NHIF'S LEGAL MANDATE TO EXTEND HEALTH INSURANCE COVERAGE IN KENYA AND ACHIEVE A UNIVERSAL HEALTH COVERAGE SYSTEM

Submitted in partial fulfillment of the requirements of the Bachelor of Laws Degree,
Strathmore University Law School

By

Mbithi Tatiana Ngutto
Registration no.129069

Prepared under the supervision of
Dr. Fancy Too

Date: 08/04/2024

Word count: 10,353

ACKNOWLEDGEMENTS

I wish to extend heartfelt thanks to all those whose involvement proved vital to the completion of this project. My sincere appreciation goes to Dr. Fancy Too, my supervisor, for her enthusiastic input and invaluable guidance. I am particularly grateful to my parents, Raphael and Phyllis, and my siblings Brandon and Wangu, whose unwavering support, encouragement, and inspiration sustained me throughout this journey.

DECLARATION

I, MBITHI TATIANA NGUTTO, do hereby declare that this research is my original work and that to the best of my knowledge and belief, it has not been previously, in its entirety or in part, been submitted to any other university for a degree or diploma. Other works cited or referred to are accordingly acknowledged.

Signed……

Date……

This dissertation has been submitted for examination with my approval as University Supervisor.

Signed……..

Dr. Fancy Too

TABLE OF CONTENTS

TABLE OF STATUTES AND INTERNATIONAL INSTRUMENTS

Constitution of the Republic of Kenya, 2010.

National Hospital Insurance Fund Act 1998.

National Health Insurance Fund Act (Amendment) 2022.

Social Health Insurance Act, 2023

Universal Declaration of Human Rights, 1948.

International Covenant on Economic, Social and Cultural Rights, 1976.

Convention on the Rights of the Child, 1990

Convention on the Elimination of all Forms of Discrimination against Women, 1981.

United Nations Convention on the Rights of Persons with Disabilities, 2006

LIST OF ABBREVIATIONS

COTU	Central Organisation of Trade Unions
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Convention on the Rights of the Child
FKE	Federation of Kenya Employers
ICESSCR.	International Covenant on Economic, Social and Cultural Rights
KMA	Kenya Medical Association
KNUT	Kenya National Union of Teachers
KUPPET	Kenya Union of Post Primary Education Teachers
MOH	Ministry of Health
NHIC	National Health Insurance Corporation
NHIF	National Hospital Insurance Fund
SHIF	Social health Insurance Fund
UCHIS	Universal Coverage Health Insurance System
UDHR	Universal Declaration of Human Rights (UDHR)
UHC	Universal Health Coverage
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities

ABSTRACT

An analysis of NHIF's history reveals efforts by Kenya to extend health insurance coverage to all Kenyan citizens. However, upon further investigation, it becomes apparent that the NHIF encountered barriers, such as socio-demographic factors and knowledge gaps, while striving on this journey. A doctrinal research method identifies deficiencies in adequacy, affordability, accessibility, and availability in NHIF's operations. Furthermore, administrative inefficiencies, inadequate communication between the NHIF and its beneficiaries, and a lack of accountability further exacerbated challenges, eroding trust in NHIF's capabilities and deepening disparities among benefit members. An exploration into the insights from South Korea experience recommends multifaceted reforms across policy, legal, and institutional domains. Policy reforms were found to be vital to enhance awareness campaigns aimed at addressing knowledge gaps. Additionally, financial support programs to assist marginalized and indigent groups would be invaluable. Legal reforms advocating for accountability measures and anti-discrimination legislation were also deemed essential, to address transparency and accountability concerns, and discrimination cases against privately insured individuals in comparison to their cash paying counterparts. Finally, essential institutional reforms in community engagement and supply chain management are crucial to raise awareness of benefit packages and ensure consistency in the drug supply chain within the community. In conclusion, sustained efforts are necessary to achieve universal health coverage in Kenya. Collaborative attempts can overcome barriers and ensure equitable, affordable, and quality healthcare for all citizens.

CHAPTER ONE: INTRODUCTION

1.1 Background of the problem

The right to the highest attainable standard of health, which encompasses access to healthcare services, is acknowledged as a fundamental human right[1] under the 2010 Constitution.[2] This right, in principle should be exercised on a non-discriminatory basis[3] and should be accorded to everyone, regardless of one's sex, ethnicity, religion, age, disability, marital status and financial status. However, access to proper healthcare remains an obscure dream to many Kenyans.[4] Access to healthcare services in the country continues to be exclusive to a privileged minority who can financially afford them, even though the right to healthcare is legally enforceable under the constitutional framework established in 2010.[5]

In efforts to ameliorate this, Kenya has embraced Universal Health Coverage as a key component of its 'big four initiatives'.[6] This program aims to guarantee that every individual in Kenya can access necessary health services without facing financial ruin, all through a unified and comprehensive benefit package.[7] A Universal Health Coverage system, as defined by the World Health Organization, means a "system where all people have access to the full range of quality health services they need, when and where they need them and without financial hardship".[8] Kenya has made achieving universal health coverage (UHC) a top

[1] Hunt, Paul, and Gunilla Backman. "Health systems and the right to the highest attainable standard of health." *Health and human rights* (2008): 81.

[2] Article 43 (1)(a), Constitution of Kenya (2010).

[3] Allan, H., 2010. Mentoring overseas nurses: barriers to effective and non-discriminatory mentoring practices. Nursing ethics, 17(5),.607.

[4] Ouma, Smith. "Structural Impediments to Access to Health Care in Kenya and the Promises of the New Constitutional Order." *Available at SSRN 3451841* (2016).

[5] Ouma, Smith. "Structural Impediments to Access to Health Care in Kenya and the Promises of the New Constitutional Order."

[6] Makokha, TIMOTHY WAFULA. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019).

[7] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023.

[8] https://www.who.int/health-topics/universal-health-coverage on 29th October 2023.

priority, focusing on broadening health insurance coverage provided by the National Hospital Insurance Fund (NHIF).[9]

The National Health Insurance Fund is a state corporation established by the government with the purpose of empowering Kenyans to reach quality healthcare that is both accessible and affordable. It does this by issuing health insurance as the primary insurance provider in Kenya.[10] Under the NHIF Act, there is the establishment of the Board for management of the Fund, and one of its objectives is to facilitate attainment of Universal Health Coverage.[11] Over the past ten years, the Kenyan government has implemented various reforms aimed at strengthening the NHIF's ability to fulfill the commitment of providing universal health coverage to Kenyans.[12] However, flaws in the design and execution of reforms constrained the NHIF's procurement capabilities, resulting in negative impacts on the health system's goals of fairness, effectiveness, and quality.[13]

Noting NHIF's shortcomings, the Kenyan government, through the Ministry of Health, initiated the establishment of a fund aimed at reducing healthcare expenses, foreseeing increased accessibility to affordable medical services for many Kenyans. The adoption of the Social Health Insurance Act, No. 16 of 2023 ("SHIFA"), occurred on October 19th, 2023, with implementation commencing on November 22nd, 2023. It sets up the Social Health Authority, a structure for overseeing social health insurance, in accordance with the stipulations outlined in Article 43(1)(a) of the Constitution.[14] A transfer of all duties, activities and operations from the Board of the National Health Insurance Fund (NHIF) will shift to the Social Insurance

[9] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023.

[10] Explanation of the Benefit Package for the National Scheme, 2015, 3.

[11] Section 5 (1)(g), National Health Insurance Fund Act (Act No.9 of 1998)

[12] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023.

[13] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023.

[14] https://www.oraro.co.ke/highlights-of-the-social-health-insurance-fund-and-related-legislation/?cv=1 on 23rd January,2024.

Authority.[15] Funding for the SHIF will be sourced from contributions made by every household in Kenya, non-Kenyan residents residing in Kenya for over twelve (12) months, employers, both national and county governments, allocations from the National Assembly for disadvantaged and vulnerable individuals, as well as donations, grants, innovative financing methods, or gifts.[16] The SHIFA and its proposed regulations strive to offer extensive medical coverage beginning with primary healthcare and extending benefits to beneficiaries who have utilized their coverage under SHIF. This guarantees that recipients will not need to worry about covering medical costs once they have depleted their regular coverage. This is apparently an improvement to the NHIF which did not make such express provisions.

When examining the history of health insurance and Universal Health Coverage (UHC) in South Korea, a divergent scenario unfolds compared to the situation in Kenya. The inception of Korea's Universal Coverage Health Insurance System (UCHIS) goes back to 1963, established under the National Medical Insurance Act. Its introduction to companies with more than 500 employees occurred in 1977.[17] By 1989, following approximately ten years of extensive national healthcare reforms, Korea attained universal health insurance coverage, requiring minimal government expenditure. This was accomplished through the provision of restricted benefits, significant co-payments and co-insurance rates, modest provider fees, and fee escalation limitations tied to general inflation rates.[18]

Although considerable legislation has been enacted and various reforms implemented within the National Health Insurance Fund (NHIF) with the aim of achieving specific objectives, there remains a noticeable challenge in the organization's efforts to provide health insurance coverage to the economically disadvantaged. Despite the well-intentioned measures put in place, it is evident that NHIF has encountered difficulties in effectively expanding healthcare coverage to reach the economically disadvantaged segment of the population. An analysis of South Korea's health insurance system and its developments would be instrumental in assisting the Kenyan government in achieving the same set goals and extending health insurance to even to the vulnerable and indigent of the community. This is also particularly useful with respect

[15] Section 4, Social Health Insurance Act, 2023.

[16] Section 26, Social Health Insurance Act, 2023.

[17] Ruger, Prah J, and Hak-Ju Kim.'Out-of-pocket healthcare spending by the poor and chronically ill in the Republic of Korea.' *American Journal of Public Health* 97, no.5, 2007: 807.

[18] Ruger, Prah J, 'Out of pocket healthcare spending by the poor and chronically ill in the Republic of Korea.'803

to the recent establishment of the SHIF, that would greatly benefit from the interrogation carried out further into the study and the informed recommendations.

1.2 Statement of the problem

The stark disparity in the accessibility of healthcare services between Kenya and South Korea underscores a critical issue plaguing the Kenyan healthcare system. Even though the 2010 Constitution acknowledges the right to the highest attainable standard of health attainable, the execution of Universal Health Coverage (UHC) encounters notable obstacles. Kenya's National Health Insurance Fund (NHIF), tasked with providing affordable health insurance, grapples with limitations in design and execution of reforms, hindering its ability to extend coverage to the economically disadvantaged.

In contrast, the South Korea healthcare system presents a notable success story in achieving Universal Health Coverage. Through comprehensive national health reforms initiated in 1963, South Korea managed to attain universal health insurance coverage by 1989, making it the fastest country globally to achieve such a milestone. The effectiveness of their approach is evident in the expeditious accomplishment, with low government costs achieved through limited benefits, high copayments, low provider fees, and controlled fee growth. The glaring difference in the analysis of the Kenyan and South Korean health insurance systems reveals a pronounced problem: the persistent inability of NHIF, despite legislative and reform efforts, to bridge the healthcare gap for its citizens, particularly the economically disadvantaged, thus emphasizing the urgent need for targeted interventions and reforms to actualize Universal Health Coverage in the Kenyan context. This study therefore seeks to review the setbacks affecting Kenya's approach towards achieving UHC. It scrutinizes Kenya's obligation, through the NHIF to fulfil these socio-cultural rights to this vulnerable group and the challenges encountered in the pursuit of its objectives.

1.3 Research objectives

1. To investigate the socio-economic barriers and challenges encountered by NHIF in extending healthcare coverage in Kenya.
2. To interrogate the recent reforms within the NHIF in Kenya and their ability to extend health insurance coverage in Kenya.
3. To draw lessons from South Korea's experience, to inform policy recommendations and strategic interventions for advancing Kenya's efforts towards universal health coverage.

4. To make recommendations identified from South Korea's experiences and Kenya's past experiences to strengthen Kenya's ability to extend health insurance coverage and achieve universal health coverage.

1.4 Research questions

1. What are the primary socio-economic barriers and challenges contributing to the low enrollment rates in the NHIF among populations in Kenya?
2. What recent reforms have been introduced within the NHIF to aid in increasing health insurance coverage among Kenyans?
3. What lessons can be drawn from South Korea's experience to inform policy recommendations for advancing universal health coverage in Kenya?
4. What recommendations can be made in light of South Korea's experience and Kenya's past experiences to improve extension of health insurance coverage in the Kenyan context.

1.5 Hypothesis

Despite NHIF's legal provisions and attempts at structural reforms, socio-economic barriers will likely impede equitable health insurance enrollment in Kenya, particularly among economically disadvantaged groups. Interrogation of South Korea's UCHIS and its applied strategies are expected to yield actionable recommendations for enhancing inclusivity in Kenya's health insurance system, advancing universal health coverage objectives.

1.6 Justification of the study

The study seeks to contribute to evidence-based policymaking and advocacy efforts aimed at promoting health equity and social justice for all citizens in Kenya.

The purpose of the study is to provide a comprehensive understanding of the challenges and opportunities associated with extending health insurance coverage to economically disadvantaged populations in Kenya. This research aims to address the critical gap between the constitutional recognition of the right to health and the actual accessibility of healthcare services, particularly for marginalized communities.

By investigating the socio-economic factors influencing low enrollment rates in the NHIF among vulnerable populations, the study seeks to identify barriers to participation and inform

targeted interventions aimed at improving accessibility and affordability of health insurance. Understanding the effectiveness of recent reforms within the NHIF and comparing Kenya's health insurance system to successful international models, such as South Korea's UCHIS, will provide in-depth perspectives into the strengths and weaknesses of current approaches and offer evidence-based recommendations for policy enhancement.

Moreover, by exploring innovative strategies and policy interventions from South Korea, the study aims to inspire novel approaches to overcome challenges in extending health insurance coverage to economically disadvantaged populations in Kenya. In essence, this research aligns with the overarching objective of advocating for universal health coverage and guaranteeing equitable access to essential healthcare services across all segments of society. This endeavor fulfills the constitutional obligation to ensure the right to the highest achievable standard of health.

1.7 Literature Review

The literature chosen for this study centered on three main areas; first, literature that discussed the socio-economic barriers and challenges encountered by NHIF in extending healthcare coverage, especially to economically disadvantaged populations in Kenya. Second, the study analyzed literature that interrogated the recent reforms within the NHIF in Kenya, and their ability to extend health insurance coverage to populations in Kenya. Finally, the study reviewed literature that examines the institutional frameworks, financing mechanisms, and policy strategies employed in realizing universal healthcare through South Korea's Universal Coverage Health Insurance System (UCHIS).

1.7.1 The socio-economic barriers and challenges encountered by NHIF in extending health insurance coverage to economically disadvantaged populations in Kenya.

Gatehi Wangari[19] underscores the key challenges impacting healthcare accessibility, including sociodemographic factors and lack of knowledge about NHIF benefits and processes. To achieve Universal Health Coverage (UHC), she advocates for streamlining NHIF processes,

[19] Gatehi, Miriam W. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya."

enhancing awareness of benefits among users, and ensuring a consistent drug supply.[20] Notably, this study emphasizes the significance of NHIF knowledge in facilitating access to healthcare services, suggesting measures such as training sessions, webinars, and improved media coverage.[21] Additionally, addressing co-pay requirements and subsidizing essential services like chemotherapy and radiology is proposed to alleviate financial barriers.[22] Collaboration between NHIF, government, and private partners is urged to provide specialized services, particularly for non-communicable diseases, thus enhancing healthcare accessibility for all.[23]

Eunice Muthoni[24] emphasizes the importance of ensuring primary care services are adequate, acceptable, affordable, physically accessible, and available for all citizens. However, findings of her study reveal shortcomings in these areas, with citizens reporting inadequate communication from NHIF, lack of accountability mechanisms, and limited access to information about benefits and services.[25] To address these issues, the author recommends leveraging existing administrative mechanisms, such as chief barasas and religious institutions, to improve communication with the public.[26] Additionally, she stresses the need for counties to upgrade and accredit all primary care providers to ensure quality services and promote geographical access to healthcare.[27] Furthermore, the author underscores the critical role of consistent drug supply in enhancing healthcare access, urging NHIF-accredited facilities to maintain adequate stocks to meet the needs of patients, particularly in public institutions where

[20] Gatehi, Miriam Wi. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya."

[21] Gatehi, Miriam W. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya."

[22] Gatehi, Miriam W. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya."

[23] Gatehi, Miriam W. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya."

[24] Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya." PhD diss., 2020.

[25] Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya."., 2020.

[26] Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya."., 2020.

[27] Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya."., 2020.

shortages have been common.[28] Overall, the author emphasizes the importance of addressing socio-economic barriers and improving NHIF's effectiveness in providing healthcare coverage to economically disadvantaged populations in Kenya.

Jin Kyung Jung[29] discusses the socio-economic barriers impeding NHIF's efforts to extend healthcare coverage to economically disadvantaged populations in Kenya. These barriers include inequitable premium contributions and benefit packages that fail to attract informal sector individuals, coupled with administrative inefficiencies in enrollment processes.[30] Additionally, multiple payer mechanisms incentivize prioritization of civil servants, exacerbating coverage discrepancies. Weak transparency and accountability mechanisms further hinder trust in NHIF's role as a principal provider, with discontent expressed over benefit package contents and access to information.[31] These challenges contribute to low coverage and hinder access to necessary healthcare services, leaving informal sector individuals vulnerable to financial burdens from out-of-pocket payments.[32] Despite introduced reforms, the author notes that progress remains stagnant due to inequitable, inefficient, and less transparent financing arrangements.[33] The author emphasizes the need for substantial improvements in premium structures, administrative procedures, and accountability mechanisms to address these barriers effectively.[34] Enhancing accessibility and financial protection for economically disadvantaged populations requires concerted efforts to overhaul NHIF's operational framework, ensuring equitable coverage and quality healthcare services for all.

[28] Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya."., 2020.

[29] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF), on 28th October 2023

[30] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." on 28th October 2023

[31] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)" on 28th October 2023

[32] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." on 28th October 2023

[33] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." on 28th October 2023

[34] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." on 28th October 2023

Edwine Barasa[35] noted that participants in their study expressed frustration over insufficient details regarding NHIF registration, membership procedures, and benefit eligibility, along with inconsistent and varying communication from the institution. Moreover, there was discrepancy regarding the contrast between the benefits outlined in the official package and the benefits individuals received, further complicating matters for members.[36] Administrative hurdles in NHIF registration processes were identified as additional barriers to obtaining membership.[37] Financial constraints posed by premium levels and contribution mechanisms deterred both current and prospective members. Furthermore, participants observed bias by healthcare providers towards NHIF members in contrast to individuals paying with cash or those covered by private insurance, exacerbating access issues for economically disadvantaged individuals.[38]

Kenneth Munge[39] identifies significant challenges within the NHIF's regulatory and policy framework, accountability mechanisms, resource mobilization, and provider payment mechanisms, all of which hinder the effective extension of healthcare coverage to economically disadvantaged populations in Kenya. Weaknesses in regulatory oversight, particularly regarding strategic purchasing practices, limit the NHIF's ability to align benefit packages with population needs and national priorities. Additionally, inadequate resources, coupled with low premium contributions from informal sector workers, impede efforts to expand coverage.[40] Moreover, poorly implemented provider payment mechanisms contribute to reluctance among healthcare providers, particularly in the private sector, to contract with NHIF due to low payment rates. Consequently, despite having an extensive range of benefits, the NHIF's efforts

[35] Barasa, Edwine W., Njeri Mwaura, Khama Rogo, and Ledia Andrawes. "Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." *Wellcome open research* 2 (2017). https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1 on 1st January, 2024.

[36] Barasa, Edwine W.. "Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." on 1st January, 2024.

[37] Barasa, Edwine W.,. "Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." on 1st January, 2024.

[38] Barasa, Edwine W.,"Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." on 1st January, 2024.

[39] Munge, Kenneth, Stephen Mulupi, Edwine W. Barasa, and Jane Chuma. "A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund." *International journal of health policy and management* 7, no. 3 (2018): 244.

[40] Munge, Kenneth,. "A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund.", 244.

to insure and protect beneficiaries were failing.[41] To address these challenges and improve healthcare coverage, his study underscores the urgent need for the development and implementation of a strategic purchasing framework.[42] Such a framework should align policy and regulations to support strategic purchasing, ensure universal availability of benefit packages offering sufficient financial risk protection, and include regulations addressing equity concerns such as balance billing and explicit exclusions. Strengthening the regulatory and policy environment, alongside enhancing accountability mechanisms and resource mobilization is essential for overcoming barriers and effectively extending healthcare coverage to economically disadvantaged populations in Kenya.

Jacob S. Kazungu[43] notes that given a substantial informal sector and close to half of the population residing below the poverty threshold, attaining widespread and fair coverage through both contributory and voluntary approaches poses significant challenges. The link between having health insurance and being employed, alongside socio-economic status, underscores the likelihood of inequities within such systems. Challenges such as irregular incomes and affordability issues further hinder coverage expansion, particularly among the informal sector. [44] The study advocates for a shift towards a universal, tax-funded mechanism to ensure equitable and efficient coverage for all, including the individuals living in poverty and those engaged in informal economic activities.[45] This shift, it argues, is essential for addressing the slow advancement in expanding coverage and ensuring that everyone can access healthcare services through NHIF regardless of their socio-economic status.

1.7.2 An interrogation of reforms within the NHIF

[41] Munge, Kenneth, "A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund." 244.

[42] Munge, Kenneth, "A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund." 244.

[43] Kazungu, Jacob S., and Edwine W. Barasa. "Examining levels, distribution and correlates of health insurance coverage in Kenya." *Tropical Medicine & International Health* 22, no. 9 (2017): 1181-1182. https://pubmed.ncbi.nlm.nih.gov/28627085/ on 3rd January 2024.

[44] Kazungu, Jacob S., and Edwine W. Barasa. "Examining levels, distribution and correlates of health insurance coverage in Kenya." 1181-1182.

[45] Kazungu, Jacob S., and Edwine W. Barasa. "Examining levels, distribution and correlates of health insurance coverage in Kenya." : 1181-1182.

Makokha Timothy conducts an analysis on the institutional reforms made within the NHIF, in the recent years. The NHIS Bill of 2004, aiming to establish a social health insurance plan, was put forth but later turned down by the President due to apprehensions regarding its technical framework[46]. In 2012, the Civil Servants Scheme (CSS) was initiated for government workers and dependents, managing funds separately with expanded benefits. However, criticisms arose regarding its discriminatory nature.[47] The Stepwise Quality Improvement System program, launched in 2013, aimed to enhance healthcare quality, particularly in resource-restricted settings.[48] In 2016, the NHIF introduced the *Linda Mama* Program to provide free maternal and infant care, addressing previous challenges with maternity policies. Additionally, programs like the Health Insurance Subsidy Program (HISP) and the Secondary School Cover aimed to provide healthcare to the indigent, elderly, disabled, and secondary school students.[49] In 2015, NHIF adjusted contribution rates and broadened the scope of the benefit package.[50] Nevertheless, it faced criticism for rendering the scheme financially burdensome for individuals with low incomes. In 2016, reimbursement rates for healthcare providers were raised, although delays in reimbursements were noted, affecting patient access to care.[51]

Rahab Mbau[52] discussed the recent reforms introduced by the NHIF in 2015 aimed at advancing Kenya's progress towards Universal Health Coverage (UHC). These reforms included upward revisions of premium contribution rates to address rising healthcare costs and expand benefits packages.[53] Moreover, NHIF broadened its coverage to encompass outpatient

[46] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

[47] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

[48] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

[49] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

[50] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

[51] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

[52] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the NationalHospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023.

[53] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023

and specialized services across all schemes. This expansion was accompanied by the introduction of new payment methods for healthcare providers, including capitation for outpatient services and case-based or fee-for-service payments for specialized services.[54] However, an evaluation of these reforms revealed significant weaknesses in their design and implementation, particularly in communication, affordability, and distribution of benefits.[55] Although the aim was to diminish direct payments at the point of service and enhance the scope of services available, inadequately communicated premium rates and unequal distribution of benefit packages across citizen groups hindered the NHIF's ability to effectively extend healthcare coverage, especially to economically disadvantaged populations. Additionally, obstacles such as late payments and deficiencies in infrastructure within public healthcare institutions further undermined the reforms' ability to encourage fairness, effectiveness, and quality in healthcare provision.[56]

Mbau underscores the importance of aligning reform design and implementation with strategic purchasing actions to enhance the NHIF's ability to achieve health system goals effectively. Despite the reforms' intentions to expand population and service coverage, their passive nature due to design and implementation weaknesses limits their impact on equitable, efficient, and quality healthcare delivery.[57] According to the author, in order to accelerate progress towards UHC, policymakers at both national and county levels, alongside the NHIF, must prioritize strategic purchasing actions that address communication gaps, affordability issues, and infrastructure challenges.[58] By ensuring alignment between reform strategies and health system goals, policymakers can better support the NHIF in extending healthcare coverage equitably,

[54] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023

[55] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023

[56] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023

[57] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023

[58] Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x on 29th October 2023

particularly to economically disadvantaged populations, and furthering Kenya's progress towards achieving Universal Health Coverage.

Edwine Barasa's[59] article examines the reforms undertaken by the National Hospital Insurance Fund (NHIF) in Kenya and their impact on the country's efforts to achieve Universal Health Coverage (UHC). These reforms involved a range of measures, such as introducing the Civil Servants Scheme (CSS), implementing a Stepwise Quality Improvement System, initiating the Health Insurance Subsidy for the Poor (HISP) program, adjusting monthly contribution rates, enhancing the benefit package, and increasing provider reimbursement rates.[60] While these reforms signify governmental commitment to advancing UHC, concerns persist regarding their equity, efficiency, feasibility, and sustainability. Despite efforts to expand population coverage and enhance service provision, observations indicate shortcomings in achieving comprehensive financial risk protection.[61] Notably, NHIF's coverage, though increased, remains modest at 14%, reflecting the obstacles encountered by other low- and middle-income nations (LMICs) when endeavoring to expand health insurance coverage through voluntary means. Although revenue collection doubled, it constitutes only a fraction of Kenya's total health expenditure, underlining the inadequacy of voluntary mechanisms in resource mobilization for healthcare. Despite halving administrative costs, NHIF's operational efficiency remains a concern at 22%.[62]

The analysis underscores the need for further evaluation of the NHIF reforms' effectiveness, particularly in extending health insurance coverage to economically disadvantaged populations.[63] While the reforms have led to positive outcomes, such as increased coverage and revenue collection, they fall short of addressing the systemic issues hindering equitable

[59] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." *Health Systems & Reform* 4, no. 4 (2018): 352-359.

[60] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage.", 352-359.

[61] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." 352-359.

[62] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." 352-359.

[63] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." 352-359.

access to healthcare.[64] The persistence of low coverage rates and limited resource mobilization through voluntary mechanisms highlights the necessity for more robust strategies to achieve UHC. Efforts to reduce administrative costs are commendable, yet concerns persist regarding NHIF's overall efficiency. Therefore, a comprehensive assessment of the NHIF reforms' impact on healthcare access and financial protection for economically disadvantaged populations is imperative to inform future policy decisions and enhance the organization's ability to fulfill its mandate of ensuring that every Kenyan has access to comprehensive healthcare coverage.[65]

Stephen Mulupi[66] in his study explores how communities understand and view health insurance, shedding light on their desired features and worries about it, with a special emphasis on the affordability of premiums and whether the contributory scheme is accessible to the poorest. The findings reveal a limited understanding of health insurance concepts among the studied communities, emphasizing the necessity for comprehensive education and engagement initiatives to elucidate the significance of risk-pooling and cross-subsidization within the context of Universal Health Coverage (UHC) reforms.[67] Affordability emerges as a significant barrier to health insurance membership, prompting considerations on the feasibility of achieving UHC through contributory versus tax-funded approaches, necessitating enhanced tax revenue collection mechanisms and innovative financing strategies. Furthermore, the perceived inadequacies in the quality of care within the public health system pose a substantial obstacle to UHC, highlighting the significance of improving service quality, especially concerning medication accessibility and interpersonal engagements between patients and healthcare professionals, to foster confidence in the public healthcare system and consequently promote enrollment in health insurance.[68]

---

[64] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." 352-359.

[65] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." 352-359.

[66] Mulupi, Stephen, Doris Kirigia, and Jane Chuma. "Community perceptions of health insurance and their preferred design features: implications for the design of universal health coverage reforms in Kenya." *BMC health services research*13, no. 1 (2013): 5-11.

[67] Mulupi, Stephen, Doris Kirigia, and Jane Chuma. "Community perceptions of health insurance and their preferred design features: implications for the design of universal health coverage reforms in Kenya." 5-11.

[68] Mulupi, Stephen, Doris Kirigia, and Jane Chuma. "Community perceptions of health insurance and their preferred design features: implications for the design of universal health coverage reforms in Kenya: 5-11.

1.7.3 Lessons drawn from South Korea's experience for legal, institutional and policy reformation.

One author, Soonman Kwon[69] in his study noted that although initially introduced for industrial workers in 1977 and extended to the entire population by 1989, South Korea's UCHIS exemplifies successful population and benefit coverage expansion strategies. The National Health Insurance Corporation (NHIC), under the jurisdiction of the Ministry of Health and Welfare, ensures accountability and efficiency through close coordination. Notably, Korea's transition to a single-payer model in 2000 facilitated efficient risk pooling and financial sustainability.[70] Mandatory enrollment, family-based membership, and subsidies for the poor and self-employed were crucial in extending coverage, while incremental benefit coverage, including outpatient care, minimized dropouts and enhanced enrollees' experiences.[71] Although South Korea favors health insurance over tax-based financing for its participatory nature, challenges remain in covering the informal sector due to enrollment costs and economic conditions. Despite these challenges, South Korea's experience offers valuable lessons for Kenya in strengthening institutional frameworks, financing mechanisms, and policy strategies to advance its goal of achieving UHC.

John W. Peabody[72] discusses how South Korea's 1977 approach focused on achieving universal coverage while retaining fee-for-service reimbursement. The system progressed gradually, initially mandating coverage for enterprises, government personnel, and educators, and later expanding to encompass impoverished individuals, self-employed persons, and inhabitants of rural areas.[73] Each scheme is managed independently by insurance societies responsible for setting premiums, co-payments, and ensuring financial viability. By 1991, public funds covered 30% of healthcare expenditures, accounting for 7.1% of GDP.[74] South Korea's

---

[69] Kwon, Soonman. "Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage." *Health policy and planning* 24, no. 1 (2009): 63-71.

[70] Kwon, Soonman. "Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage." 63-71.

[71] Kwon, Soonman. "Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage." 63-71.

[72] Peabody, John W., Sung-Woo Lee, and Stephen R. Bickel. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." *Health Policy* 31, no. 1 (1995): 42.

[73] Peabody, John W., Sung-Woo Lee, and Stephen R. Bickel. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." 43.

[74] Peabody, John W., Sung-Woo Lee, and Stephen R. Bickel. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." 43.

healthcare reforms have successfully achieved universal coverage, provided comprehensive services, and mitigated adverse selection. The system's financial sustainability, equitable cost distribution, and government subsidies for those in need have ensured economic viability without unduly burdening small businesses.[75] South Korea's experience presents valuable insights for Kenya in structuring institutional frameworks, financing mechanisms, and policy strategies to advance towards universal health coverage.

Sseung-Hum Yu[76] noted how South Korea's framework was modeled after Bismarck's plan for Germany in the 1880s with adaptations to suit its modern developing context. One critical consideration was determining the priority groups for coverage. While there was debate within the Korean government regarding coverage initiation, eventually, the program began with those in greatest need, including rural residents and the self-employed, although concerns persisted about their ability to afford premiums and access healthcare.[77] To address this, regional medical insurance programs were piloted before implementing a national system. Premium collection proved challenging, particularly in rural areas, prompting the development of new premium rating methods and decentralized collection approaches involving insurance societies and village chiefs, which eventually led to higher collection rates.[78] However, administrative expenses remained a significant challenge, with administrative costs comprising a considerable portion of premiums and escalating over time, highlighting the need for sustainable financing mechanisms.

According to Soonman Kwon[79] the expansion of coverage to include the informal sector in South Korea was propelled by both public backing and governmental intervention. When health insurance was expanded to include the self-employed, particularly farmers in rural areas, protests arose over the perceived unfairness of full contributions compared to the subsidized

[75] Peabody, John W., Sung-Woo Lee, and Stephen R. Bickel. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." 43.

[76] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." *Health Policy* 20, no. 3 (1992): 294.

[77] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?."294.

[78] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." 294.

[79] Kwon, Soonman. "Advancing universal health coverage: what developing countries can learn from the Korean experience?." (2018).

payments of formal sector workers.[80] In response, the government introduced a partial subsidy, which covered fifty percent of the contributions made by the self-employed, thus incentivizing their enrollment.[81] Moreover, South Korea's decentralized system, with multiple insurance funds, facilitated social marketing efforts by each insurance society to boost enrollment and emphasize the value of health insurance.[82] Furthermore, the incorporation of Civil Registration and Vital Statistics alongside national identification systems into health coverage procedures simplified enrollment and facilitated the broadening of coverage, especially within the informal sector.[83]

1.8 Research methodology

The doctrinal method of research was chosen for this study to effectively analyze existing laws, policies, and institutional frameworks related to health insurance coverage in Kenya. The purpose of the study was to understand the legal and policy landscape governing healthcare accessibility and identify systemic challenges to inform potential policy reforms. The NHIF Act of 2010, the 2010 Kenya Constitution, and the Universal Health Coverage (UHC) Policy were central to the research as they establish the NHIF institution, delineate its powers, obligations and functions and regulate the health insurance coverage process. These documents were selected for their pertinence to the study's objectives, serving as primary sources of legal authority and policy guidance in the realm of healthcare financing and provision in Kenya.

Accessing relevant legal and policy documents involved desktop research of legal material repositories, databases, hard law and soft law materials. Primary sources and secondary sources of law were also relied on. Key variables such as affordability, accessibility, adequacy, and availability were identified and scrutinized within the selected documents to assess the efficacy of existing health insurance mechanisms.

---

[80] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." 294.

[81] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." 294.

[82] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." 294.

[83] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." 294.

A limitation that was encountered when applying this approach was the accessibility and comprehensiveness of some of the legal and policy documents, particularly in cases where certain regulations or guidelines were not publicly accessible or where interpretations varied among legal scholars or practitioners. Despite this, the doctrinal approach provided comprehensive insights into the legal and policy framework governing health insurance in Kenya. By systematically analyzing statutes, regulations, and policies, this method facilitated the identification of structural barriers to healthcare access and informed recommendations for policy reforms aimed at enhancing affordability, equity, and quality in healthcare provision.

1.9. Chapter Breakdown

Chapter one serves as an introduction to the study, offering background information and delineating the statement of the problem. It provides a background and outlines the statement of the problem. Additionally, it lists the statement of objectives and the research questions as well as the hypothesis examined by the study. Thereafter, it provides the justification of the study and a discussion of the literature review, and the research methodology. Finally, a chapter breakdown is provided.

Chapter two conducts a discussion of the theoretical framework. It will provide the lens through which the research problem will be examined. The theories that will be discussed here is the human rights theory and the social justice theory.

Chapter three will discuss the legal and policy framework governing the operations of the NHIF and the recently established SHIF. Furthermore, it will investigate the socio-economic barriers and challenges encountered by NHIF in extending healthcare coverage to Kenyan citizens. It will also interrogate the recent reforms implemented within the NHIF to address these challenges.

Chapter four will investigate what lessons can be drawn from South Korea's experience to inform policy recommendations for advancing universal health coverage in Kenya.

Chapter five will provide a conclusion and recommendations to inform policies in the extension of health insurance coverage in the Kenyan context.

2.0 CHAPTER TWO: THEORETICAL FRAMEWORK

This chapter shall delve into two foundational theories that underpin the examination of the research problem outlined above. The theories to be analysed are the human rights theory and John Rawls's social justice theory. The ensuing discussion will annotate the essence of these theories and their relevance to the research problem at hand.

2.1 Human-rights theory

The adoption of this human-rights-based approach has its foundations on the international plane. This approach is evident in global legal agreements such as the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW), and the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). It is also implemented under the 2010 Constitution.[84] Under the aforementioned instruments, the right to the highest attainable standard of health is recognised as a fundamental human right. Article 25 of the UDHR asserts that: "access to healthcare is a fundamental human right, essential for the realization of other rights such as the right to life, health, and well-being". The human rights theory posits that all individuals possess inherent dignity and worth by virtue of their humanity.[85] Health is intricately linked to human dignity, when individuals are deprived of access to healthcare and health care services, their ability to live with dignity is compromised.[86] Consequently, an obligation is placed on states as duty bearers to protect, promote and fulfill the right to health and ensure access to health care goods and services to all individuals.[87]

The entitlement to health as a fundamental human right is guided by several key principles, these include the principles of equity, non-discrimination, and participation. The principle of equity is underlied by the notions of fairness and social justice and human dignity. It recognises the utilitarian implications that access to proper healthcare can have on a society and its welfare.

---

[84] Kinyua, Benson. "A Revolution of Human Rights in Kenya: Assessing the Enforceability of Socio-Economic Rights Under the Constitution of Kenya 2010." *Available at SSRN 1864585*(2011).

[85] Amoloye-Adebayo, Azizat O. "Violations of socio-economic rights in developing states: a case for the recognition of the right to inheritance in international human rights law." *Africa Nazarene University Law Journal* 1,2015, 87.

[86] Amoloye-Adebayo,."Violations of socio-economic rights in developing states: a case for the recognition of the right to inheritance in international human rights law." *88.*

[87] Leary, Virginia A. "The right to health in international human rights law." *Health and human rights* (1994): 44.

The application of this principle prioritises the needs of marginalised and vulnerable populations and asserts that all individuals should have access to healthcare services. The principle of non-discrimination is based on the notion of equality and inherent dignity of every individual. It recognises that discrimination in healthcare leads to disparities in health outcomes and further perpetuates social inequality. Furthermore, discriminatory practices deny individuals their right to access essential healthcare services, and in turn, violates their inherent dignity as human beings. The principle of non-discrimination mandates that healthcare access must be granted impartially, irrespective of race, ethnicity, gender, age, disability, socio-economic status, or any other criteria.[88]

The principle of participation is based on the notions of democracy, autonomy, and empowerment. It asserts that individuals have the right to actively participate in decisions that affect their health and healthcare. Involving individuals in healthcare decision making processes ensures that policies and programs are responsive to their diverse needs, preferences, and priorities. This will enhance accountability, transparency and legitimacy of healthcare systems. The right to health has been further categorised as a socio-economic right. However, due to the supposedly vague and resource-dependent nature of such rights, the standard of progressive realisation[89] was adopted for their realisation.[90]

2.2 Social justice theory

John Rawls, in his seminal work, “A Theory of Justice " introduced the concept of social justice. This theory advocates for fairness and equity in the distribution of resources, rights, and opportunities within society. At the heart of Rawl’s framework lies the "veil of ignorance" thought experiment, which suggests that decisions about societal arrangements should be made without knowledge of one's own social status to ensure fairness. In Rawl’s work "A Theory of Justice," he aimed to utilize the widespread liberal consensus on principles ensuring specific equal fundamental freedoms to establish a principle constraining socioeconomic disparities.[91]

---

[88] Wasonga, Obat Joseph, and P. L. O. Lumumba. "Socio-economic and cultural rights under the 2010 Constitution of Kenya: justiciable or aspirational?." *Africa Nazarene University Law Journal* 3, 1 (2015), 125.

[89] Orago, Nicholas Wasonga, “Limitation of Socio-Economic Rights in the 2010 Kenyan Constitution: A Proposal for the Adoption of a Proportionality Approach in the Judicial Adjudication of Socio-Economic Rights Disputes’ https://doi.org/10.17159/1727-3781/2013/v16i5a2433 on 2nd February 2024

[90] Orago, Nicholas Wasonga, “Limitation of Socio-Economic Rights in the 2010 Kenyan Constitution: A Proposal for the Adoption of a Proportionality Approach in the Judicial Adjudication of Socio-Economic Rights Disputes’ https://doi.org/10.17159/1727-3781/2013/v16i5a2433 on 2nd February 2024

[91] Rawls, John. "A theory of justice." In *Applied Ethics*, Routledge, 2017, 25.

His strategy was to show that a social contract designed to be fair to free and equal people ("justice as fairness") would not only justify the choice of those equal basic liberties. It would also justify the choice of principles guaranteeing equal opportunity and limiting inequalities to those that work to make the worst-off groups fare as well as possible.[92]

Rawls posits that it is the responsibility of society to allocate primary goods essential for individuals to achieve their rational life goals.[93] He seeks to formulate a theory of justice by ensuring the equitable allocation of these primary goods.[94] He argues that the social systems responsible for distributing these goods should be organized to adhere to principles of justice while allocating fundamental rights and responsibilities.[95] Rawls explores the concept of justice through the lens of fairness, asserting that fairness is attained when every individual has access to the services they require. Primary goods are characterized as the essential resources necessary for free and equal citizens to lead typical and socially integrated lives within society throughout their lifetimes. The core components of the primary goods set encompass rights, freedoms, income and welfare.[96] When Rawls first defined his theory of justice as fairness in 1971, he left health out of the theory intentionally on the grounds that health is a natural good.[97]

While Rawls did not directly address the right to health within his theory, efforts to expand the theory to include the notion of health have progressed significantly.[98] Ronald Green contends that individuals in the original position would establish a fundamental right to healthcare.[99]

[92] https://www.scribd.com/document/373347349/Amartya-Sen-Public-Health-Ethics-and-Equity on 4th February, 2024.

[93] Daniels, Norman, Bruce Kennedy, and Ichiro Kawachi. "Why justice is good for our health." *Interfaces between bioethics and the empirical social sciences. Publication Series-2002. Santiago de Chile: Regional Program on Bioethics, PAHO, WHO* (2002): 40.

[94] Rawls, John. "A theory of justice." In *Applied Ethics*, Routledge, 2017, 25.

[95] Ekmekci, Perihan Elif, and Berna Arda. "Enhancing John Rawls's theory of justice to cover health and social determinants of health." *Acta bioethica* 21, 2, 2015, 227.

[96] Ekmekci, Perihan "Enhancing John Rawls's theory of justice to cover health and social determinants of health." 227.

[97] Ruger, Jenniffer Prah, "Toward a Theory of a right to health: capability and incompletely theorized agreements." Yale journal of law & the humanities 18, no 2.2 (2006): 3.

[98] Norheim, Ole Frithjof, and Yukiko Asada. "The ideal of equal health revisited: definitions and measures of inequity in health should be better integrated with theories of distributive justice." *International Journal for Equity in Health* 8 (2009): 4.

[99] https://www.scribd.com/document/373347349/Amartya-Sen-Public-Health-Ethics-and-Equity on 2nd February 2024.

However, Green's approach necessitates a significant relaxation of the limitations Rawls imposes on the original position, thereby undermining Rawls' arguments for the two principles of justice.[100] Norman Daniels asserts that healthcare is most effectively viewed as a tool for advancing Rawls' objective of ensuring equality of fair opportunity.[101] He also acknowledges that his interpretation cannot endorse a fundamental right to healthcare; instead, it would, at most, mandate that specific types of care be accessible to particular categories of individuals. [102] According to this perspective, the societal delivery of healthcare may appropriately differ substantially across different cultural contexts. Fabienne Peters acknowledged the consistent and robust empirical evidence supporting social disparities in health, noting that generally, the lower a group's social standing, the poorer the overall health status of its members. Expanding upon Rawls' theory of justice as fairness, Peters contended that social disparities in health are unjust or inequitable when they stem from an unjust foundational framework of society.[103]

The Rawlsian concept of democratic equality also entails adherence to a principle ensuring fair equality of opportunity. This principle necessitates substantial measures aimed at alleviating the impacts of socioeconomic disparities and other societal circumstances on equal opportunity. In summary, Rawls' principles of justice govern the allocation of crucial social determinants of health. When comprehensively interpreted, justice as fairness guides us on what is necessary for justice in distributing all socially manageable determinants of health.[104]

[100] https://www.scribd.com/document/373347349/Amartya-Sen-Public-Health-Ethics-and-Equity on 2nd February 2024.

[101] https://www.scribd.com/document/373347349/Amartya-Sen-Public-Health-Ethics-and-Equity on 2nd February 2024.

[102] Ekmekci, Perihan Elif,. "Enhancing John Rawls's theory of justice to cover health and social determinants of health." 227.

[103] Peter Fabienne. "Health equity and social justice." *Journal of applied philosophy* (2001): 163.

[104] Daniels, Norman,. "Why justice is good for our health." *Interfaces between bioethics and the empirical social sciences*, 47.

3.0 CHAPTER THREE

3.1 The legal and policy framework of the NHIF and the SHIF

The National Health Insurance Fund Act of 1998, updated in 2022, outlines the formation of the National Health Insurance Fund (NHIF Fund) and the National Health Insurance Fund Management Board (NHIF Board), as well as procedures for contributions to and disbursement of benefits from the NHIF Fund. According to Section 3 of the NHIF Act, the NHIF Fund comprises funds allocated by the National Assembly specifically for the support of indigent and vulnerable individuals. Under the Act, an "indigent" is described as; "a person who is poor and needy to the extent that the person cannot meet the basic necessities of life." It defines a vulnerable person as "one who needs special care, support or protection, including orphans and vulnerable children, widows or widowers, a person with a disability, elderly persons or indigent due to a risk of abuse or neglect and who has been identified as such by the relevant government body." Section 4 of the Act establishes a Board of Management for the National Hospital Insurance Fund, comprising a Chairman appointed by the President, representatives from various organizations such as the Federation of Kenya Employers (FKE), Central Organisation of Trade Unions (COTU), Kenya National Union of Teachers (KNUT), Kenya Union of Post Primary Education Teachers (KUPPET), Kenya Medical Association (KMA), and faith-based organizations, as well as the Principal Secretaries of Health and Treasury, and the Director of Medical Services.

According to Section 5(1)(g) of the NHIF Act, one of the aims of the Board is to support the achievement of universal health coverage through health insurance. Additionally, Section 15 of the Act stipulates that individuals who are ordinarily residents in Kenya, aged 18 and above, and earn income from salary or self-employment are obligated to contribute to the Fund. Section 15(1B) of the NHIF Act holds the National Government responsible for contributing to the NHIF fund for the benefit of indigent and vulnerable individuals identified by the relevant governmental entity. Under section 16, employed contributors are required to make the standard contribution through monthly deductions from their salary or other earnings, with their employer responsible for deducting and remitting the contribution to the Board on their behalf. Failure to pay the standard contribution without a valid reason constitutes an offense.

Self-employed individuals under section 19 are obligated to make monthly special contributions to the NHIF at a prescribed rate. Failure to remit these contributions promptly

incurs a penalty equal to five times the contribution amount. The Act also stipulates that neglecting to submit these special contributions constitutes an offense. Section 20 permits voluntary contributions in accordance with the Act. Section 22 outlines the procedures for benefit payments and restricts benefits disbursed from the Fund to expenses related to pharmaceuticals, laboratory examinations, , doctor's fees, as well as food and lodging expenses.

The Board is empowered by Section 30, in collaboration with the Minister and the chairman of the Medical Practitioners and Dentists Board, to designate any hospital, nursing home, or maternity home as a recognized healthcare facility under the Act. Additionally, Section 34 grants the Board authority to invest NHIF funds. It is also authorized to provide financial assistance to any designated hospital for the enhancement of medical and healthcare services, provided it is convinced that the hospital is financially sustainable and located in an underserved area. The Auditor-General conducts audits of the NHIF, with the Cabinet Secretary responsible for presenting the audit report to the National Assembly within nine months of receiving it.

The Social Health Insurance Act, 2023 (SHIA) marks a significant shift in Kenya's healthcare landscape, which intends to replace the National Health Insurance Fund (NHIF) with a more comprehensive and inclusive framework for managing social health insurance. In a Gazette Notice issued on November 21, 2023, the Cabinet Secretary for Health announced November 22, 2023, as the official commencement date for the Social Health Insurance Act, 2023 (SHIA). However, a recent decision by the High Court has halted its implementation until February 2024, due to insufficient public participation. Despite this delay, the Act signifies a fundamental change in healthcare financing, aiming to provide universal coverage and financial protection to all Kenyans.

One of the central components of the SHIA is the establishment of the Social Health Authority, managed by a Board, as detailed in Section 4. This Authority holds critical functions, including receiving contributions, contracting healthcare providers and carrying out governmental directives concerning social health insurance, as stipulated in Section 5.

The Primary Healthcare Fund, as established in section 20, is funded partly by appropriations from the National Assembly and designated to procure primary healthcare services from health facilities. The establishment of the Social Health Insurance Fund, as outlined in Section 25

replaces the NHI, aims to ensure every Kenyan is registered as a member, including newborns, and contributions are mandated for all residents exceeding 12 months of residency under section 26. Section 27 delineates the contributions to the SHIF, which differ depending on household categories: employed, self-employed, and individuals requiring financial aid. The Act introduces testing instruments to determine contribution amounts, ensuring affordability and equity. Failure to contribute results in penalties, reinforcing the mandatory nature of participation. Section 28 establishes the Emergency Chronic and Critical Illness Fund, which is financed through National Assembly allocations. It serves to cover chronic illness management and emergency treatments. These funds complement SHIF, ensuring continuous access to healthcare services even after SHIF depletion.

The recent modifications in SHIF, particularly concerning the establishment of the three Funds, are consistent with the WHO's recommendations for health system reform, which emphasize a primary healthcare approach.[105] This strategy ensures that healthcare services are accessible at the community level and delivered with a focus on quality, thereby improving both coverage and financial stability.[106]

3.2 The socio-economic barriers and challenges encountered by Kenya's NHIF in extending Health Insurance Coverage and achieving Universal Health Coverage.

Despite concerted efforts by Kenya's NHIF to extend health insurance coverage and provide universal healthcare services, this endeavor has been fraught with various barriers and challenges. These obstacles encompass a range of issues, including: sociodemographic factors and a lack of knowledge regarding NHIF benefits and processes were identified as major impediments to healthcare accessibility.[107] Citizens were particularly frustrated over inadequate information regarding registration, membership processes, and benefit entitlements,

[105] Simiren N, "An Analysis of the Social Health Insurance Act and General Regulations, 2023 " https://vellum.co.ke/an-analysis-of-the-social-health-insurance-act-and-general-regulations-2023/?cv=1 on 20th February 2024.

[106] Kazungu, Jacob S., and Edwine W. Barasa. "Examining levels, distribution and correlates of health insurance coverage in Kenya." *Tropical Medicine & International Health* 22, no. 9 (2017): 1181-1182. https://pubmed.ncbi.nlm.nih.gov/28627085/ on 3rd January 2024.

[107] Wambua, Ruth M. "Association Between Health Insurance and Access to Universal Health Care in Makueni County, Kenya." PhD diss., University of Nairobi, 2022.

compounded by inconsistent communication from NHIF.[108] This highlighted the need for targeted interventions aimed at enhancing awareness among potential beneficiaries and streamlining NHIF procedures. An emphasis was also made on the need to tackle financial barriers for the sake of accessibility.[109]

Substantial deficiencies were also found in the areas of adequacy, acceptability, affordability, physical accessibility and availability for all citizens[110]. This was seen as a result of inadequate communication from the NHIF as aforementioned, and lack of accountability mechanisms[111]. The importance of utilising community structures such as chief barasas and religious institutions to bridge information gaps and improve citizen engagement with NHIF services was regarded as paramount.[112] The critical role of consistent drug supply in improving healthcare access was also underscored. [113]

Transparency and accountability concerns significantly eroded public confidence in NHIF's role as a primary healthcare provider.[114] The disparities between the benefits outlined in the official package and the benefits individuals actually receive introduced further intricacy into the situation. This inconsistency eroded trust and exacerbated confusion among beneficiaries, potentially deterring them from seeking necessary healthcare services.[115] Administrative

---

[108] Oraro-Lawrence, Tessa, and Kaspar Wyss. "Policy levers and priority-setting in universal health coverage: a qualitative analysis of healthcare financing agenda setting in Kenya." *BMC health services research* 20 (2020): 2.

[109] Gatehi, Miriam Wangari. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya." PhD diss., KeMU, 2022.

[110] Chelogoi, Davies N., Fred O. Jonyo, and Henry Amadi. "The Influence of Socio-Cultural Factors in Access to Healthcare in Kenya: A Case of Nairobi County, Kenya." *Journal of Social and Political Sciences* 3, no. 3 (2020).

[111] Oraro-Lawrence, Tessa, and Kaspar Wyss. "Policy levers and priority-setting in universal health coverage: a qualitative analysis of healthcare financing agenda setting in Kenya." *BMC health services research* 20 (2020): 2. Gatehi, Miriam Wangari. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya.".

[112] Okumu, Mary. "Determinants of Health Insurance Uptake Among Informal Sector Workers: a Case of National Health Insurance Fund Program at Kenyatta Market, Kibra Sub-county, Kenya." PhD diss., University of Nairobi, 2023.

[113] Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya." PhD diss., 2020.

[114] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1 on 28th Ocober 2023

[115] Barasa, Edwine W., Njeri Mwaura, Khama Rogo, and Ledia Andrawes. "Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." *Wellcome open research* 2

inefficiencies in the enrollment processes exacerbated the health insurance coverage process, creating barriers to entry for those most in need. Moreover, the existence of multiple payer mechanisms skewed priorities towards civil servants, widening coverage gaps and fostering discontent among marginalised groups. Consequently, informal sector individuals face heightened financial vulnerability due to reliance on out-of-pocket payments.[116] Moreover, cases of discrimination by healthcare providers against NHIF members, when compared to individuals paying with cash or those covered by private insurance, were observed.[117]

Regulatory weaknesses, particularly in strategic purchasing practices, limited NHIF's ability to tailor benefit packages to meet population needs and national priorities effectively.[118] Inadequate resources, compounded by low premium contributions from the informal sector, hampered NHIF's efforts to broaden coverage, exacerbating disparities in access to healthcare services.[119] Given the significant presence of an informal sector and with about half of the population residing below the poverty threshold, accomplishing widespread and fair coverage through contributory and voluntary means posed considerable difficulties.[120]

The challenges highlighted above prompted strategically designed reforms within the NHIF to address the socio-economic challenges identified within Kenya's health insurance system. Firstly, the implementation of the Civil Servants Scheme (CSS) in 2012 targeted the disparity in healthcare accessibility. This initiative extended a broader range of benefits, encompassing comprehensive outpatient and inpatient services, to formal sector government employees and

(2017). https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1 on 1st January, 2024.

[116] Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1 on 28th October 2023.

[117] Barasa, Edwine W., Njeri Mwaura, Khama Rogo, and Ledia Andrawes. "Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." *Wellcome open research* 2 (2017). https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1 on 1st January, 2024.

[118] Njoka, Jamleck M. "Effectiveness Of Purchasing Mechanisms In Achieving Universal Health: A Case Of National Hospital Insurance Fund In Kenya, 2010-2018." PhD diss., University of Nairobi, 2022.

[119] Munge, Kenneth, Stephen Mulupi, Edwine W. Barasa, and Jane Chuma. "A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund." *International journal of health policy and management* 7, no. 3 (2018): 244

[120] Kazungu, Jacob S., and Edwine W. Barasa. "Examining levels, distribution and correlates of health insurance coverage in Kenya." *Tropical Medicine & International Health* 22, no. 9 (2017): 1181-1182. https://pubmed.ncbi.nlm.nih.gov/28627085/ on 3rd January 2024.

their dependents.[121] The objective of the CSS was to narrow the divide among various socio-economic strata and guarantee more even-handed access to high-quality healthcare services.[122] Secondly, the Stepwise Quality Improvement System program, initiated in 2013, directly tackled the issue of insufficient healthcare quality, particularly in resource-constrained environments. Through offering guidance and technical aid to primary healthcare providers, the program sought to elevate the provision of secure and high-quality healthcare services.[123] This endeavor strengthened the enhancement of healthcare quality, especially at the grassroots level, where access to high-quality healthcare might be constrained.

Thirdly, the Health Insurance Subsidy Program (HISP) and Subsidy Programs for Older Persons and Persons with Severe Disabilities (OPPPD) were introduced to provide healthcare coverage for vulnerable groups, including indigents, older persons, and disabled individuals.[124] By offering outpatient and inpatient care tailored to the specific needs of these populations, these programs aimed to address socio-economic disparities in healthcare access and ensure inclusivity. Lastly, the rebranded *Linda Mama* Program launched in 2016 directly targeted maternal and infant health challenges, which are often exacerbated by socio-economic factors. By offering a comprehensive benefits package to expectant mothers, including antenatal, delivery, postnatal care, and infant care, the program aimed to improve maternal and child health outcomes and address disparities in access to essential healthcare services.[125]

In conclusion, the challenges faced by Kenya's National Health Insurance Fund (NHIF), ranging from sociodemographic barriers to administrative inefficiencies and regulatory weaknesses, have underscored the pressing need for reform within the country's health

---

[121] Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." *Health Systems & Reform* 4, no. 4 (2018): 350.

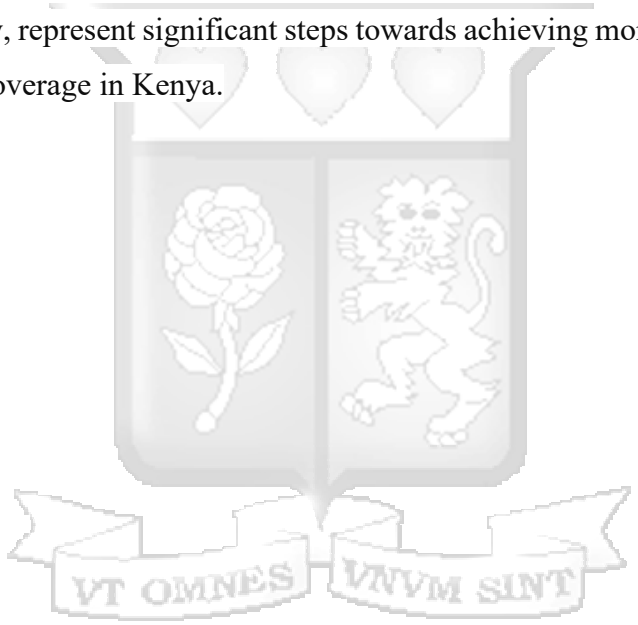
[122] Barasa, Edwine, "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." 350.

[123] Barasa, Edwine, "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage.", 350.

[124] Barasa, Edwine, "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage.",350.

[125] Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

insurance system. Issues such as a lack of awareness about NHIF benefits and processes, compounded by inconsistent communication, hindered healthcare accessibility, while discrepancies between promised and received benefits eroded public trust. In response, the NHIF strategically designed reforms, including the Civil Servants Scheme (CSS) introduced in 2012 to address healthcare inequality by extending comprehensive services to formal sector government workers. Subsequent initiatives such as the Stepwise Quality Improvement System aimed at enhancing healthcare quality, particularly in resource-restricted areas, while subsidy programs for vulnerable groups like indigents and older persons aimed to mitigate socio-economic disparities in access. Furthermore, the rebranded Linda Mama Program, targeting maternal and infant health challenges, reflects a concerted effort to address socio-economic factors exacerbating healthcare disparities. These reforms, aimed at bridging gaps in access, quality, and inclusivity, represent significant steps towards achieving more comprehensive and equitable healthcare coverage in Kenya.



4.0 CHAPTER FOUR

4.1 Lessons drawn from South Korea's Positive Experience in extending health insurance to its citizens.

South Korea's remarkable journey towards achieving universal health coverage (UHC) offers invaluable lessons for Kenya as it endeavors to make quality healthcare accessible to all its citizens. As Kenya grapples with challenges in premium collection and administrative expenses, South Korea's decentralized collection approaches and focus on addressing equity concerns provide actionable insights. By embracing South Korea's successful strategies while tailoring them to its own context, Kenya can pave the way towards achieving UHC, ensuring economic viability and equitable access to healthcare for all its citizens.

An inspection of South Korea's healthcare framework reveals that it was inspired by Bismarck's plan for Germany in the 1880s, with adaptations to suit its modern developing context. One crucial aspect was determining priority groups for coverage initiation.[126] While the Korean government debated this issue, the program eventually began with those in greatest need, such as rural residents and the self-employed.[127] Expanding health insurance coverage to incorporate self-employed individuals, notably farmers in rural regions, sparked protests due to perceived inequities in full contributions compared to subsidized payments made by formal sector employees. In reaction, the government introduced a partial subsidy, covering half of the self-employed individuals' contributions, thereby encouraging their enrollment.[128]

Originally implemented for industrial workers in 1977, South Korea's UCHIS was later expanded to cover the entire populace by 1989. This expansion stands as a testament to the efficient governance and coordination facilitated by the National Health Insurance Corporation (NHIC), under the auspices of the Ministry of Health and Welfare. The transition to a single-payer model in 2000 facilitated efficient risk pooling and financial sustainability, ensuring

[126] Lehmbruch, Gerhard. "The institutional embedding of market economies: the German 'model' and its impact on Japan." *The origins of non-liberal capitalism: Germany and Japan in comparison* (2001): 58-60.

[127] Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?" *Health Policy* 20, no. 3 (1992): 294.

[128] Kwon, Soonman. "Advancing universal health coverage: what developing countries can learn from the Korean experience?" (2018).

accountability and efficiency in healthcare delivery.[129] Key features of South Korea's UCHIS, such as mandatory enrollment, family-based membership, and subsidies for the poor and self-employed, played pivotal roles in extending coverage and minimizing dropouts. Incremental benefit coverage, including outpatient care, further enhanced enrollees' experiences and contributed to the success of the system.[130]

The healthcare system in South Korea progressed gradually, starting with compulsory coverage for corporations, government staff, and educators, and progressively broadening to encompass impoverished individuals, self-employed persons, and residents in rural areas.[131] Each scheme is managed independently by insurance societies, responsible for setting premiums, co-payments, and ensuring financial viability.[132] By 1991, public funds covered 30% of healthcare expenditures, accounting for 7.1% of GDP. South Korea's healthcare reforms have successfully achieved universal coverage, provided comprehensive services, and mitigated adverse selection. The system's financial sustainability, equitable cost distribution, and government subsidies for those in need have ensured economic viability without unduly burdening small businesses.[133] Peabody's research provides important lessons for Kenya, highlighting the significance of incremental reforms, mandatory coverage, independent management by insurance societies, and equitable cost distribution in achieving universal health coverage.[134]

Premium collection posed challenges, especially in rural areas, leading to the development of new premium rating methods and decentralized collection approaches involving insurance societies and village chiefs, which ultimately improved collection rates.[135] However, administrative expenses remained a significant challenge, with costs comprising a considerable

---

[129] Lee, Jong-Chan. "Health care reform in South Korea: success or failure?" *American journal of public health* 93, no. 1 (2003): 48.

[130] Kwon, Soonman. "Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage." *Health policy and planning* 24, no. 1 (2009): 63-71.

[131] Chun, Chang Bae, Soon Yang Kim, Jun Young Lee, Sang Yi Lee, and World Health Organization. "Republic of Korea: health system review." (2009).

[132] Peabody, John W., Sung-Woo Lee, and Stephen R. Bickel. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." *Health Policy* 31, no. 1 (1995): 33

[133] Peabody, John W. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." 35

[134] Peabody, John W. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." 42.

[135] Anderson, Gerard V. "Universal health care coverage in Korea." *Health affairs* 8, no. 2 (1989): 26.

portion of premiums and escalating over time.[136]The importance of addressing equity concerns and implementing targeted subsidies to encourage enrollment among the informal sector has been greatly underscored.[137]

In conclusion, an examination of South Korea's Universal Comprehensive Health Insurance System (UCHIS), offers valuable insights into successful population and benefit coverage expansion strategies. South Korea's experience can serve as a valuable model for Kenya in structuring institutional frameworks, financing mechanisms, and policy strategies to advance towards universal health coverage. By examining South Korea's successful approach to achieving UHC, policymakers in Kenya can gain insights into how to design and implement effective healthcare reforms tailored to their own context.

[136] Lee, Tae-Jin. "Universal health coverage assessment: South Korea." *Global Network for Health Equity (GNHE)* (2015).

[137] Kwon, Soonman. "Advancing universal health coverage: what developing countries can learn from the Korean experience?." (2018).

5.0 CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 Conclusion

In conclusion, this study has illuminated a persistent issue: despite NHIF's earnest endeavors to expand universal health coverage, socio-economic barriers persist, thereby impeding Kenya's progress. While commendable reforms have been initiated within the institution to address these challenges, further action is warranted. By drawing insights from both domestic experiences and South Korea's experiences, this study offers valuable guidance for crafting targeted interventions and implementing impactful reforms.

5.2 Recommendations

Drawing from the experiences of both the NHIF and South Korea's healthcare system, various suggestions arise to improve health insurance inclusivity and advance towards attaining universal health coverage (UHC) in Kenya. Firstly, comprehensive policy reforms are imperative to bolster healthcare accessibility and awareness. From the analysis conducted earlier on in this study, significant challenges were underscored, highlighting substantial deficiencies in accessibility, a lack of knowledge in NHIF's benefit packages and resource limitation. To mitigate these barriers, targeted interventions, including widespread campaigns through diverse communication channels and financial support programs like subsidies, can enhance access, especially for low-income individuals and families. By increasing awareness of health insurance benefits and procedures, these initiatives foster a more inclusive and informed healthcare landscape, essential for advancing towards UHC.

Legal reforms are equally vital for fostering accountability and fairness within the healthcare system. Transparency and accountability concerns as earlier identified, coupled with the disparities between the benefits outlined in the official package and the benefits individuals actually received, underscore the need for legal reforms. Strengthening legal frameworks in order to ensure transparent benefit packages, mechanisms for addressing grievances, and anti-discrimination legislation safeguards against disparities in healthcare access, which is crucial. By promoting equitable treatment and access to services regardless of payment method, legal provisions uphold principles of inclusivity and fairness which are pivotal for building public trust and confidence in the health insurance system.

Institutional reforms to the organisational structures governing healthcare financing and provision are pivotal for optimizing the efficiency and effectiveness of healthcare delivery.

Challenges such as socio-demographic factors, hindered community engagement and inconsistency in the drug supply chain management which consequently impeded NHIF's efforts. By leveraging community engagement strategies such as *chamas,* youth groups, interfaith groups and community-based organisations, coupled with partnering with local leaders can bridge information gaps as well as improve citizen engagement. Bolstering drug supply chain management systems can ensure consistent access to medications and medical supplies. Additionally, adopting strategic benefit packages that align with population health needs promotes optimal resource allocation and coverage. By continuously assessing and adjusting benefit packages, healthcare systems can adapt to evolving healthcare demands, ensuring sustainability and efficiency in service delivery, essential components of achieving UHC.

.

BIBLIOGRAPHY

Abuya, Timothy, Thomas Maina, and Jane Chuma. "Historical account of the national health insurance formulation in Kenya: experiences from the past decade." *BMC health services research* 15, no. 1 (2015): 7.

Allan, H., 2010. Mentoring overseas nurses: barriers to effective and non-discriminatory mentoring practices. Nursing ethics, 17(5),.607.

Amoloye-Adebayo, Azizat O. "Violations of socio-economic rights in developing states: a case for the recognition of the right to inheritance in international human rights law." *88.*

Anderson, Gerard V. "Universal health care coverage in Korea." *Health affairs* 8, no. 2 (1989): 26.

Barasa, Edwine W., Njeri Mwaura, Khama Rogo, and Ledia Andrawes. "Extending voluntary health insurance to the informal sector: experiences and expectations of the informal sector in Kenya." *Wellcome open research* 2 (2017). https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1

Barasa, Edwine, Khama Rogo, Njeri Mwaura, and Jane Chuma. "Kenya National Hospital Insurance Fund Reforms: implications and lessons for universal health coverage." *Health Systems & Reform* 4, no. 4 (2018): 352-359.

Chelogoi, Davies N., Fred O. Jonyo, and Henry Amadi. "The Influence of Socio-Cultural Factors in Access to Healthcare in Kenya: A Case of Nairobi County, Kenya." *Journal of Social and Political Sciences* 3, no. 3 (2020).

Chun, Chang Bae, Soon Yang Kim, Jun Young Lee, Sang Yi Lee, and World Health Organization. "Republic of Korea: health system review." (2009).

Daniels, Norman, Bruce Kennedy, and Ichiro Kawachi. "Why justice is good for our health." *Interfaces between bioethics and the empirical social sciences. Publication Series-2002. Santiago de Chile: Regional Program on Bioethics, PAHO, WHO* (2002): 40.

Ekmekci, Perihan Elif, and Berna Arda. "Enhancing John Rawls's theory of justice to cover health and social determinants of health." 227.

Explanation of the Benefit Package for the National Scheme, 2015, 3.

Gatehi, Miriam Wangari. "Factors Influencing Access to Health Services for NHIF Insured Persons within Makadara Constituency, Nairobi County, Kenya." PhD diss., KeMU, 2022.

Hunt, Paul, and Gunilla Backman. "Health systems and the right to the highest attainable standard of health." *Health and human rights* (2008): 81

Jung, Jin-Kyung. "Social Health Insurance for Informal Sector on the path to Universal Health Coverage: A Case of Kenya National Hospital Insurance Fund (NHIF)." https://www.grafiati.com/en/literature-selections/health-insurance-kenya/journal/?cv=1

Kazungu, Jacob S., and Edwine W. Barasa. "Examining levels, distribution and correlates of health insurance coverage in Kenya." *Tropical Medicine & International Health* 22, no. 9 (2017): 1181-1182. https://pubmed.ncbi.nlm.nih.gov/28627085/ .

Kinyua, Benson. "A Revolution of Human Rights in Kenya: Assessing the Enforceability of Socio-Economic Rights Under the Constitution of Kenya 2010." *Available at SSRN 1864585*(2011).

Kwon, Soonman. "Thirty years of national health insurance in South Korea: lessons for achieving universal health care coverage." *Health policy and planning* 24, no. 1 (2009): 63-71

Kwon, Soonman. "Advancing universal health coverage: what developing countries can learn from the Korean experience?." (2018).

Lee, Jong-Chan. "Health care reform in South Korea: success or failure?." *American journal of public health* 93, no. 1 (2003): 48.

Lehmbruch, Gerhard. "The institutional embedding of market economies: the German 'model'and its impact on Japan." *The origins of nonliberal capitalism: Germany and Japan in comparison* (2001): 58-60.

Makokha, Timothy. "An examination of the legal, policy and institutional framework for universal health coverage in Kenya." *University of Nairobi* (2019)

.

Mbau, R., Kabia, E., Honda, A. *et al.* Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. *Int J Equity Health* 19 (2020). https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x

Mulupi, Stephen, Doris Kirigia, and Jane Chuma. "Community perceptions of health insurance and their preferred design features: implications for the design of universal health coverage reforms in Kenya." *BMC health services research*13, no. 1 (2013): 5-11.S

Munge, Kenneth, Stephen Mulupi, Edwine W. Barasa, and Jane Chuma. "A critical analysis of purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund." *International journal of health policy and management* 7, no. 3 (2018): 244

Mwangi, Eunice Muthoni. "National Hospital Insurance Funds Purchasing Mechanism and Access to Primary Care Health Services in Kenya." PhD diss., 2020.

Okumu, Mary. "Determinants of Health Insurance Uptake Among Informal Sector Workers: a Case of National Health Insurance Fund Program at Kenyatta Market, Kibra Sub-county, Kenya." PhD diss., University of Nairobi, 2023.

Orago, Nicholas Wasonga, "Limitation of Socio-Economic Rights in the 2010 Kenyan Constitution: A Proposal for the Adoption of a Proportionality Approach in the Judicial Adjudication of Socio-Economic Rights Disputes' https://doi.org/10.17159/1727-3781/2013/v16i5a2433

Ouma, Smith. "Structural Impediments to Access to Health Care in Kenya and the Promises of the New Constitutional Order." *Available at SSRN 3451841* (2016).

Peabody, John W., Sung-Woo Lee, and Stephen R. Bickel. "Health for all in the Republic of Korea: one country's experience with implementing universal health care." *Health Policy* 31, no. 1 (1995): 42.

Peter, Fabienne. "Health equity and social justice." *Journal of applied philosophy* (2001): 159-170.

Rawls, John. "A theory of justice." In *Applied Ethics*, Routledge, 2017, 25.

Ruger, Prah J, and Hak-Ju Kim, 'Out of pocket healthcare spending by the poor and chronically ill in the Republic of Korea.'803.

Simiren N, "An Analysis of the Social Health Insurance Act and General Regulations, 2023 " https://vellum.co.ke/an-analysis-of-the-social-health-insurance-act-and-general-regulations-2023/?cv=1

Wambua, Ruth M. "Association Between Health Insurance and Access to Universal Health Care in Makueni County, Kenya." PhD diss., University of Nairobi, 2022.

Wasonga, Obat Joseph, and P. L. O. Lumumba. "Socio-economic and cultural rights under the 2010 Constitution of Kenya: justiciable or aspirational?." *Africa Nazarene University Law Journal* 3, 1 (2015), 125.

Yu, Seung-Hum, and Gerard F. Anderson. "Achieving universal health insurance in Korea: a model for other developing countries?." *Health Policy* 20, no. 3 (1992): 294.

https://www.who.int/health-topics/universal-health-coverage

https://vellum.co.ke/an-analysis-of-the-social-health-insurance-act-and-general-regulations-2023/?cv=1

VT OMNES
VNVM SINT