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# UNIVERSAL HEALTH COVERAGE IN KENYA: FINANCING MECHANISMS AND POLICY OPTIONS FOR SUSTAINABLE HEALTHCARE DELIVERY.

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## ABSTRACT

Kenya's pursuit of Universal Health Coverage (UHC) faces critical financing challenges threatening sustainability and equity. This article examines Kenya's healthcare financing landscape following the 2024 transition from NHIF to the Social Health Insurance Fund (SHIF). Using household expenditure data from 18,450 households and health facility records (2019-2024), we assess financing adequacy, equity, and sustainability through descriptive analysis, benefit incidence analysis, and microsimulation modeling. The findings reveal that healthcare spending of 4.8% of GDP remains below the 15% Abuja target, with out-of-pocket expenditure at 27% of total health spending, exceeding the UHC threshold of 20%. Catastrophic health expenditure affects 11.3% of households, reaching 23.7% among the poorest quintile. SHIF generates approximately KES 98 billion annually, leaving a financing gap of KES 29-180 billion depending on benefit package comprehensiveness. The study proposes a multi-pronged financing strategy combining progressive payroll contributions, earmarked health taxes, efficiency improvements, and strategic purchasing reforms. Our recommendations emphasize evidence-based priority-setting, strengthened primary healthcare, and enhanced financial protection for vulnerable populations while acknowledging implementation challenges within Kenya's devolved governance structure.

**KEYWORDS:** Universal health coverage, healthcare financing, health insurance, equity.

## INTRODUCTION

Access to quality, affordable healthcare remains a fundamental development challenge in Kenya. Despite progress in reducing child mortality and increasing life expectancy, profound

health inequities persist (World Health Organization, 2022). Approximately 1 million Kenyans fall below the poverty line annually due to healthcare costs, while 34% of households report members who forego needed care, with cost cited as the primary barrier in 72% of cases (KNBS, 2024). The transition from the National Hospital Insurance Fund (NHIF) to SHIF in October 2024 marked a fundamental restructuring of healthcare financing.

However, questions persist regarding financing adequacy, equity implications, and implementation capacity. This article addresses four critical research questions:

1. What is the current state of healthcare financing and how does it compare to UHC requirements?
2. Who bears the financial burden and how equitable is the current financing structure?
3. What is the magnitude of the healthcare financing gap for achieving UHC?
4. What feasible policy options exist for sustainable healthcare financing within Kenya's fiscal constraints? This analysis contributes to policy discourse by providing comprehensive empirical analysis of healthcare financing drawing on recent post-SHIF data, examining the entire financing architecture including public expenditure, household spending, and donor contributions.

**Literature Review and Policy Context**

**Theoretical Framework**

Healthcare economics recognizes market failures stemming from information asymmetries, positive externalities, and unpredictable health shocks that justify government intervention. Optimal health insurance balances risk protection against moral hazard, with theory suggesting coverage of high-cost, low-probability events while incorporating cost- sharing for routine expenses (WHO, 2022). Risk pooling mechanisms enable cross-subsidization between healthy and sickness, rich and poor. However, voluntary insurance faces adverse selection problems, potentially triggering a "death spiral" where rising costs drive away healthier members. Mandatory enrollment addresses this but requires effective enforcement (World Bank Group, 2024).

**International Evidence**

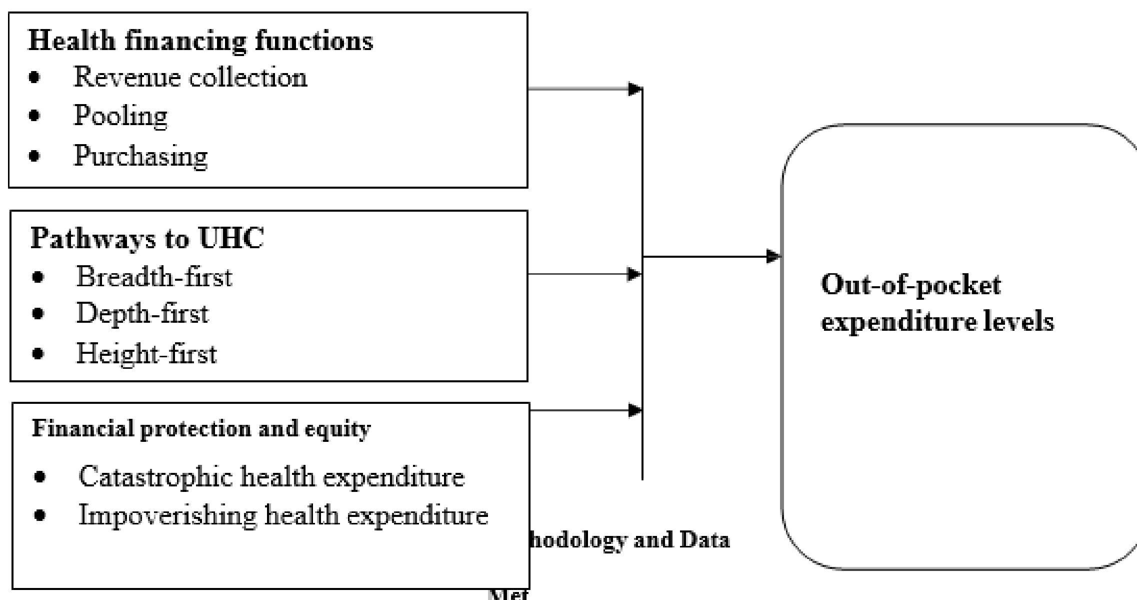
Countries achieving UHC share common features: high prepaid funding (>80% of total health expenditure), low out- of-pocket payments (<20%), and strong primary healthcare systems. Thailand's UHC reforms (2001) expanded coverage from 70% to 99% through tax-financed

universal coverage alongside contributory schemes, increasing health expenditure from 3.4% to 4.1% of GDP. Success factors included political commitment, fiscal space creation, and primary healthcare emphasis (World Bank Group, 2024). Ghana's National Health Insurance Scheme initially achieved substantial coverage expansion but faced sustainability challenges. Overreliance on VAT revenues created fiscal volatility, while weak expenditure controls led to cost escalation and provider reimbursement delays. This demonstrates the importance of sustainable financing and efficient purchasing (Ifeagwu et al., 2021).

**Kenya's Healthcare Financing Evolution**

Kenya’s healthcare financing system has undergone substantial transformation over the decades, shifting from a predominantly tax-funded model to a more diversified insurance-based approach. In the pre-independence and early post-independence period, healthcare relied largely on general taxation with nominal user fees and was delivered through a tiered public system ranging from local health posts to national referral hospitals (Nungo et al., 2025). Despite notable improvements in health indicators, chronic underfunding limited system performance. The introduction of cost-sharing between 1989 and 2013 under World Bank–supported structural adjustment programs marked a major shift; however, user fees suppressed service utilization especially among the poor while contributing less than 5 percent of facility budgets, prompting partial fee removal in 2004 and full removal for maternal and child health services in 2013 (Langat et al., 2025). Meanwhile, the National Hospital Insurance Fund (NHIF), established in 1966, gradually expanded beyond formal sector employees to include voluntary and subsidized members, reaching about 28 million people by 2024 but facing persistent inequities, governance weaknesses, and financial sustainability issues. Efforts to advance universal health coverage included the 2018–2022 pilot in four counties, which boosted utilization but exceeded budget projections (Odipo et al., 2024). In 2024, Kenya replaced NHIF with the Social Health Insurance Fund (SHIF), instituting mandatory coverage, progressive contributions, broader benefits, strengthened governance, and tighter integration with facility financing mechanisms (Langat et al., 2025).

### Conceptual Framework




## Methodology and Data

### Data Sources

This analysis utilizes:

- Kenya Household Health Expenditure and Utilization Survey (KHHUS) 2024: 18,450 households with detailed healthcare utilization, expenditure, insurance coverage, and income data
- National Treasury budget documents (2019-2024): Public health expenditure and SHIF financial statements
- Kenya Health Information System: Facility-level service utilization and quality indicators
- SHIF administrative data: Enrollment, contribution, and claims data

### Analytical Approach

**Equity Analysis:** Employed benefit incidence analysis to allocate public health expenditure and SHIF spending to population quintiles based on utilization patterns. Kakwani indices measure financing progressivity by comparing concentration of health payments to income distribution.

**Financial Protection Analysis:** Measured catastrophic health expenditure (OOP exceeding 10% or 25% of total household expenditure) and impoverishing expenditure (healthcare costs pushing households below poverty line).

**Financing Gap Analysis:** Estimated comprehensive UHC costs using WHO guidelines and Kenya-specific unit costs across three scenarios (basic, comprehensive, full packages), compare to current financing, and calculate gaps.

**Microsimulation:** Using household survey data, we simulate revenue generation under alternative financing mechanisms including enhanced progressive contributions, earmarked health taxes, and efficiency improvements.

### Statistical Analysis

Employment of various statistical techniques:

- **Descriptive statistics:** Means, medians, distributions of key variables
- **Concentration curves and indices:** Measuring inequality in financing and benefits
- **Multivariate regression:** Identifying determinants of catastrophic health expenditure, controlling for household characteristics, insurance status, and health needs
- **Scenario analysis:** Comparing outcomes under different policy options

## RESULTS

### Healthcare Financing Overview

Kenya's total health expenditure reached KES 632 billion (4.8% of GDP) in 2023/24, comprising: **Table 1: Healthcare Financing Sources**

| Financing Source | Amount (KES Billions) | percentage | Per Capita (KES) |
|---|---|---|---|
| Government (National & County) | 218 | 34.50% | 4,160 |
| Social Health Insurance (SHIF) | 98 | 15.50% | 1,870 |
| Out-of-Pocket Expenditure | 171 | 27.10% | 3,260 |
| Development Partners | 92 | 14.60% | 1,755 |
| Private Health Insurance | 39 | 6.20% | 744 |
| Other sources | 14 | 2.10% | 267 |
| **TOTAL** | **632** | **100%** | **12,056** |

Government health expenditure of 8.2% of total budget falls far below the 15% Abuja target. Per capita government spending of KES 4,160 ($32) compares unfavorably to Rwanda ($61) and South Africa ($87). OOP payments of 27.1% significantly exceed the UHC threshold of 20%, exposing households to financial risk.

**Table 2: Healthcare Financing - Regional Comparison.**

| Country | THE as % GDP | Govt. Health as % Total Govt | OOP as % THE | UHC Service Coverage Index |
|---|---|---|---|---|
| Kenya | 4.8% | 8.2% | 27.1% | 61 |
| Rwanda | 7.3% | 17.2% | 7.1% | 72 |
| Ghana | 5.8% | 11.4% | 38.2% | 59 |
| Ethiopia | 3.5% | 10.8% | 33.9% | 48 |
| South Africa | 8.1% | 13.9% | 7.3% | 69 |
| Tanzania | 5.2% | 9.1% | 22.8% | 54 |

## Equity in Healthcare Financing

**Financing Incidence:** Out-of-pocket payments are highly regressive, with the poorest quintile bearing 12.4% of OOP burden despite holding only 7.2% of income (Kakwani index: -0.18). Poor households spend 8.9% of income on healthcare versus 3.4% for the richest. SHIF contributions show mild progressivity (Kakwani index: +0.09), representing improvement over NHIF's regressive flat premiums.

**Table 3: Healthcare Financing Incidence by Income Quintile.**

| Quintile | Income Share (%) | OOP Share (%) | SHIF Share (%) | Tax-financed Share (%) | Total HC Financing (% of Income) |
|---|---|---|---|---|---|
| Q1 (Poorest) | 7.2% | 12.4% | 2.8% | 7.8% | 8.9% |
| Q2 | 11.3% | 15.7% | 8.1% | 11.5% | 6.7% |
| Q3 | 16.8% | 19.2% | 16.3% | 17.2% | 5.4% |
| Q4 | 24.1% | 23.9% | 28.5% | 24.7% | 4.8% |
| Q5 (Richest) | 40.6% | 28.8% | 44.3% | 38.8% | 3.4% |
| **Kakwani Index** | — | **-0.18** | **0.09** | **0.02** | **0.08** |

**Geographic Inequities:** County-level analysis reveals substantial disparities. Semi-arid regions experience volatility 35-40% higher than national averages. The poorest counties receive 51% less per capita (KES 8,620) than Nairobi (KES 18,450). SHIF enrollment ranges from 71% in urban areas to 38% in arid regions.

**Table 4: Healthcare Financing by County Category. (Per Capita, KES)**

| County Category | Population (millions) | Government Spending | SHIF Coverage Rate | Total Per Capita | Facilities per 100k |
|---|---|---|---|---|---|
| Nairobi & Major Urban | 6.8 | 6,240 | 71% | 18,450 | 24 |
| High-income Rural | 8.2 | 5,120 | 63% | 13,780 | 18 |
| Middle-income Rural | 18.4 | 3,840 | 52% | 10,240 | 14 |
| Low-income Rural | 14.2 | 3,120 | 41% | 8,620 | 11 |
| Arid & Semi-Arid | 5.1 | 4,680 | 38% | 9,340 | 8 |
| **National Average** | **52.7** | **4,160** | **55%** | **12,056** | **16** |

## Financial Protection

**Catastrophic Health Expenditure:** 11.3% of households face catastrophic costs at the 10%

threshold nationally, but 23.7% of the poorest quintile experience this burden—nearly five times higher than the richest quintile (4.9%). SHIF- enrolled households have 58% lower CHE incidence (8.2%) compared to uninsured (19.4%), but substantial gaps remain. Multivariate analysis reveals that being in the poorest quintile increases CHE risk six-fold (OR: 6.42), while lacking insurance nearly triples risk (OR: 2.87). Chronic illness, hospitalization, rural residence, and female household headship significantly increase vulnerability.

**Table 5: Determinants of Catastrophic Health Expenditure. (Logit Model)**

| Variable | Odds Ratio | 95% CI | P-value |
|---|---|---|---|
| Poorest quintile (ref: richest) | 6.42 | [5.38, 7.65] | <0.001 |
| Second quintile | 4.18 | [3.52, 4.96] | <0.001 |
| Third quintile | 2.71 | [2.29, 3.21] | <0.001 |
| Fourth quintile | 1.83 | [1.54, 2.17] | <0.001 |
| Uninsured (ref: SHIF enrolled) | 2.87 | [2.64, 3.12] | <0.001 |
| Chronic illness in household | 3.24 | [2.98, 3.53] | <0.001 |
| Hospitalization in past year | 4.56 | [4.18, 4.98] | <0.001 |
| Rural residence (ref: urban) | 1.34 | [1.23, 1.46] | <0.001 |
| Household size (per additional member) | 1.08 | [1.06, 1.10] | <0.001 |
| Female-headed household | 1.21 | [1.11, 1.32] | <0.001 |

**Impoverishing Expenditure:** Healthcare costs push approximately 1.2 million Kenyans (2.3% of population) below the poverty line annually, increasing the poverty headcount from 34.8% to 37.1%.

**Table 6: Impoverishing Impact of Health Expenditure.**

| Indicator | Before Healthcare Costs | After Healthcare Costs | Impact |
|---|---|---|---|
| Poverty headcount (%) | 34.80% | 37.10% | +2.3 pp |
| Number of poor (millions) | 18.3 | 19.5 | +1.2 million |
| Poverty gap (%) | 11.20% | 12.40% | +1.2 pp |
| Average distance to poverty line (poor households, KES/month) | 3,840 | 4,670 | 21.60% |

**Benefit Incidence**

Public facilities show pro-poor distribution, with the poorest quintile receiving 24.2% of visits (benefit-incidence ratio: 1.21). However, private facilities heavily favor the rich (richest quintile: 32.7% of visits), and SHIF benefits show slight pro-rich concentration (concentration index: +0.052). Sophisticated services (specialist care, diagnostics, surgery) show steep gradients favoring wealthier quintiles.

**Table 7: Healthcare Utilization and Benefit Incidence.**

| Quintile | Population Share (%) | Public Facility Visits (%) | Private Facility Visits (%) | Total SHIF Benefits (%) | Benefit-Incidence Ratio |
|---|---|---|---|---|---|
| Q1 (Poorest) | 20% | 24.2% | 8.7% | 14.3% | 1.21 |
| Q2 | 20% | 22.8% | 13.4% | 17.2% | 1.14 |
| Q3 | 20% | 20.5% | 18.9% | 20.8% | 1.03 |
| Q4 | 20% | 18.7% | 26.3% | 23.1% | 0.94 |
| Q5 (Richest) | 20% | 13.8% | 32.7% | 24.6% | 0.69 |
| **Concentration Index** | — | **-0.089** | **0.243** | **0.052** | |

**Healthcare Financing Gap Analysis**

Comprehensive UHC costing reveals current financing exceeds basic UHC costs by KES 99 billion, suggesting Kenya could achieve basic universal coverage with improved resource allocation. Comprehensive UHC requires modest additional financing (KES 29 billion, 0.2% of GDP). Full UHC requires substantial mobilization (KES 180 billion, 1.3% of GDP).

**Table 8: UHC Financing Gap Analysis.**

| Component | Basic Package | Comprehensive Package | Full Package |
|---|---|---|---|
| **Cost Requirements** | | | |
| Per capita cost (KES) | 6,500 | 9,200 | 12,400 |
| Total population (millions) | 52.7 | 52.7 | 52.7 |
| **Total UHC Cost** | **343** | **485** | **653** |
| **Current Financing** | | | |
| Government spending | 218 | 218 | 218 |
| SHIF contributions | 98 | 98 | 98 |
| Development partners | 92 | 92 | 92 |
| Sustainable OOP (target: 10% of THE) | 34 | 48 | 65 |
| **Total Available** | **442** | **456** | **473** |
| **Financing Position** | | | |
| Gap/Surplus | **99** | **-29** | **-180** |
| Gap as % of requirement | — | 6.00% | 27.60% |

**SHIF Performance**

SHIF's first year achieved only 18.8% of targeted enrollment (9.9 million of 52.7 million), primarily due to low informal sector participation (22.0% of target). Revenue collections of KES 136 billion fell 14% short of projections. Service utilization (88-89% of projections) suggests supply-side constraints or access barriers. Administrative costs of 11.2% exceed the 8% target, reflecting start-up challenges. Survey of healthcare facilities reveals concerns, 37% of facilities report claim reimbursement delays exceeding 60 days, 42% report rejected claims due to documentation issues, and provider payment rates perceived as inadequate by 58% of

private facilities.

**Table 9: SHIF Performance Indicators (Year 1)**

| Indicator | Target | Actual | Achievement Rate |
|---|---|---|---|
| **Enrollment** | | | |
| Formal sector (millions) | 8.2 | 1.8 | 22.0% |
| Informal sector (millions) | 28.4 | 3.7 | 13.0% |
| Subsidized/indigent (millions) | 16.1 | 4.4 | 27.3% |
| **Total enrolled** | **52.7** | **9.9** | 18.8% |
| **Revenue Collection (KES Billions)** | | | |
| Formal sector contributions | 68 | 72 | 106% |
| Informal sector contributions | 42 | 18 | 43% |
| Government subsidy | 48 | 46 | 96% |
| **Total revenue** | **158** | **136** | **86%** |
| **Service Utilization** | | | |
| Outpatient visits per enrollee | 3.2 | 2.8 | 88% |
| Inpatient admissions per 1,000 | 65 | 58 | 89% |
| **Financial Indicators** | | | |
| Claims paid (KES Billions) | — | 112 | — |
| Administrative costs (% of revenue) | 8% | 11.20% | — |
| Reserve accumulation (KES Billions) | 15 | 24 | 160% |

## Discussion and Policy Implications

### Key Insights

Kenya faces a paradox: sufficient aggregate financing for basic UHC exists, yet financial protection remains inadequate and access inequitable. This stems from inefficient resource allocation, fragmented financing undermining risk pooling, and implementation capacity constraints. The finding that basic UHC is achievable within current financing, if properly allocated, suggests governance and management reforms could yield substantial dividends.

### Critical Trade-offs

**Comprehensiveness vs. Sustainability:** While comprehensive UHC is desirable, the KES 180 billion cost for full coverage represents substantial fiscal burden. Policy must balance benefit breadth with fiscal capacity through prioritization, graduated expansion, or risk-based approaches.

**Mandatory vs. Voluntary:** SHIF mandates universal enrollment but faces enforcement challenges. Strict enforcement may be regressive and difficult; alternatively, enhanced benefits and trust-building could encourage voluntary compliance, or tax-financing could replace contributory mechanisms for informal workers.

**Centralization vs. Devolution:** Healthcare devolution created coordination challenges

between SHIF's centralized financing and county service delivery. Optimal arrangements must balance local responsiveness with national efficiency and equity through strengthened intergovernmental mechanisms.

**Political Economy Considerations**

Healthcare financing reforms face vested interests (private providers, pharmaceutical suppliers, facility managers benefiting from fragmentation), public sector unions resisting payment reforms, county-national tensions over autonomy, and electoral pressures for visible but potentially unsustainable interventions. Success requires stakeholder consultation, transparent communication about trade-offs, and protection of reform momentum.

**Policy Recommendations**

Based on empirical findings and policy analysis, a comprehensive healthcare financing reform agenda organized around five strategic pillars:

**Revenue Mobilization**

**Enhanced SHIF Contributions:** Increase formal sector contribution from 2.75% to 3.5% of gross salary progressively over three years, with higher rates (4.0-4.5%) for incomes above KES 100,000/month. Projected revenue: KES 28-35 billion annually.

**Informal Sector Mechanisms:** Establish tiered contribution system (KES 500-2,500/month) based on observable proxies rather than precise income verification. Leverage mobile money platforms and informal sector associations for enrollment. Subsidize contributions for poorest quintiles. Projected net revenue: KES 6-9 billion.

**Earmarked Health Taxes:** Implement sugar-sweetened beverage tax (KES 5/liter), increase tobacco excise to 50% of retail price, and adjust alcohol duties upward. Dedicate 75% of incremental revenue to SHIF. Projected revenue: KES 17-26 billion annually with public health co-benefits.

**Enhanced Government Allocation:** Increase health budget allocation by 0.5 percentage points annually, reaching 12% of total budget within eight years. Improve budget execution from current 87% average. Protect health spending from austerity cuts.

**Efficiency Improvements**

**Pharmaceutical Procurement Reform:** Establish centralized Kenya National Health Products Authority for bulk procurement, prioritize generics, join regional procurement mechanisms, and publish reference prices. Projected savings: KES 22-30 billion annually.

**Strategic Purchasing:** Transition from fee-for-service to capitation for primary care and case-

based payment (DRGs) for hospitals. Implement pay-for-performance components (10-15% of payments) and pre-authorization for high-cost interventions. Projected savings: KES 50-75 billion through reduced inappropriate care.

**Financial Management:** Enhance transparency through public expenditure tracking, strengthen audit functions, digitize financial flows, mandate competitive procurement, and establish whistleblower protection. Expected savings: KES 35-50 billion from reduced leakage.

**Benefit Package Rationalization**

**Evidence-Based Prioritization:** Establish independent Health Benefits Advisory Committee applying cost- effectiveness criteria to recommend priorities. Implement tiered structure:

- Tier 1 (universal, no cost-sharing): Essential primary care, maternal/child health, preventive services, communicable diseases
- Tier 2 (modest co-payments): Secondary care, selected specialized services
- Tier 3 (conditional coverage): High-cost interventions subject to clinical criteria and fiscal space

**Primary Healthcare Strengthening:** Increase primary care allocation to 40% of public health expenditure. Expand Community Health Promoters from 47,000 to 70,000 (cost: KES 8 billion annually). Invest KES 25 billion over five years in facility upgrading, equipment, and medicine supply. Implement gatekeeping requiring primary care consultation before specialist access.

**Financial Protection for Vulnerable Populations**

**Subsidized Coverage:** Fully subsidize SHIF contributions for bottom two quintiles (21 million individuals, cost: KES 12-15 billion annually). Establish health equity funds for OOP costs of indigent patients (KES 5 billion). Create catastrophic illness fund for extremely high-cost cases (KES 3-4 billion).

**OOP Cost Reduction:** Eliminate user fees for primary care at health centers and dispensaries. Ensure SHIF covers all WHO essential medicines. Provide transportation vouchers for remote area referrals. Waive all co-payments for poor households. Total cost: KES 11-14 billion annually.

**Institutional Strengthening**

**SHIF Capacity Building:** Develop digital enrollment platform linking civil registration and tax data (KES 2 billion investment). Implement automated claims adjudication reducing

processing time from 45-60 days to 14-21 days. Establish health economics and analytics unit. Create decentralized county service centers. Recruit technical specialists (health economists, actuaries, data scientists).

**Intergovernmental Coordination:** Formalize National-County Health Sector Forum for policy coordination. Negotiate county-level service agreements specifying quality standards and payment terms. Develop shared platforms for health information, procurement, and quality assurance. Establish functional referral systems with clear protocols.

**Transparency and Accountability:** Publish quarterly health expenditure reports and facility scorecards. Commission independent evaluations of major reforms. Strengthen facility health committees for participatory monitoring. Engage media proactively for public accountability.

**Implementation Sequencing**

**Phase 1 (Years 1-2):** Quick-win efficiency improvements, institutional frameworks, pilot informal sector mechanisms, expand subsidized enrollment, eliminate primary care user fees, strengthen digital systems.

**Phase 2 (Years 2-4):** Scale successful pilots, implement provider payment reforms, introduce earmarked taxes, increase SHIF rates progressively, expand community health promoters, launch facility upgrading program.

**Phase 3 (Years 4-7):** Achieve 85%+ enrollment, expand benefit package based on fiscal space, full strategic purchasing implementation, comprehensive coordination mechanisms, continuous system improvement.

## CONCLUSION

Kenya's healthcare financing system stands at a critical juncture. While the SHIF transition represents significant policy ambition, substantial challenges remain. Current spending of 4.8% of GDP and government allocation of 8.2% of total budget fall short of commitments, yet our analysis demonstrates that basic UHC is achievable within current resources if complemented by efficiency improvements and reallocation. Comprehensive UHC requires modest additional financing (0.2-1.3% of GDP).

Financial protection remains inadequate, with 27% OOP expenditure and nearly one-quarter of the poorest households facing catastrophic costs. Approximately 1.2 million Kenyans are impoverished annually by healthcare expenses. SHIF's first-year challenges, particularly 44% informal sector enrollment, reflect broader constraints in administrative capacity and enforcement.

However, substantial efficiency opportunities exist, with conservative estimates suggesting KES 95-158 billion (15- 25% of total health expenditure) could be reallocated from inefficient uses. Our multi-pronged policy framework addresses revenue mobilization, efficiency, benefit rationalization, financial protection, and institutional strengthening simultaneously, recognizing that no single intervention suffices.

Achieving equitable UHC requires explicit priority-setting, progressive financing mechanisms, and pro-poor benefit distribution. Implementation must be sequenced to build early momentum while developing capacity for complex reforms. Political economy considerations demand stakeholder engagement, transparent communication, and sustained commitment across electoral cycles.

Healthcare financing is ultimately about societal values: the priority placed on health, how costs and benefits are distributed, and the level of solidarity between healthy and sick, rich and poor. This analysis provides a roadmap; political will and social commitment will determine whether it is followed. With appropriate policy choices and sustained effort, Kenya's vision of healthcare as a right rather than privilege can become reality.

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