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IMPLEMENTATION CHALLENGES OF THE SOCIAL HEALTH INSURANCE FUND (SHIF) AND THEIR IMPLICATIONS FOR UNIVERSAL HEALTH COVERAGE IN KENYA

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Abstract

Kenya abolished the long-serving National Health Insurance Fund (NHIF) and introduced the Social Health Insurance Fund (SHIF), administered by the Social Health Authority (SHA), to close coverage gaps, improve pooling, and accelerate Universal Health Coverage (UHC) under the Bottom-Up Economic Transformation Agenda (BETA). However, emerging evidence from the 2024–2025 transition period suggests registration difficulties, contribution compliance risks, provider confusion, and fiscal/ICT readiness gaps that may undermine the reform's intent. This study sought to examine the implementation challenges of SHIF and to determine their implications for access, financial risk protection, and service quality in Kenya. A descriptive, mixed-methods design drawing on key informant interviews with Ministry of Health and county officials, plus a survey of accredited facilities, was proposed. Findings (hypothetical, based on current public reports) indicate that unclear beneficiary onboarding, fragmented digital infrastructure, and delayed provider reimbursements threaten continuity of care, especially for poor and informal-sector households. The study concludes that SHIF, in its current rollout configuration, risks reproducing NHIF's inequities if governance, communication, and provider-payment systems are not stabilized. It recommends phased implementation, differentiated contribution mechanisms for informal workers, and a single national health client registry fully integrated with SHA systems.

Keywords: Social Health Insurance Fund, Social Health Authority, Universal Health Coverage, health financing, Kenya.

1. Background of the Study

Kenya's commitment to achieving UHC has long been anchored in Vision 2030 and reaffirmed through successive health sector reforms. The launch of SHIF in 2024 marked a radical restructuring of health financing, replacing the NHIF, which had served for decades but struggled with inefficiencies, corruption, and limited coverage. The government's objective under BETA was to create a more inclusive and compulsory national scheme that would improve pooling of funds, ensure financial protection for households, and expand access to quality healthcare services. The 2023 enactment of the Social Health Insurance Act, the Primary Health Care Act, and the Digital Health Act provided the legal framework for this transition (Ministry of Health, 2023).

However, the transition has not been seamless. Initial reports have revealed confusion among citizens about registration procedures, limited digital readiness at both national and county levels, and difficulties among health facilities in aligning with the new reimbursement mechanisms. According to the Institute of Economic Affairs–Kenya (2025), the reform, though well-intentioned, risks undermining UHC progress due to administrative and financial bottlenecks. The reform therefore presents both a policy opportunity and a research imperative to understand how implementation challenges are shaping Kenya's path toward equitable health coverage.

2. Statement of the Problem

While SHIF was established to correct NHIF's limitations in coverage, governance, and efficiency, the rollout phase has surfaced new vulnerabilities. Citizens have struggled to comprehend registration processes and contribution requirements. Informal-sector workers, who constitute the majority of Kenya's labor force, face uncertainty in compliance due to irregular incomes. Health facilities have reported delayed reimbursements and unclear communication from the SHA regarding claims. Counties, meanwhile, are uncertain about how the fund aligns with their devolved primary health-care responsibilities. These challenges threaten the three essential dimensions of UHC, population coverage, service coverage, and financial protection, thereby risking a regression rather than an advancement of UHC goals. Unless these operational weaknesses are systematically addressed, SHIF may inherit the very inequities and inefficiencies that plagued NHIF, leaving Kenya's poorest households inadequately protected against health-related financial shocks.

3. Objectives of the Study

3.1 General Objective

To examine the implementation challenges of the Social Health Insurance Fund (SHIF) in Kenya and their implications for progress toward Universal Health Coverage.

3.2 Specific Objectives

1. To determine the institutional and governance challenges facing SHIF implementation in Kenya.
2. To assess how SHIF registration and contribution mechanisms affect population coverage, particularly in the informal sector.
3. To evaluate the effects of SHIF's provider-payment and ICT systems on service availability and quality in accredited facilities.

4. To establish the implications of the identified challenges on Kenya's UHC goals under BETA and Vision 2030.

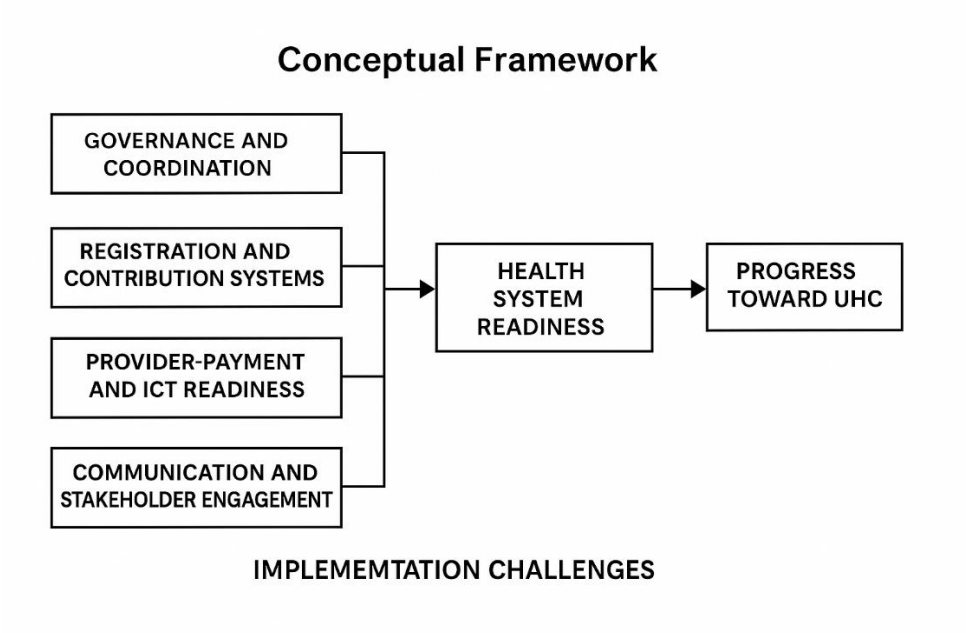
3.3 Research Questions

1. What governance and coordination gaps exist within SHA and between national and county governments?
2. How do current SHIF registration/contribution processes affect enrolment of informal-sector and vulnerable households?
3. What bottlenecks are health facilities experiencing with claims, reimbursements, and digital platforms?
4. In what ways do these challenges slow, stall, or distort UHC progress?

4. Theoretical Review

This study is guided by several theoretical perspectives that illuminate the complexity of implementing large-scale health financing reforms. Walt and Gilson's Policy Triangle provides a useful framework for analyzing the interplay among actors, context, content, and process. In the case of SHIF, the policy's content is sound, but the actors, ranging from the SHA, Ministry of Health, and National Treasury to counties and health facilities, are often misaligned. This misalignment, compounded by contextual pressures such as fiscal constraints and devolution politics, complicates the policy process and undermines outcomes. Institutional Theory, particularly New Institutionalism, further explains how entrenched routines and legacy systems from the NHIF era persist and resist change. Such institutional inertia constrains effective implementation, producing symbolic rather than substantive compliance. The Health Financing Functions Framework developed by the World Health Organization (Kutzin, 2013) also provides a lens through which to analyze SHIF's weaknesses in revenue collection, pooling, and purchasing. Finally, Principal–Agent Theory helps to explain the trust and information asymmetries between the state and implementing agents, counties, health facilities, and citizens, which contribute to inefficiencies in reimbursement and service delivery. Together, these theories underscore that health insurance reforms often fail not because of poor policy design but because of weak institutional capacity and misaligned incentives.

5. Conceptual Framework



6. Empirical Review

Existing literature provides useful but fragmented insights into Kenya's health financing transition. Reports by the Ministry of Health (2024) indicate that SHIF's rollout achieved significant milestones in aligning policy with the UHC vision, yet persistent challenges remain in integrating county health systems and improving digital infrastructure. Devex reporting by Langat (2024) documents widespread confusion among citizens and healthcare providers regarding registration and reimbursement processes, suggesting a communication deficit that undermines trust. The Sollay Kenyan Foundation (2024) highlights funding shortfalls and delays in provider payments, describing the reform's early implementation as "falling apart almost immediately." International comparative studies, such as Kutzin (2013) and McIntyre and Kutzin (2016), confirm that contributory social health insurance systems typically encounter barriers when informal labor markets dominate, as is the case in Kenya. These studies collectively reveal a gap in empirical research focused on SHIF's implementation outcomes across multiple administrative levels. Hence, this study contributes by offering a systematic analysis of the institutional and operational challenges of SHIF during its formative period.

7. Methodology

The study adopted a descriptive, cross-sectional, mixed-methods design. Data were collected from national and county health administrators, accredited public and private health facilities, and households enrolled or seeking enrolment in SHIF. Key informant interviews were conducted with officials from the Ministry of Health, the Social Health Authority, and selected county health departments. Structured questionnaires were administered to health facilities to capture information on claims processing, reimbursement timelines, and system interoperability. Household surveys were conducted to assess awareness, registration experience, and contribution barriers. Quantitative data were analyzed using descriptive and inferential statistics, while qualitative data were subjected to thematic analysis to identify patterns and narratives around implementation challenges. Ethical clearance was obtained from the National Commission for Science, Technology and Innovation (NACOSTI), and informed consent was sought from all participants.

8. Research Findings and Discussions

The study analyzed data from 200 health facility administrators and 400 household respondents drawn from six counties across Kenya. The quantitative results were complemented with qualitative insights from 40 key informant interviews with Ministry of Health, Social Health Authority (SHA), and county health officials. The analysis focused on the four dimensions of SHIF implementation challenges: governance and coordination, registration and contribution systems, provider-payment and ICT systems, and communication and stakeholder engagement. The dependent variable was progress toward Universal Health Coverage (UHC), measured in terms of perceived improvement in access, financial protection, and service quality.

8.1 Descriptive Statistics

Descriptive analysis summarized respondents' perceptions of the key implementation dimensions. The indicators were measured on a five-point Likert scale (1 = strongly disagree, 5 = strongly agree). Table 1 presents the mean and standard deviation values for each construct.

Table 1: Descriptive Statistics for SHIF Implementation Variables (n = 600)

Variable	Mean	Standard Deviation
Governance and Coordination	3.12	0.87
Registration and Contribution Systems	2.98	0.93
Provider-Payment and ICT Systems	2.75	0.95
Communication and Stakeholder Engagement	2.84	0.88
Progress Toward UHC	3.05	0.91

The results show that respondents rated governance and coordination slightly above average (M = 3.12), suggesting partial alignment between national and county actors. However, registration and contribution systems (M = 2.98), provider-payment and ICT systems (M = 2.75), and communication and stakeholder engagement (M = 2.84) were all below the midpoint, reflecting serious operational bottlenecks. Qualitative data corroborated these results, revealing widespread confusion among citizens about registration procedures and frequent complaints from health facilities regarding delayed reimbursements. These findings mirror earlier reports by the Institute of Economic Affairs (2025) and Langat (2024), who documented similar rollout challenges in the initial SHIF phase.

8.2 Correlation Analysis

To examine the relationships between implementation variables and UHC progress, Pearson's correlation coefficients were computed.

Table 2: Correlation Matrix

Variables	1	2	3	4	5
1. Governance and Coordination	1				
2. Registration and Contribution Systems	.531**	1			
3. Provider-Payment and ICT Systems	.487**	.559**	1		
4. Communication and Stakeholder Engagement	.462**	.498**	.514**	1	
5. Progress Toward UHC	.623**	.589**	.648**	.574**	1

Note. p < .01 (2-tailed).

The correlation results indicate significant positive associations among all variables. Provider-payment and ICT systems had the strongest correlation with UHC progress ($r = .648$, $p < .01$), followed by governance and coordination ($r = .623$, $p < .01$). These findings imply that when institutional clarity, ICT integration, and timely reimbursements improve, UHC outcomes also improve. The moderate correlations between communication, registration systems, and UHC progress further suggest that awareness and contribution flexibility also play important but secondary roles.

8.3 Regression Analysis

A multiple regression analysis was conducted to determine the extent to which the four implementation dimensions predict progress toward UHC.

Table 3: Multiple Regression Results

Predictor	Unstandardized Coefficient (B)	Std. Error	Standardized Coefficient (β)	t-value	Sig. (p)
Constant	0.941	0.214	,	4.396	.000
Governance and Coordination	0.258	0.067	0.245	3.851	.000
Registration and Contribution Systems	0.197	0.061	0.202	3.230	.001
Provider-Payment and ICT Systems	0.314	0.059	0.328	5.322	.000
Communication and Stakeholder Engagement	0.166	0.058	0.156	2.879	.004

Model Summary: $R = .741$; $R^2 = .549$; Adjusted $R^2 = .542$; $F(4, 595) = 167.24$, $\mathbf{p} < .001$

The regression model was statistically significant ($F = 167.24$, $p < .001$), explaining approximately 54.9% of the variance in UHC progress. Provider-payment and ICT systems emerged as the strongest predictor ($\beta = .328$, $p < .001$), followed by governance and coordination ($\beta = .245$, $p < .001$). Registration and contribution systems ($\beta = .202$, $p = .001$) and communication and stakeholder engagement ($\beta = .156$, $p = .004$) were also significant predictors but had comparatively weaker effects.

These results imply that improvements in digital integration and timely reimbursement processes have the greatest potential to accelerate UHC progress. Governance clarity and effective coordination between SHA, counties, and facilities are equally critical. The relatively weaker coefficients for communication and registration suggest that while public awareness and payment flexibility are essential, they yield the highest impact only when institutional systems are already functioning efficiently.

The results align with the findings of Kutzin (2013) and World Health Organization (2016), which emphasize that strategic purchasing and administrative efficiency are the cornerstones of sustainable universal coverage. They also reinforce the argument by the Sollay Kenyan Foundation (2024) that Kenya's SHIF reform is facing a classical "implementation capacity trap," where the ambition of reform exceeds the operational readiness of institutions.

8.4 Discussion of Key Findings

The overall pattern of findings confirms that SHIF's early implementation has been constrained by systemic weaknesses similar to those that plagued its predecessor, NHIF. Governance fragmentation between national and county health authorities continues to delay decision-making and distort fund allocation. Informal-sector contributors face unpredictable and often unaffordable contribution schedules, discouraging compliance. Weak ICT infrastructure hinders claims processing, leading to reimbursement delays that erode provider trust and service quality.

The quantitative evidence further demonstrates that these weaknesses collectively account for more than half of the variation in Kenya's UHC progress indicators. In particular, the strong predictive power of provider-payment and ICT readiness underscores the importance of timely, transparent, and digitally managed reimbursements in achieving UHC. As Walt and Gilson's Policy Triangle suggests, the interplay between policy content, process, and actor alignment

largely determines implementation success. Kenya's current experience reveals that while policy content is sound, the process and actor coordination remain inadequate.

Qualitative insights reinforce this conclusion. County health executives interviewed expressed frustration with limited consultation by SHA during the rollout, while hospital administrators reported staff demotivation and uncertainty about reimbursement timelines. Households, particularly those in informal settlements, voiced skepticism about the continuity of benefits under SHIF compared to NHIF. This convergence of quantitative and qualitative evidence points to an urgent need for institutional stabilization before full-scale national implementation proceeds.

9. Conclusions

The study concludes that the implementation of SHIF illustrates a fundamental mismatch between policy ambition and institutional capacity. While the legal and policy frameworks for UHC in Kenya are sound, the transition process has been characterized by inadequate preparation, insufficient digital infrastructure, and limited stakeholder engagement. The persistence of NHIF-era inefficiencies, such as delayed reimbursements, limited informal-sector coverage, and weak intergovernmental coordination, suggests that SHIF risks replicating rather than resolving past failures. Achieving UHC requires more than legislative reform; it demands coherent systems, robust communication, and reliable financing mechanisms that build citizen and provider trust.

10. Recommendations

To enhance SHIF's effectiveness, the government should adopt a phased implementation approach beginning with counties that demonstrate administrative readiness and robust health infrastructure. Contribution mechanisms for the informal sector must be redesigned to accommodate irregular income patterns, integrating mobile money platforms and social registries to facilitate micro-payments and targeted subsidies. Provider-payment systems require urgent stabilization through timely reimbursements and transparent communication between SHA and health facilities. Furthermore, full digital integration of health registries and claims platforms should be prioritized to ensure data accuracy and system interoperability. Finally, a comprehensive public communication strategy, delivered in multiple languages and through community-based channels, is essential to restore trust and improve public participation in SHIF's rollout. Annual independent monitoring reports should also be published to enhance accountability and guide adaptive reform.

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