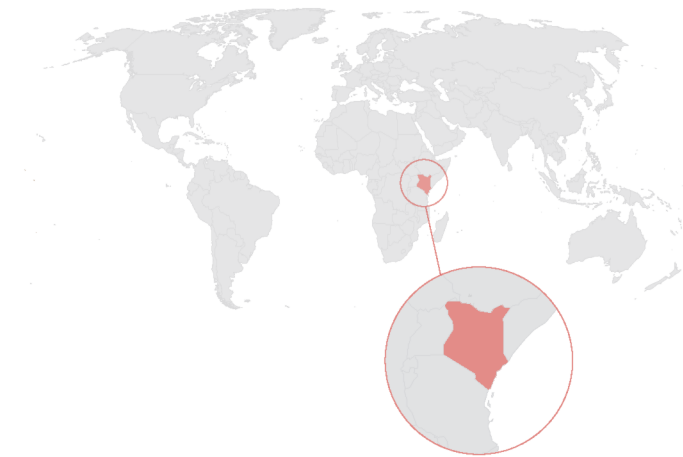


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Kenya



Julian Götsch
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The Health Care
System in Kenya



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No. 40

THE HEALTH CARE SYSTEM IN KENYA

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1. COUNTRY OVERVIEW (LATEST DATA AVAILABLE)



Source: <https://ontheworldmap.com/kenya/> (Accessed May 21, 2024)

- » Sub-Region: Eastern Africa (UN Data 2022)
- » Capital: Nairobi (UN Data 2022)
- » Official Language: Swahili/ English (UN Data 2022)
- » Population size: 54,027,487 (World Bank 2022)
- » Share of rural population: 71% (World Bank 2022)
- » GDP: US\$ 113.42 billion (World Bank 2022)
- » Income group: lower-middle-income (World Bank 2022)
- » Gini Index: 38.7 (World Bank 2021)
- » Colonial period and independence: The Heligoland-Zanzibar Treaty recognized British claims to the territory, which was formerly an area of interest for Great Britain and the German Empire. In 1888, the Imperial British East Africa Company was granted a Royal Charter, and the East African Protectorate was established in 1895. Kenya was declared a British colony in 1920 and gained independence in 1963 (Encyclopaedia Britannica 2024).

2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy	At birth: 59 (World Bank 2021)	69 (World Bank 2021)
Female life expectancy	At birth: 64 (World Bank 2021)	74 (World Bank 2020)
Under-5 mortality rate (per 1000 live births) in 2020	37 (World Bank 2021)	38 (World Bank 2021)
Maternal mortality rate (per 100000)	377 in 2014 (World Bank 2022)	211 in 2017 (World Bank 2022)
HIV prevalence (Adult population, 15-49) in 2021	4 (World Bank 2021)	0,7 (World Bank, 2021)
Tuberculosis prevalence – (per 100000) in 2022	237 (World Bank 2022)	133 i(World Bank 2022)

3. HEALTHCARE DURING THE COLONIAL PERIOD

Colonialism brought with it the introduction of Western biomedicine and the suppression of pre-existing medical knowledge and practises in Kenya (Ndege 2017: 1). During the more than 70 years of British rule, the colonial administration lacked a coherent health policy and acted mainly in response to labour migration, the two world wars, political pressures and outbreaks of diseases such as malaria, sleeping sickness, and the bubonic plague (Ndege 2017). Healthcare activities only began to increase very gradually after the 1920s (Chaiken 1998: 1705) and were fostered in the 1950s and 1960s in the context of the Mau Mau War (Latif 2018: 4828). Utility considerations and self-interest primarily drove the colonial state's motives for providing healthcare. The main focus was on providing services to white settlers (Mburu 1981: 522) and maintaining the African labour force on which the colonial economy depended (Ndege 2017: 8). In addition to the colonial government, the Imperial British East African Company (I.B.E.A.) and missionary groups were active in the field of healthcare (Mburu 1981). While the latter focused on the health of their workers, the missions used healthcare as a means to win converts.

a. Organisational structure and regulation

The Colonial Administration established a Medical Department in 1901, marking the beginning of state-controlled medical organizations in the protectorate. In 1903, the objectives of the Medical Department were "first, to preserve the health of the European Community, second, to keep the African and Asiatic labour force in good working condition, and third, to prevent the spread of tropical diseases" (Kimalu et al. 2004). The early health objectives were set by the Colonial Office in London, as were the strategies for achieving the objectives at times (Mburu 1981). However, effective supervision by the Colonial Office was minimal (Chaiken 1998: 1704). The organizational structure was such that the central government in the colony delegated responsibility for local medical services, prevention, and sanitation to provinces while remaining responsible for policy development and the provision of specialized care. Below the provincial level, the District and Divisional staff reported to the Provincial authorities. The medical system established by the colonial administration was based on the division of the population into three racialized groups: European, Asian, and African. These groups received healthcare in separate facilities and by different staff. The so-called Asian group consisted of about 35,000 labourers from India who were brought to Kenya to build the Uganda Railway to connect landlocked Uganda to the coast (MBC 2019). The quality and availability of services reflected the racialized hierarchies of the colonial society, with the European settlers at the top. Services provided to the African population ranked lowest and served only to keep them "usable" (Mburu 1981) for the needs of the colonial economy.

b. Coverage

As noted above, there were three entities providing health services in Kenya, each covering different groups. The I.B.E.A. provided medical services only to its employees and did not cover their dependents. The missionary organizations provided health services only to the African and Asian populations, but the coverage did not meet the needs, neither qualitatively nor quantitatively (Mburu 1981). The colonial administration provided health

services mainly in urban centres where the settlers resided, as well as in the areas where trade was conducted (Latif 2018: 4828).

c. Financing

Health was not a priority of British colonial policy in Kenya, which instead focused on investment in trade (Latif 2018: 4828). The long-standing British policy that colonies should be financially self-sufficient further limited the scope for healthcare spending (Stammer 1967: 195-197). The Colonial Development Act of 1929 and subsequent Colonial Development and Welfare Acts broke with this tradition, providing a limited amount of funding earmarked for specific purposes such as malaria control in the colony (Ndege 2017: 113). An additional source of funding came from local communities, which had to share the costs for healthcare with the colonial state between the mid-1920s and the 1950s (Latif 2018: 4828; Ndege 2017: 10). During this period, Local Native Councils were established that were responsible for, among other things, building dispensaries and maternities wards and, in some cases, purchasing medicine. Meanwhile, the state remained responsible for the training of health workers and paying their salaries. In order to strengthen services in rural areas, missionary healthcare activities were subsidized by the colonial government after the First World War (Latif 2018: 4828).

The Annual Medical Report of 1925 stated that "6.9 % of the estimated expenditure of the colony was spent on public health and medical relief" (Colony and Protectorate of Kenya 1925).

d. Service provision

In 1914, there were 24 civilian doctors in Kenya (Azevedo 2017). In 1922, the colonial administration's annual report included only European medical staff, of which 39 were counted (Chaiken 1998: 1706). Their number peaked at 72 in 1930 and stagnated between 40 and 60 until the Second World War. The training of African medical staff began in the 1920s and was initially aimed at training dispensary staff (Mburu 1981: 524). It was not until 1935 that the first African doctors were trained at Makerere College.

Provision was built around a hierarchical government structure, with dispensaries providing access to the rural population, provincial hospitals being available in some of the provinces and a referral hospital existing at the national level (Latif 2018: 4828). At independence, there were 9,683 beds in 148 hospitals across the country (Ministry of Finance and Planning 1973: 140). For "African and Asian patients", statistics show the importance of out-patient care with a ratio of 29,676 to 151,222 in-patients to out-patients in 1924 and 156,888 to 801,395 in 1947, respectively (Chaiken 1998: 1706).

Services were mostly available in urban centres, where white settlers lived, or in areas that were relevant to trade (Latif 2018: 4828). The I.B.E.A. provided a minimum standard of healthcare to its employees where it was economically advantageous to do so and also neglected the rural areas from which its workers originated (Mburu 1981: 523). Thus, the colonial state relied on missionary services, especially in rural and poor areas where Local Native Councils had few resources to invest in healthcare (Latif 2018: 4828). However, the impact of missionary activities remained low or nil in most communities, although outposts in rural areas and "health centres" were opened in more important areas (Mburu 1981). Another way in which the state reached out to the rural population was through the "medical safaris", which were conducted to provide curative care, perform vaccinations, and health education (Chaiken 1998: 1708).

The lack of quantity and quality of healthcare available to the general population during the period of colonial rule is illustrated by the fact that during the First World War, Kenyans were medically screened to determine whether they were physically fit to serve in British Army battalions. The results were that 34% were deemed unfit to be porters and another 33% were deemed unfit even to be labourers (Mburu 1981).

4. LEGAL BEGINNING OF THE SYSTEM AFTER POLITICAL INDEPENDENCE

Name and type of legal act	Sessional Paper No. 10 of 1965: African Socialism and Its Application to Planning in Kenya
Date the law was passed	1965
Date of <i>de jure</i> implementation	1965
Brief summary of content	<p>Sessional Paper No. 10 outlined the government's ideology of African socialism and served as a blueprint for socio-economic development policies following Kenya's independence in 1963 (Wamai 2009a: 137). With regard to the healthcare system, it declares the government's goal of providing free health services to all (Republic of Kenya 1965: 29-30). At the same time, it contextualizes the limitations of implementation, namely, the lack of financial resources and qualified personnel. Furthermore, the government declares its efforts to establish a national provident fund and a national health insurance.</p> <p>In the same year, the first steps towards free healthcare for all were announced, making services for children and all out-patients free of charge. The 1966-1970 Development Plan further operationalized the guidelines of the Sessional Paper, and additionally addressed regional imbalances in access to healthcare and adequate training of the workforce (Latif 2018: 4829).</p> <p>The provision of free healthcare in line with the vision of the Sessional Paper continued until 1989 when co-payments were introduced due to the deteriorating economic conditions and a growing population (Wamai 2009a: 137).</p>
Socio-political context of introduction	<p>The Kenya African National Union (KANU) formed the government after independence and remained in power for the next 39 years, making Kenya officially a one-party state at times (Latif 2018: 4829). Sessional Paper No. 10 set out the party's vision for a post-colonial society, in which colonial inequalities would be overcome and the people would benefit from the country's anticipated economic growth (Republic of Kenya 1965: 1-2). Growth had been significant in the 18 months since independence from Britain and was seen as the basis for the expansion of social policies. KANU had already campaigned on the latter during pre-independence elections, promoting sweeping changes in areas such as education and healthcare (Sanger and Nottingham 1964: 3).</p>

5. CHARACTERISTICS OF THE SYSTEM AT INTRODUCTION

a. Organisational structure

At independence, Kenya inherited a three-tier health system in which the central government provided services at the district, provincial, and national levels; missionaries provided health services at the sub district level; and local governments provided services in urban areas (Kimalu et al. 2004). The first development plan, introduced in 1965, called for centralization of service delivery responsibilities under the Ministry of Health (Wamai 2009a).

b. Coverage

In line with the ideal of the Sessional Paper No. 10 and its stated goal of free healthcare for all Kenyans, President Jomo Kenyatta declared free healthcare for children in government clinics and hospitals in his Madarake Day speech on 1st June, 1965 (Kenyatta 1965: 3). Free out-patient care for all was declared in the same year (Government of Kenya 1965: 314). The limitation of services and groups was due to the limited financial resources and was seen as an intermediate step towards the stated goal.

c. Provision

At independence, Kenya had 750 doctors, 49 of whom were African (Azevedo 2017). The immunization rate was less than 30%, and there were 11,344 beds and cots in all health facilities (Kimalu et al. 2004).

The promise of free healthcare failed to deliver quality healthcare to all Kenyans due to inefficiencies and inequities (Abuya et al. 2015; Kimalu et al. 2004).

d. Financing

Two years after independence, in 1965, the government abolished the five shilling user fee introduced by the colonial administration for child-related services and all out-patient care (Abuya et al. 2015; Künzler 2016, Wamai 2009a: 139). These services were funded by the government through taxation and remained free to users until 1989 when co-payments were reintroduced due to deteriorating socio-economic conditions (Abuya et al. 2015: 3).

e. Regulation

The only actor responsible for regulating and organizing the healthcare system was the government, which, until the 1980s, developed its health policy as part of its five-year development plans (Wamai 2009a: 139).

6. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTHCARE

a. Major reform I

Name and type of legal act	National Hospital Insurance Fund Act 1966
Date the law was passed	1966
Date of <i>de jure</i> implementation	1966
Brief summary of content	<p>The National Hospital Insurance Fund was created by an act of parliament in 1966 to replace the discriminatory colonial policy by establishing a compulsory insurance scheme covering all Kenyans from the age of 18 who were formally employed and earned more than 1,000 Kenyan shillings (Abuya et al. 2015: 5).</p> <p>Since then, the act has been reviewed and amended several times, changing the benefit package and expanding coverage over the years. More recently, the NHIF has been part of Kenya's plans to achieve universal health coverage (UHC). In this context, the 2022 amendment to the National Hospital Insurance Fund Act introduced compulsory membership and renamed the fund, replacing "Hospital" with the more generic term "Health" (Republic of Kenya 2022: 1). In 2023, the NHIF was abolished since it is intended that the National Social Health Insurance Fund (NSHIF) is to replace the current scheme (Owoko 2024). After a transition period of approximately one year, the NHIF is scheduled to cease operations in December 2024.</p>
Population coverage	<p>Initially, the NHIF covered contributors, spouses, and children under the age of 18 (Wamai 2009a: 139-140). The coverage of the population was very limited, as only civil servants and formal employees could become contributors. Several reforms in the following decades attempted to expand coverage. In 1998, membership was made mandatory for informal workers, and in 2006, membership became optional for those over 65. An attempt to establish a mandatory health insurance in 2004 was rejected by the president and sent back to parliament for modifications (Abuya et al. 2015: 5-6). However, the requested changes were never addressed.</p> <p>According to the 2022 amendment, every person over the age of 18 is required to register as a member of the fund (Republic of Kenya 2022: 9).</p> <p>However, the number of <i>de facto</i> members never reached the majority of the population, with the scheme covering 206,000 people in 1998 (Wamai 2009b: 137), 9 million people in 2003 (Wamai 2009a: 140), and 13 million of Kenya's 54 million inhabitants in 2022 (KNBS 2022: 12).</p>
Type of benefits	<p>At its inception, civil servants received in-patient and out-patient care, while those formally employed outside the civil service received only in-patient care (Suchman et al. 2020: 3-4).</p> <p>Today's NHIF benefit packages depend on the patient's membership tier. The standard tier for statutory members is the National Health Scheme, also known as "UHC Supacover". It covers in-patient care in public hospitals, including diagnosis, procedures, and treatment, including specialist doctor's fees, bed charges, nursing care, diagnostic laboratory, and radiology, prescribed drugs and dressings (NHIF 2024a). Out-patient benefits under the "Supacover" scheme include consultations, laboratory, and radiological investigations, day-care procedures, health education, mental health services, counselling, physiotherapy,</p>

Type of benefits (continued)	antenatal and postnatal care, and immunization. Enhanced schemes for civil servants offer a more comprehensive benefits package and additional providers (NHIF 2024a).
Socio-political context of introduction	Initially, the NHIF aimed to provide government employees with access to higher quality private hospitals while, at the same time, reducing the pressure on public facilities that provided healthcare for the general population in line with the vision of the Sessional Paper No. 10 (Anangwe 2008).

b. Major reform II

Name and type of legal act	Social Health Insurance Bill
Date the law was passed	September 2023
Date of <i>de jure</i> implementation	July 2024
Brief summary of content	<p>The Bill abolishes the NHIF and establishes the National Social Health Insurance Fund (NSHIF) as its replacement. It consists of three separate funds to finance different health services: The Primary Healthcare Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund (Wambui 2023). Within this institutional framework, the government aims to provide a comprehensive health insurance to all Kenyans, covering their expenses at all accredited public, private, and faith-based health facilities.</p> <p>The Social Health Authority is established as the body that is responsible for managing the relevant Funds, contracting and reimbursing providers, monitoring the program, and advising on policy development (Republic of Kenya 2023: 1637-1638). Contributions from the National Assembly, donations, grants, fees, and levies will finance the Primary Healthcare Fund. Contributions to the Social Health Insurance Fund will be collected from enrolled members above a certain income threshold, from the National Assembly, which will cover costs for indigent and vulnerable persons, from employers who will pay for the administration of employee benefits, from the national and county governments, which will cover the insurance of public servants, and from international donors (Republic of Kenya 2023: 1682-1683). The Emergency, Chronic and Critical Illness Fund is to be financed by funds appropriated by the National Assembly, donations, and "monies from any other lawful source" (Republic of Kenya 2023: 1685).</p>
Population coverage	<p>The timing of the introduction of the new NSHIF has been subject to change due to delays and court challenges (Mabel 2024). The Health Cabinet previously announced that the deduction would start in March 2024, which was later postponed. The Social Health Insurance (General) Regulations gazetted in March 2024 set 1st July, 2024, as the starting date for payment of contributions and the access to services under the new act.</p> <p>Every person residing in Kenya is encouraged to register for the NSHIF by 30th July 2024, and children born after the implementation of the Social Health Insurance Bill should be registered at birth (Owoko 2024; Republic of Kenya 2024: 10). Current NHIF members will have to re-register to benefit from the NSHIF (Muthomi 2024). To achieve the goal of universal coverage, it will be crucial to cover the rural population and informal workers, who were significantly underrepresented in the NHIF (Maritim 2024). Currently, informal workers make up 80 % of Kenya's workforce.</p>
Available benefits	<p>The Cabinet Secretary for Health determines benefits in consultation with the Board of the Social Health Authority (Republic of Kenya 2023: 1685). The benefit package under the Primary Healthcare Fund includes "preventive, promotive, curative, rehabilitative and palliative health services provided at the level 1, 2 and 3 health care facilities" (Republic of Kenya 2024: 31). The Social Health Insurance Fund benefit package covers the same services at level 4, 5 and 6 health facilities, while the Emergency, Chronic and Critical Illness Fund covers emergency services provided by licensed facilities as well as treatment of chronic illnesses and critical care beyond the benefits of the Social Health Insurance Fund.</p> <p>Under the NSHIF, there are no plans for enhanced benefit packages for civil servants, unlike the preferential treatment that existed under the NHIF (People Daily 2024). This has currently resulted in government agencies shifting their medical insurance to private providers.</p> <p>Contributions will be collected on the basis of a 2.75 % tax on household's gross income (Republic of Kenya 2024: 15). Households without income from salaried employment pay 2.75 % of their household income, as determined by means testing, with a minimum contribution of 300 Kenyan shillings per month (Republic of Kenya 2024: 16). The government will cover the contributions for households in need of financial assistance (Republic of Kenya 2023: 1684).</p>

Available benefits(continued)	Household resources are determined by assessing housing characteristics, access to basic services, household composition and characteristics and any other socio-economic factors that are deemed relevant (Republic of Kenya 2024: 18).
Socio-political context of introduction	<p>The 2010 Constitution framed health as a right for every Kenyan citizen (Muinde & Prince 2023: 3). In the following years, and in line with the WHO global policy, UHC became a central theme of Kenya’s health policy that aligns with the National Vision 2030 and the former president Uhuru Kenyatta’s Big Four Agenda (Njoroge 2024: 2). An initial attempt to achieve universal access by 2022 was not met, although UHC pilots were launched from 2018 to 2020 in the four counties of Kisumu, Nyeri, Machakos and Isiolo where access to services was free upon registration.</p> <p>The Social Health Insurance Bill was formulated under the presidency of William Ruto of the United Democratic Alliance (UDA).</p>

7. DESCRIPTION OF CURRENT HEALTHCARE SYSTEM

a. Organisational structure

In principle, the HCS has a hierarchical pyramidal structure led by the Ministry of Health (MOH), which is responsible for policy formulation, setting and monitoring standards, and mobilizing resources (Wamai 2009b: 135). Since the formation of a coalition government in 2008, the Ministry of Health has been divided into two separate ministries: The Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS) (Wamai 2009b: 138). Starting with the highest level of healthcare and service provision, the structure goes from the National Referral and Teaching Hospitals (NRTHS) through provincial hospitals, the sub-district hospitals, followed by health centres, dispensaries, and finally, community health organizations (Turin 2010). The two main referral hospitals are the Kenyatta National Hospital in Nairobi and the Moi Teaching and Referral Hospital in Eldoret (Marangu 2020: 414).

The country is divided into eight subordinate administrative levels called districts. These are responsible for delivering health services and implementing health programs (Turin 2010). Management responsibilities are divided between the Provincial Health Management Team (PHMT, part of the MOPHS) and the Provincial Medical Services Management Team (PMSMT, part of the MOMS). The PHMT is headed by the Provincial Director of Public Health and Sanitation. Together with the scope of the MOPHS and all primary healthcare services, these are among the core responsibilities of the PHMT and its subordinate District Health Management Teams (DHMTs). The PMSMT is based at the Provincial General Hospital and is headed by the Provincial Director of Medical Services. Under the MOMS, curative services are provided by the PMSMT (Luoma et al. 2010).

The work of non-governmental organizations (NGOs), faith-based organizations (FBOs), and private health facilities has a major impact on the healthcare system in Kenya. In 2008, 48% of the healthcare was provided by the Government of Kenya, 13% by FBOs, 2% by NGOs, and 34% by the private for-profit sector. The latter provides a higher quality of care than the others but cannot be afforded by the majority of the population (Turin 2010).

The health system is based on a Sector Wide Approach (SWAp), which is set out in the National Health Sector Strategic Plan II (NHSSP II). It aims to integrate the efforts of public, private not-for-profit (NGO/FBO), and private for-profit health facilities in a unified effort to achieve “health for all” (Turin 2010).

b. Coverage

Percentage of population covered by government schemes	23.5 % (NHIF) in 2022
Percentage of population covered by private schemes	3.8% in 2022
Percentage of population covered by community based schemes	0.6 % in 2022
Percentage of population uncovered	74% in 2022

(KNBS 2022: 12)

There are three different insurance systems in Kenya: The National Hospital Insurance Fund (NHIF), Community Based Health Insurances Schemes (CBHIs), and the private health insurance sector (Chuma & Okungu 2011).

The NHIF is the main form of health insurance in Kenya. As noted above, membership was made mandatory for all Kenyans in 2022 in an attempt to achieve universal health coverage. In reality, however, large segments of the population remain uncovered and mechanisms to enforce contributions are weak, especially in the informal sector. A household survey by Maritim et al. (2023) found that several factors contributed to households opting out of the NHIF. The high cost of premiums makes membership unaffordable for many and is reported as the main barrier to joining or the reason for dropping out of the insurance (Maritim et al. 2023: 5). In addition, insurance often does not cover the full cost of healthcare, forcing insured households to spend 10% of their annual expenditure on out-of-pocket payments (Maritim et al. 2023: 6-7). Another factor is that accredited health facilities often lack drugs that would be provided free of charge, so drugs must be purchased from private pharmacies. Long distances to the nearest accredited facility add to transportation costs. Finally, poor quality of care is cited as a major reason for avoiding enrolment.

The private sector includes three different types of insurance companies: First, general insurance companies, which provide a wide range of insurance services unrelated to healthcare but which insures people against illness on a small scale. Second, there are providers that operate their own clinics and hospitals where their customers receive treatment, and the same facilities are also open to non-payers. Third, providers that deliver healthcare through third-party facilities, also known as health management organizations, which are widely used in employer insurance plans. Due to the cost of premiums, private health insurance covers mainly the wealthier population. (Chuma & Okungu 2011).

In addition, there are 32 registered CBHIs. CBHIs have limited membership and are composed of small-scale farmers in rural areas. They are not financially sustainable and cannot continue to exist without donor funding. They operate mainly in rural areas and are relatively small which undermines the potential for risk pooling and cross-subsidization (Chuma & Okungu 2011).

In general, men are more likely to be insured than women, while the insurance rate in urban areas is twice as high as in rural areas (Wamai 2009b).

c. Provision

Access to health facilities is estimated to be good in urban areas but inadequate in rural areas. Accessibility varies widely across the country (Luoma et al. 2010). There is a health facility every 50 - 200 km, making availability non-existent in some cases (Turin 2010). The hospitalization rate is 50% higher in urban areas than in rural areas. This reflects the higher concentration of in-patient facilities and doctors (Wamai 2009b).

In 2002, there were 59,000 health workers (189 per 100,000 inhabitants), including about 5,000 doctors. The 2023 Health Facility Census puts the total number of health workers at about the same level as in 2002, with 42,000 working as nurses (Ministry of Health 2023). 60% of the total health personnel work in the public sector, of whom 70% are concentrated in hospitals (Wamai 2009b). There were 0.2 physicians per 1,000 people in 2021 (World Bank 2021) and 1.2 nurses and midwives per 1,000 people in 2018 (World Bank 2018). In 2006, there were 14 hospital beds per 10,000 inhabitants (Luoma et al. 2010), and in 2023, there was a total of 140,000 beds in Kenya, resulting in a ratio of 26 hospital beds per 10,000 people (Ministry of Health 2023: 36).

In 2020, half of Kenya's more than 12,600 health facilities were operated by the public sector (Di Gorgio et al. 2022: 11 - 12). The vast majority of these facilities (93 %) are health centres, dispensaries, or clinics that provide primary care. Of these primary care facilities, 49.5% are public, 40% are private, 8.5% are faith-based, and 3% are run by NGOs. Of the secondary care hospitals, 62% are public, 24% private and 14% faith-based, while tertiary care is provided only in public facilities. In 2023, the NHIF system comprised 414 health facilities, of which 120 were run by the government, 210 by private organizations, 63 by NGOs or faith-based organizations, and 21 by communities (Wamai 2009a: 140). A total of 36,463 beds were available to NHIF enrollees at that time. In the same year, 40% of Kenya's health facilities were accredited by the NHIF (Ministry of Health 2023: 9).

The benefits package varies depending on the insured's membership tier and is divided into the above-mentioned National Health Scheme, also known as "UHC Supacover", and the Enhanced Schemes (NHIF 2024a). The Enhanced Schemes offer civil servants, members of the National Police and Prison System, Country Government workers, workers at parastatals and retired Public Officers a more comprehensive benefits package and access to different facilities than the "Supacover". The NHIF administered maternity program called Linda Mama, supported by the World Bank and the Japan international Cooperation Agency, provides free maternity

services for the period of one year after activation. Additionally, the NHIF's Edu Afya scheme covers services for all registered secondary school students.

The monthly premium for formally employed individuals is determined by their gross income and starts at 150 Kshs for those earning up to 5,999 Kshs. The maximum monthly contribution is 1,700 Kshs for those earning 100,000 Kshs or more (NHIF 2024b). Self-employed individuals are obligated to contribute 500 Kshs. According to Muinde and Prince (2023: 3), the monthly premium for those employed in the informal sector or those who are unemployed is 5€, with is approximately 700 Kshs. The "UHC Insurance Scheme" offers government subsidies for poor and vulnerable households.

Private insurance schemes offer predetermined packages that individuals can choose from based on their ability to pay. CBHIs cover mainly in-patient services for all illnesses at specific health facilities (Chuma & Okungu 2011).

The NHIF system is a highly unequal system that favors civil servants over the general population since its benefits package and access to facilities depend on the membership tier. The service package offered in the "Supacover" tier is limited and is often further restricted due to the lack of sufficient resources in facilities that sometimes operate in the absence of basic amenities such as electricity, a reliable water source or the surrounding transportation infrastructure (Ministry of Health 2023: 11). Furthermore, access to high-quality services is highly unequal due to an urban-rural divide and the historical neglect of certain areas.

d. Financing

According to 2020 World Bank data, the Kenyan government is allocating 4.29% of its GDP to healthcare. The health sector is financed by government (central and local) funds covering 47.4 % of the overall expenditure, households paying 24.04 % out of pocket and donors (international and domestic) contributing 16%. Notably, the out-of-pocket-payments rate has significantly decreased from 45% in 2005 to the aforementioned 16%. However, costs remain a significant barrier to healthcare and impose a financial burden, particularly on individuals with a low income.

e. Regulation of dominant system

The NHIF is the dominant system, covering the largest share of the population. It was established in 1966 under the Ministry of Health (MOH) and was transformed into a state corporation in 1998, becoming independent from the MOH (Chuma & Okungu 2011).

8. CO-EXISTING SYSTEMS

The use of traditional medicine remains prevalent in Kenya. However, practitioners and patients face several challenges (Gakuya et al. 2020: 2-3). On the one hand, there is minimal official recognition for traditional health care, and little effort is made to conserve and expand the existing knowledge of herbalists, birth attendants, and spiritualists. On the other hand, the safety and quality of many products are not verified, posing a significant threat to users. Despite this, traditional medicine remains more accessible and affordable than consulting a medical doctor for some groups of the population, particularly those residing in rural areas. According to a 2011 WHO publication, the ratio of traditional practitioners to patients was estimated to be 1:950, compared to a ratio of 1:33,000 medical doctors to patients (Kohn et al. 2011). It was further estimated that 70% of all Kenyans rely on traditional medicine.

Although the long-term goal "to standardize and modernize traditional practice" (Harrington 2018) is still far from being achieved, recent progress has been made. Several policies have been implemented to regulate and promote traditional medicine, such as the Traditional Medicine and Medical Plant Bill drafted in 2008 and the upcoming Sessional Paper on Traditional Medicine in Kenya. In addition, the National Traditional Health Practitioners Association is responsible for registering traditional practitioners. Although there have been calls to transfer responsibility to the Ministry of Health, the Ministry of Gender, Sports, and Culture currently oversees traditional health care (Gakuya et al. 2020: 3).

9. ROLE OF GLOBAL ACTORS

Global actors have a significant impact on the Kenyan health system. This is evident in the increase of donor funding for the health sector from 8% in 1994/94 to 16% in 2020. The major donors in Kenya are the US, UK, Japan, and the European Commission. The Kenyan government has limited ability to allocate foreign aid according to its priorities, as most of the donor funds are directly allocated to specific programs. Efforts to establish a coordinating mechanism for donors and NGOs within the Ministry of Health have been unsuccessful (Wamai 2009b).

As previously stated, faith-based organizations and NGOs are involved in healthcare provision. NGOs manage 3% of the country's health centres, dispensaries, and clinics that offer primary care, while faith-based organizations operate 8.5% of these facilities. The latter also contribute 14% of the country's secondary care hospitals. NGO-operated facilities often provide better services, but they require continuous donor funding (Turin 2010).

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