



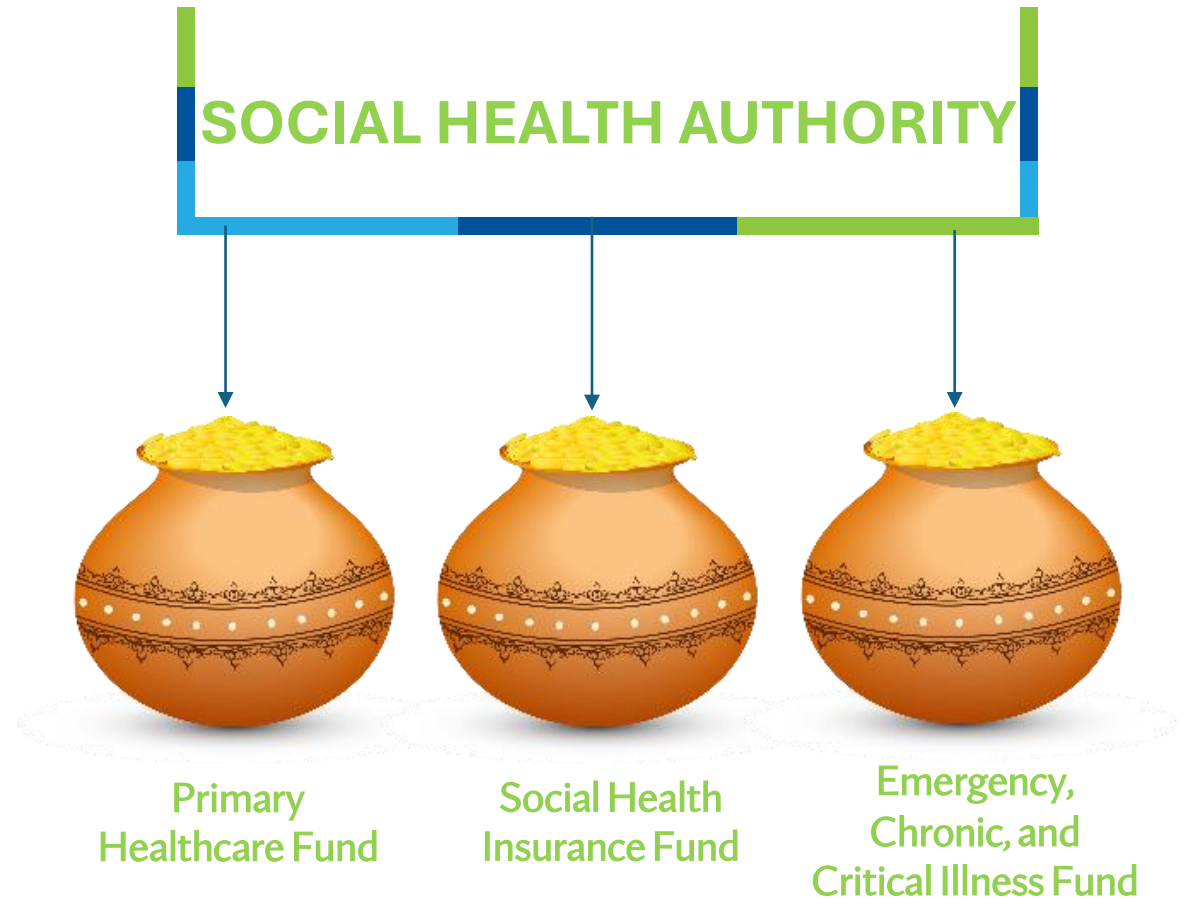
Bima Bora, Afya Nyumbani

WHERE ARE WE



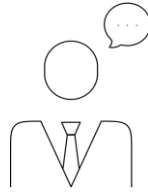
The Social Health Authority

The Social Health Authority (SHA) is mandated to manage and oversee Kenya's social health insurance system, ensuring that all residents have equitable access to quality, affordable healthcare services without financial hardship.



TRANSITION GOALS

National Health Insurance Fund



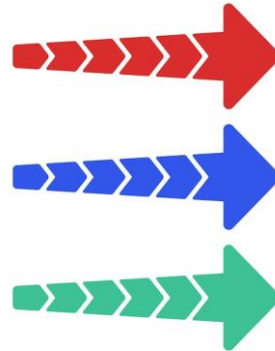
Regressive Funding Model – Low-income earners paid more

Purely insurance-based (member's club), disadvantaged the vulnerable populations

Informal Sector quagmire – 83.5% of employed persons. Voluntariness led to adverse selection

Fragmented pools hindered equity in access

Underfunded primary healthcare facilities



Social Health Authority



Equitable – contribution based on a standard percentage of total income

Government Funding (taxes) for free Primary Health Services and Emergency Care accessible to all Kenyans.
Targeted financing for vulnerable populations.

Mandatory cover for all Kenyans – Target 85%, with strategies to net the informal sector

Review of the financing model: One progressive benefit package to cover at least 70% of the disease burden

Investment in primary healthcare facilities

KEY ACHIEVEMENTS



Overall Registrations – 21,796,423



Average registrations per day – 45,000



Submitted claims – 2.4 million worth 55 Billion



147 Call centre

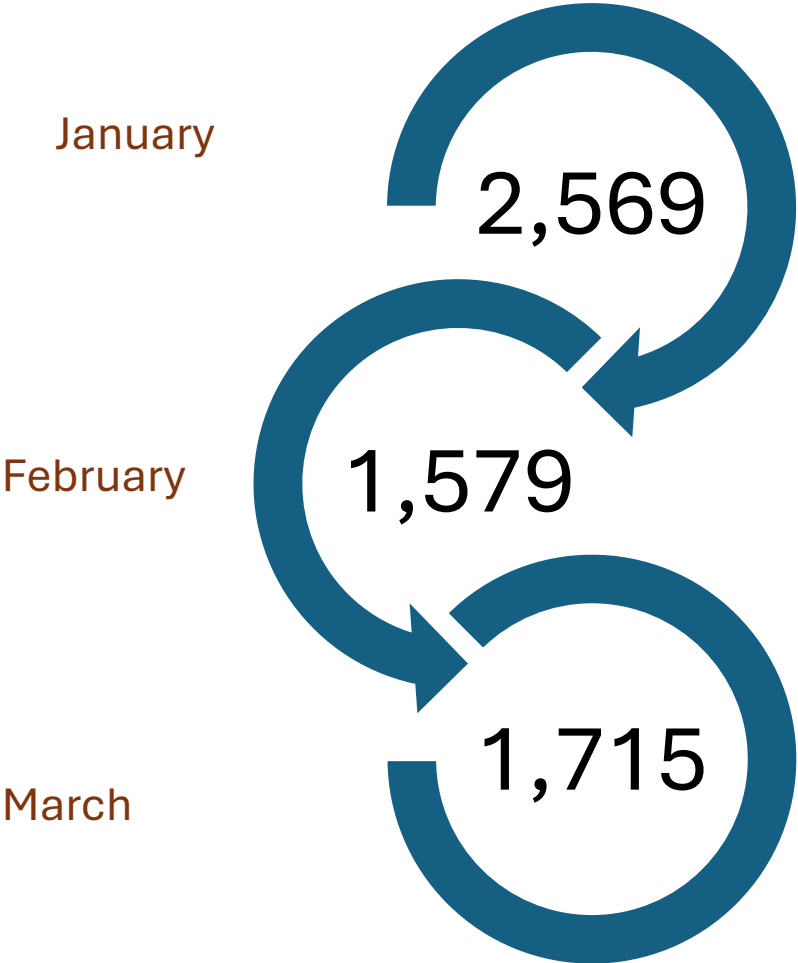
ACCESS TO OTHER BENEFITS



FBO PERFORMANCE

Benefits	Claim Value	Dist.	National Dist.
Accident & Emergency services	15,644,036	0.2%	0.1%
Critical Care Services	27,555,120	0.3%	0.4%
Eye Health	2,750	0.0%	0.0%
Hematology and Oncology	333,581,176	3.7%	6.6%
Inpatient Services	2,666,034,668	29.9%	44.4%
Maternity and Newborn Health	784,859,562	8.8%	0.0%
Medical Imaging	116,355,355	1.3%	10.2%
Mental Wellness	1,413,040	0.0%	1.4%
Outpatient Services	1,457,273	0.0%	1.1%
Palliative Care	4,580,240	0.1%	0.0%
Renal Care Services	804,890,650	9.0%	7.1%
Specialised Laboratory Services	136,349	0.0%	0.0%
Surgical Services	4,155,426,555	46.6%	28.5%
	8,912,596,080		

Average reimbursement per visit for PHC outpatient










Highest financial efficiency across the different provider categories

Average Reimbursement for 3 months	
Government	1,386
FBO	1,880
Private	1,831

CHALLENGES

Emerging issues

-  Formal sector registration and contributions on track
-  Informal sector collections remain below target (~500,000 households)
-  Progress underway in identifying and subsidising indigent households
-  Initial rollout challenges of the new system are still being addressed
-  Limited understanding of benefit packages among members and providers
-  Outstanding NHIF legacy bills impacting transition
-  Need for stronger public awareness and trust-building

Way forward



Strengthening informal sector engagement



IPF for the informal sector



Stabilise the system Implementation



Biometrics roll out



Monitor, evaluate, and Adapt: Use data-driven insights to refine benefits access



Strengthening POMF roll out: System-wise and facility contracts

Contacts

Customer Experience Centre

- Toll Free Line: 147

Social Media Handles

- Facebook/Instagram: @SocialHealthAuthority
- X: @_SHAKenya
- Website: www.sha.go.ke
- LinkedIn: @SocialHealthAuthority
- TikTok: SocialHealthAuthority





THANK YOU

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Primary Healthcare Services



How it works

- **Participating facilities:** Level 2, Level 3, all Level 4 County Hospitals and select Level 4 Private and Faith-based hospitals that opt to offer outpatient PHC services.
- **Capitation:** Each County receives *KES 75 p.m. per beneficiary (KES 900 annually)*.
- **Facility Share:** Capitation is shared among participating facilities monthly based on *the recorded visits* captured by each hospital.

From NHIF to SHA: How Capitation Has Evolved in Kenya

NHIF MODEL	SHA MODEL
 Fixed to 1 facility for 6 months	 Free choice across the County
 Based on selected enrolees (7M/16M)	 Based on all registered persons (14M)
 Formula: population only	 Formula: population + disease burden
 Paid quarterly	 Paid monthly

SHA's model promotes portability of service, equity, allocative efficiency, incentivize quality of care, aligning funds with both service utilization and disease burden.