service-utilisation data. While concerns about potential incentive effects arising from the claims-based payment design are theoretically plausible, this study found no evidence of claims being submitted for services that were not delivered. These potential effects should therefore be regarded as risks requiring ongoing monitoring rather than as observed outcomes. Future

*“You should come to my facility right now – I have no issue with drugs, I have no issue with diagnostics. My facility is clean, the casuals are paid, things are looking up and we are seeing more people.”*

— CHMT official, relaying facility in-charges

analyses linking PHC financing and claims data to routine health information system data will be important for assessing whether increased facility funding leads to sustained changes in service utilisation, service delivery, and health system performance.

## The payment formula is often misunderstood, but inadequate PHC financing remains a real concern

### QUESTION 1 · OFTEN MISUNDERSTOOD

#### How is the pool shared?

By each facility's share of case-weighted claims. KES 900 (USD 6.9) sets the county envelope, not per-patient pay.

Respondents frequently argued that the KES 900 per registered person per year allocation was insufficient to finance the full range of PHC services expected of facilities. However, many discussions conflated two separate issues: how the payment formula distributes funds and whether the overall PHC budget is adequately financed. The KES 900 rate is used to determine the size of the county PHC funding envelope; it is not the amount paid directly to facilities on a per-person basis. Facility payments are instead determined by each facility's share of case-weighted claims submitted within that envelope.

### QUESTION 2 · A REAL CONCERN

#### Is the pool big enough?

Disbursements run about a third below what the KES 900 (USD 6.9) rate itself implies.

Although the payment formula was often misunderstood, concerns about overall PHC financing were not unfounded. By early 2026, cumulative national PHC Fund disbursements had reached approximately KES 19 billion. Applying the KES 900 per-capita rate to SHA's registered population of roughly 32 million people yields an expected annual financing requirement of about KES 28.8 billion (Fig 6). Actual disbursements therefore fell approximately 34% below the level implied by the formula itself. This represents a funding shortfall relative to the existing design of the PHC Fund, distinct from the separate policy question of whether the KES 900 rate and underlying case weights are themselves sufficient and should be revised.

**Figure 6: PHC Fund disbursements against the requirement implied by the KES 900 rate**

Implied by the formula · KES 900 × ~32 million registered

**KES 28.8bn a year**

Cumulative national disbursements by early 2026

**~KES 19bn**

**≈34% short**

**Data source:** SHA; authors' calculation (KES 900 × ~32 million SHA-registered people). The requirement is annual; disbursement is cumulative to early 2026.

#### UNDER NHIF

**KES  
0.6 – 0.7m**

in a whole year

#### UNDER SHA GBC

**KES 3–4m**

in a single quarter  
(some facilities)

*“Some facilities that used to get 600–700,000 shillings in a whole year under NHIF are now getting 3–4 million in a single quarter... but even that 900 shillings per person is not adequate for everything we are expected to provide.”*

— Sub-county official

## 6 Health-worker strikes and staffing gaps limited what facilities could claim and deliver

Increased funding did not automatically translate into improved performance. Health-worker strikes and staffing shortages constrained facilities' ability to deliver services, generate claims, and utilise available resources effectively. These challenges were especially pronounced in level 2 facilities, where one or two nurses often carried responsibility for clinical care, accounting, and supply-chain management. The findings underscore that financing reforms must be accompanied by investments in workforce stability and operational capacity if they are to achieve their intended effects.

Nairobi's response offers one practical model for addressing these constraints. The county deployed dedicated procurement officers at sub-county level, allowing facility in-charges to focus more on oversight and service management rather than day-to-day administrative tasks. However, respondents noted that implementation remains uneven, with some facilities benefiting more than others. Because this challenge relates to broader health-system building blocks, particularly workforce and management capacity, rather than PHC financing alone, we revisit it below as a county-level policy consideration rather than a recommendation for SHA.

*"We have not worked continuously for two or three months without a strike. We want to claim this money, but we can only claim it by seeing patients. If patients don't come because we are not there, we do not generate any income for the facility."*

— SCHMT representative

*"You can't teach a nurse to be a nurse in a workshop... an accountant is an accountant. We need accountants at least to cover us – this is not just Nairobi, it's across all the counties."*

— CHMT official

## What Made the Money Work in Nairobi

Four conditions shaped whether GBC funding became better services:

| Condition                                        | What we saw in Nairobi                                                                                  |
|--------------------------------------------------|---------------------------------------------------------------------------------------------------------|
| <b>Facility financial autonomy</b>               | Funds retained and spent at facility level against an approved workplan; quarterly procurement planning |
| <b>Active county-SHA troubleshooting</b>         | Joint audit, escalation pathway and case tracking lifted coverage from ~10% to over 90%                 |
| <b>Financial management training and support</b> | Public Finance Management Training and deployment of cluster level procurement officers                 |
| <b>Stable workforce</b>                          | Strikes and thin staffing reduced the visits that generate claims                                       |

**Equity caution:** Nairobi's ability to troubleshoot, dedicate financial-management staff and engage SHA directly may not be replicable in marginalised or remote counties without deliberate support.



## 7 Facility autonomy enabled facilities to translate PHC funds into service improvements - where specific PFM conditions were in place

Under Nairobi's Facility Improvement Financing (FIF) arrangements, facilities retain and directly manage their PHC Fund receipts, rather than routing them through the County Revenue Fund. Respondents reported using these resources to reduce medicine stock-outs, restore laboratory services, support outreach (NCD screening, immunisation, reproductive health), and make minor infrastructure and patient-care improvements.

The productive use of PHC funding depended not only on the availability of funds, but also on specific public financial management (PFM) arrangements. Respondents highlighted two features as particularly important: direct retention of funds at the facility level, rather than channelling them through the County Revenue Fund, and a quarterly procurement-planning cycle that enabled facilities to respond more rapidly to stock-outs. These findings suggest that policymakers should focus on the specific PFM design features that shape facility responsiveness, rather than treating "facility autonomy" as a broad or undifferentiated objective.

*"Stock-outs have reduced, and facilities can offer the basic PHC package more reliably."*

— County official

*"We were dependent on partners for outreaches... now the dispensary can do an outreach every month."*

— Facility in-charge

## Policy Considerations

The considerations presented below are derived from Nairobi County's early experience with GBC implementation and should be interpreted with appropriate caution. Nairobi is Kenya's largest and predominantly urban county, accounting for approximately 10% of the country's population, with around 60% of its residents living in informal settlements. These characteristics make Nairobi an important setting for understanding implementation in a large, predominantly informal urban population. As such, these findings are intended to inform policy dialogue and the development of future guidance rather than to provide prescriptive recommendations. To avoid overinterpretation, each consideration is limited to a policy implication that follows directly from a specific finding reported above.

### For the Social Health Authority (SHA)

- Payment delays were the most persistent weakness identified by respondents. SHA could work with the National Treasury to map the sources of delay along the reimbursement chain, routinely track turnaround times from claim submission to payment, and establish a publicly reported service standard for payment timeliness.
- Communicate the payment mechanism more clearly while addressing concerns about financing adequacy separately. Respondents frequently conflated the operation of the payment formula with questions about whether the overall PHC budget is sufficient. SHA could clarify that the KES 900 per-capita rate is used to determine the size of the county PHC funding envelope rather than to set facility-level per-patient payments.
- Examine the case-weighting formula and its distributional effects. Disbursements to level 4 facilities increased substantially faster than those to level 2 and 3 facilities. This study cannot determine whether this reflects differences in service mix, claims volume, claiming capacity, or the operation of the case-weighting formula itself.
- Scale up structured onboarding and claims-resolution support. Nairobi's experience suggests that early implementation bottlenecks can be addressed through deliberate county-purchaser collaboration rather than simply resolving over time. SHA could consider offering counties a standard implementation support package comprising facility-list reconciliation, a direct facility-to-purchaser escalation mechanism, and systematic tracking of unresolved claims. Providing this support proactively, particularly in counties beginning implementation, may accelerate facility onboarding and improve payment coverage.

### For the Ministry of Health

- Consider what stakeholder engagement and capacity-strengthening GBC still needs. This study finds early implementation challenges are still being resolved in the study county; MOH should assess whether facility and county readiness nationally has kept pace with rollout, to protect quality of care.
- Provide national guidance on the complementary health-system building blocks this study found necessary for GBC funding to translate into better services – workforce deployment and retention, and harmonised public financial management (PFM) rules for facility-level fund retention – since these sit within MOH's broader stewardship role rather than SHA's purchasing mandate.

### For the National Treasury

- Stabilise and make transparent the PHC Fund release schedule to SHA. Delayed and irregular Treasury releases were the most frequently cited root cause of facility-level payment delays; a predictable, published release schedule would flow directly through to facility-level timeliness.
- Address the national financing gap directly. Actual disbursement runs roughly 34% below what the KES 900 per-capita rate implies is required nationally; closing this gap is a precondition for GBC to deliver on its own designed intent, independent of any future changes to the rate itself.

### For county governments

- Seek clarity on expected PHC Fund allocations. Counties' ability to budget, plan facility support and manage accountability depends on knowing what to expect from a nationally pooled fund; this was a source of uncertainty even in Nairobi City County.
- Protect and standardise facility-level financial autonomy. Nairobi's experience shows that facilities able to retain and directly manage GBC funds, with delegated authority to spend against an approved workplan, accessed funds faster and used them more effectively.
- Invest in dedicated facility-level financial management capacity, sized to the facility. Larger or higher-volume facilities may need a dedicated accountant; smaller level 2 facilities may be adequately served by shared PFM expertise across a cluster of facilities or a sub-county team, as Nairobi has begun doing – the key finding is that clinical staff should not be expected to absorb this role through short training alone.
- Prepare for onboarding friction and resource troubleshooting capacity from the outset. Bank-detail and facility-identifier mismatches nearly stalled disbursement in Nairobi before active county intervention; counties should anticipate this and assign a dedicated point of contact with SHA before rollout begins.
- Address complementary health system building blocks alongside financing. Workforce shortages and industrial action limited what facilities could achieve even where funding flowed well; GBC's effectiveness is bounded by staffing and service-continuity conditions that financing reform alone cannot fix.
- Consider the equity implications for counties with less digital or administrative capacity, or where PCNs are not yet fully established. Nairobi's ability to trouble-shoot, dedicate staff for financial management, and engage SHA directly may not be replicable in marginalised or remote counties without deliberate support.

## Policy Considerations

### For development partners

- Support evidence generation and monitoring of service-delivery outcomes – for example, a monitoring, data-linkage and risk-assessment initiative connecting SHA claims data to routine health information system (KHIS) records – to test whether reported utilisation gains are real and can be sustained.
- Support counties with weaker fiscal space or administrative capacity to build the specific PFM and troubleshooting functions this study identifies as enablers in Nairobi.

### For researchers

- Track cross-county variation as GBC scales nationally. Nairobi is an atypical, well-resourced, politically engaged county; comparative studies across counties with different fiscal space, facility autonomy and administrative capacity are needed before generalising its experience – and policymakers should weigh this as a real risk before extending any single county's lessons into national policy.
- Prioritise research that links SHA claims data with routine service-utilisation and health-outcomes data, to establish whether the funding and preference gains documented here (Findings 1 and 5) translate into better care, not only more revenue for facilities.

### About the Evidence

This brief draws on SHA PHC Fund disbursement data (January–December 2025) for 111 public PHC facilities in Nairobi, a self-administered survey of facility in-charges, and eight key informant interviews with SHA, county, sub-county and facility respondents. Our brief provides insight into funding flows, provider experiences and the early implementation of GBC. Findings on service delivery and utilisation are based primarily on respondents' reported experiences and were not assessed against routine service-utilisation data. The study captures an early period of GBC implementation and therefore cannot establish causal effects or assess how implementation and outcomes may change as the reform matures. Nairobi is a predominantly urban setting with particular fiscal, administrative and facility-autonomy arrangements; findings should be interpreted with caution when considering implementation in other county contexts, where geography, fiscal space and administrative capacity may differ substantially.

### References

1. Nairobi County Government. 2023. Health Reforms Taskforce Report. Nairobi.
2. Musyoki, Rebecca, Beryl Maritim, Dawe Gambo, Emmanuel Mulaa, Kaugi Kibaara, Malkia Abuga, Margaret Macharia, Michira Nyakaba, Patrick Katana, Suzanne Silantoi, and Edwine Barasa. 2026. "Early Experience with Global Budget Capitation for Primary Health Care in Kenya: A Mixed-Methods Study in Nairobi County."
3. Government of Kenya. 2023. Social Health Insurance Act, 2023.
4. Hanson, Kara, Nouria Brikci, Darius Erlangga, et al. 2022. "The Lancet Global Health Commission on Financing Primary Health Care: Putting People at the Centre." *The Lancet Global Health* 10 (5). [https://doi.org/10.1016/S2214-109X\(22\)00005-5](https://doi.org/10.1016/S2214-109X(22)00005-5).
5. Ministry of Health. 2023. Kenya Health Facility Census Report. Nairobi: Government of Kenya.

### ABOUT THIS BRIEF

Musyoki R, Maritim B, Gambo D, Mulaa E, Kibaara K, Abuga M, Macharia M, Nyakaba M, Katana P, Silantoi S, Barasa E. Early experience with global budget capitation for primary health care in Kenya: a mixed-methods study in Nairobi County. (Forthcoming)

