Social Health Authority Reforms and Health Service Delivery in Kenya: Early Implementation Lessons for Training Institutions

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ABSTRACT

Kenya's transition from the National Health Insurance Fund to the Social Health Authority represents one of the most significant health financing reforms in the country's pursuit of universal health coverage. The reform links social health insurance, primary health care strengthening, facility financing, provider payment reform, digital health administration and health workforce preparedness within a single implementation framework. This paper examines early implementation lessons from the Social Health Authority reforms and analyses their implications for health service delivery and training institutions in Kenya. The paper adopts a structured narrative review approach with scoping elements. It draws on peer-reviewed studies, health financing literature, official policy and legal documents, Ministry of Health implementation updates, credible policy briefs and selected media reports on early implementation developments. Sources were reviewed thematically around reform architecture, enrolment and means testing, provider empanelment, claims administration, county-level uptake, digital system readiness, governance risks, fraud control, workforce preparedness and curriculum adaptation. The review shows that the Social Health Authority has recorded rapid administrative progress in registration, facility onboarding, claims processing and primary health care utilisation. However, early implementation evidence also points to persistent gaps in means testing, contribution assessment, provider reimbursement, system reliability, fraud prevention, county-level equity and public understanding of the reform. These challenges suggest that the success of the reform cannot be judged only by enrolment figures or legal redesign. Rather, it depends on whether the country can translate policy ambition into reliable service delivery, accountable purchasing, functional digital systems, timely provider payment and a workforce that understands the operational demands of social health insurance. The paper argues that training institutions should be treated as core implementation partners because SHA requires new competencies in health financing, claims administration, pre-authorization, digital health systems, health data governance, fraud prevention, patient guidance and community engagement. The early experience of SHA therefore demonstrates that sustainable universal health coverage reform in Kenya will depend on the alignment of financing design, institutional capacity, service-delivery readiness, governance accountability and health workforce preparation.

Keywords: Social Health Authority, universal health coverage, Kenya, health service delivery, training institutions, health financing, digital health

INTRODUCTION

Background to Universal Health Coverage Reform in Kenya

Universal health coverage remains one of Kenya's most important health-sector reform goals because it is directly connected to equity, financial protection, service access and the quality of care received by households. The pursuit of universal health coverage in Kenya has been shaped by persistent inequalities in access to healthcare, high household expenditure on treatment, uneven quality across levels of care, fragmented purchasing arrangements and long-standing weaknesses in provider payment. Although the country has made several policy and institutional attempts to expand health coverage, financial protection remains incomplete. World Bank data show that out-of-pocket expenditure accounted for 24.25 percent of Kenya's current health expenditure in 2023, indicating that many households still relied on direct payment at the point of care despite earlier insurance and financing reforms (World Bank, 2025).

The persistence of out-of-pocket payments is important because universal health coverage is not achieved by expanding insurance registration alone. It also requires that households can access needed services without being pushed into financial hardship, that providers are reimbursed reliably, and that the health system has sufficient capacity to deliver quality care. Before the Social Health Authority reform, Kenya's health insurance system was largely centred on the National Health Insurance Fund. However, pre-SHA insurance coverage remained shallow and uneven. A 2025 analysis by FSD Kenya and the Kenya National Bureau of Statistics found that NHIF coverage was only about one-fifth of the population, with particularly weak retention among households in the informal sector (FSD Kenya & Kenya National Bureau of Statistics [KNBS], 2025). This indicated that the previous financing model had not sufficiently addressed the structural challenges of equity, pooling, contribution compliance and protection of vulnerable households.

The introduction of the Social Health Authority therefore emerged from a reform context in which the central question was no longer whether Kenya needed health financing reform, but whether the country could design and implement a model capable of improving access, financial protection and service delivery at the same time. SHA is significant because it attempts to link health financing reform with primary health care strengthening, facility financing, provider payment, digital administration and workforce preparedness. This broader framing is important because the success of universal health coverage depends not only on the collection of contributions and registration of members, but also on the institutional capacity to translate financial coverage into actual care.

Legacy Problems under NHIF

The transition from NHIF to SHA cannot be understood outside the historical limitations of Kenya's previous insurance model. Although NHIF played an important role in expanding health insurance, policy and scholarly reviews consistently identified unresolved problems in inclusion, purchasing, governance, provider payment and service readiness. Earlier research on universal health coverage and equity in Kenya reported that the country's health financing system faced persistent challenges related to governance, limited benefits, weak purchasing capacity and inadequate protection of poor and informal-sector households (Okech & Lelegwe, 2016). These problems weakened the ability of NHIF to function as a strategic purchaser of health services and limited its contribution to equitable service delivery.

Recent reflections on Kenya's UHC reform pathway also show that the previous system was constrained by fragmented pooling, weak alignment between financing design and service delivery realities, and limited institutional capacity to absorb reform demands. Ng'ang'a et al. (2024) argue that health reforms in Kenya have often had to respond to a combination of technical, political and institutional constraints, including the difficulty of aligning financing mechanisms with actual provider behaviour and patient needs. This means that the weaknesses of NHIF were not only administrative; they were also structural. They reflected a deeper mismatch between the design of health financing and the realities of county health systems, provider reimbursement, informal-sector participation and service-delivery capacity.

The NHIF experience also demonstrated that insurance reform without delivery-system readiness produces partial benefits. A household may hold an insurance card, but the value of that coverage depends on whether facilities have medicines, staff, digital systems, claims-processing capacity and trust in reimbursement. If facilities experience delayed payments, weak referral systems or uncertainty in benefit interpretation, insured patients may still face service denial, out-of-pocket payments or long waiting times. For that reason, SHA should not be treated simply as a replacement for NHIF. It should be understood as an attempt to correct deeper weaknesses in pooling, purchasing, accountability, digital administration and service-delivery coordination that limited previous UHC efforts in Kenya (Edwin, 2026; Ng'ang'a et al., 2024).

Emergence of the Social Health Authority

Kenya's current health reform architecture was established through a major legislative package enacted in 2023. The package included the Primary Health Care Act, the Social Health Insurance Act, the Facility Improvement Financing Act and the Digital Health Act. These laws collectively sought to redesign the legal foundation of health financing and service delivery by strengthening primary health care, restructuring social health insurance, improving facility-level financial management and supporting interoperable digital health governance (PATH,

2024). The Social Health Insurance Act repealed NHIF and established the Social Health Authority as the institution responsible for administering a three-fund model consisting of the Primary Health Care Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund (Kenya Law, 2024; PATH, 2024).

The three-fund model is important because it shows that SHA was designed as more than a conventional insurance scheme. The Primary Health Care Fund is intended to support access to primary healthcare services, the Social Health Insurance Fund is expected to pool contributions and purchase services from empanelled and contracted providers, while the Emergency, Chronic and Critical Illness Fund is meant to support high-cost and catastrophic care needs (Kenya Law, 2024). At the same time, the Facility Improvement Financing Act was intended to strengthen facility-level financial autonomy, while the Digital Health Act was expected to support digital administration, data exchange and more efficient claims and information management. Taken together, these reforms suggest that Kenya attempted to redesign financing, service delivery and digital governance within a single reform moment.

Early implementation updates show both progress and strain. According to the Ministry of Health, more than 19.3 million Kenyans had registered under SHA by 12 February 2025, but only 3.33 million had undergone means testing. The same update reported that 8,813 out of 17,755 active health facilities had enrolled, that 89 percent of enrolled facilities were accessing the system, and that more than one million Kenyans had accessed primary healthcare services under SHA since October 2024 (Ministry of Health, 2025a). Subsequent reporting indicated continued enrolment momentum. Daily Nation reported that by mid-April 2025, enrolment had reached approximately 21.4 million, while about 4.3 million Kenyans had undergone means testing and the average contribution among tested individuals was about KSh 590 (Daily Nation, 2025). Later Ministry of Health reporting indicated that SHA had transitioned 29.8 million Kenyans, collected KSh 142.8 billion, and paid KSh 109 billion in claims, showing the increasing financial and administrative scale of the reform (Ministry of Health, 2026).

These early figures show that SHA moved rapidly from legal establishment to national implementation. However, they also reveal that the reform's greatest challenge lies in converting legal design and mass registration into reliable service delivery, contribution readiness, claims accountability and public trust. The gap between registration and means testing is especially important because means testing determines contribution capacity and subsidy targeting. Similarly, facility onboarding does not automatically mean that providers are digitally prepared, claims-literate, adequately reimbursed or confident in the new system. Therefore, early implementation must be interpreted as a mixed process: SHA has achieved significant administrative expansion, but this expansion has exposed serious questions about operational capacity, governance and long-term sustainability.

Governance controversy has also made the study of SHA urgent. Public debate has intensified around fraud investigations, provider reimbursement concerns, procurement questions and the ownership and control of the digital infrastructure supporting the scheme. These concerns suggest that SHA is not merely a technical health financing reform. It is also a governance reform that depends on procurement transparency, claims integrity, digital system accountability and public confidence. If these governance issues are not addressed, the credibility of the reform may weaken even where enrolment numbers continue to rise (Daily Nation, 2025; Nairobi Leo, 2025).

Problem and Significance of the Study

The central problem addressed in this paper is that Kenya's SHA reform has advanced more rapidly in legal redesign, mass registration and administrative rollout than in the operational, institutional and workforce conditions required for effective health service delivery. Early implementation has exposed weaknesses in means testing, contribution assessment, provider reimbursement, digital system use, claims administration, fraud control, county-level uptake, public understanding and workforce preparedness. These weaknesses suggest that the success of SHA cannot be measured through enrolment numbers alone. Instead, it should be assessed by whether registered members can access services, whether providers are paid on time, whether claims are verified

transparently, whether digital systems support continuity of care, and whether health workers and training institutions are prepared for the operational demands of the new model.

This paper distinguishes between two categories of challenges. The first category consists of **implementation bottlenecks**, which are operational problems that emerge during rollout. These include delayed means testing, incomplete profile updates, system downtime, provider onboarding difficulties, reimbursement delays, weak public awareness and county-specific registration gaps. Such problems may be addressed through stronger administration, technical support, outreach, staff training and better communication. The second category consists of structural policy design flaws, which are deeper issues embedded in the design, governance and sustainability of the reform. These include the long-term viability of the contribution model, clarity of benefit packages, digital system ownership, claims governance, purchasing accountability, fraud-control architecture and the alignment between health financing reform and workforce preparation. Distinguishing between these two categories is important because operational bottlenecks require implementation correction, while structural flaws may require policy redesign, stronger regulation and institutional reform.

The significance of this study lies in its focus on early implementation lessons rather than policy aspiration alone. Much of the public discussion around SHA has focused on registration numbers, legal reform and political commitments to universal health coverage. However, early implementation evidence indicates that the reform's success will depend on the strength of the institutions that translate policy into practice. This includes national agencies, county governments, health facilities, digital system managers, providers, claims officers and training institutions. Evidence from healthcare students strengthens this concern. Aldousari et al. (2025) found that only 21.7 percent of surveyed undergraduate healthcare students had adequate knowledge of SHA/SHIF and only 54 percent demonstrated high eHealth literacy. This suggests that future health workers may not yet be sufficiently prepared for the financing, digital and administrative requirements of the new system.

The study is therefore significant in two ways. First, it contributes to emerging scholarship on SHA by shifting attention from the formal design of the reform to the realities of early implementation. Second, it foregrounds training institutions as strategic actors in reform success. Training institutions are not peripheral to SHA because the reform requires new competencies in social health financing, claims administration, pre-authorization, digital health systems, health data governance, fraud prevention, patient guidance and community engagement. If training institutions are not aligned with the new reform architecture, Kenya may expand registration while leaving the workforce insufficiently prepared to implement the system effectively. Therefore, the early experience of SHA provides important lessons on how universal health coverage reform must be supported by governance accountability, service-delivery readiness and workforce preparation (Aldousari et al., 2025; GeoPoll, 2025).

METHODOLOGICAL APPROACH

Review Design

This paper adopted a structured narrative review design with scoping elements to examine early implementation lessons from Kenya's Social Health Authority reforms and their implications for health service delivery and training institutions. This design was considered appropriate because SHA is still in the early implementation phase and the available evidence is diverse, emerging and spread across peer-reviewed studies, legal documents, government updates, policy briefs, institutional statements and credible media reports. A purely systematic review was not considered suitable because the reform is recent, implementation data are still evolving, and many of the most relevant sources are policy and administrative documents rather than completed empirical impact studies. However, to reduce the weaknesses commonly associated with unsystematic narrative reviews, the paper used a transparent source identification, screening and thematic synthesis process.

The review was therefore structured around four analytical concerns. First, it examined the legal and policy architecture of SHA, including the transition from NHIF and the establishment of the three-fund model. Second, it assessed early implementation progress using available evidence on enrolment, means testing, facility onboarding, claims processing and county-level uptake. Third, it analysed implementation constraints related to provider reimbursement, digital systems, fraud control, governance and public understanding. Fourth, it

examined the implications of the reform for health training institutions, particularly in relation to health financing literacy, digital health competence, claims administration, curriculum responsiveness and continuing professional development. This approach is consistent with guidance that scoping and structured reviews are useful where the purpose is to map an emerging field, identify implementation patterns and clarify knowledge gaps rather than estimate a single pooled effect size (Dhollande et al., 2021; Munn et al., 2018).

Search Strategy and Sources of Evidence

The review drew on peer-reviewed literature, official legal and policy documents, Ministry of Health implementation updates, health financing reports, institutional statements and selected credible media reports. Peer-reviewed literature was used to situate SHA within Kenya's broader UHC reform pathway, health financing debates, primary health care reform, health workforce preparedness and digital health readiness. Legal and policy documents were used to clarify the formal design of the reform, especially the Social Health Insurance Act, Social Health Insurance Regulations, Primary Health Care Act, Facility Improvement Financing Act and Digital Health Act. Ministry of Health updates were used to capture early implementation statistics such as enrolment, means testing, provider onboarding, claims activity and government-led capacity-building initiatives. Policy briefs and think-tank reports were used to interpret financing design, reform sequencing and administrative risks. Credible media reports were used cautiously where they provided recent implementation details not yet reflected in peer-reviewed publications, especially on fraud investigations, provider distress, digital system controversy and reimbursement concerns.

The search was conducted using Google Scholar, PubMed, official Ministry of Health webpages, Kenya Law, institutional websites, policy repositories and selected Kenyan news sources. The search terms included combinations of "Social Health Authority Kenya," "SHA Kenya," "Social Health Insurance Fund Kenya," "SHIF Kenya," "NHIF reform Kenya," "universal health coverage Kenya," "health financing reform Kenya," "primary health care networks Kenya," "provider payment Kenya," "health insurance claims Kenya," "digital health Kenya," "health workforce training Kenya," and "training institutions universal health coverage Kenya." The review prioritised sources published between 2023 and 2026 because this period corresponds with the legal establishment and early implementation of SHA. Earlier sources were included where they provided historical context on NHIF, UHC, health financing, equity, governance or workforce challenges that shaped the reform environment.

Inclusion and Exclusion Criteria

Sources were included if they met at least one of five criteria. First, they directly discussed Kenya's Social Health Authority, Social Health Insurance Fund, NHIF transition or UHC financing reforms. Second, they provided legal, policy or institutional evidence on the structure, mandate or implementation of SHA.

Third, they presented empirical, administrative or analytical evidence on registration, means testing, provider empanelment, claims processing, service utilisation, digital health systems, county-level uptake or provider payment. Fourth, they addressed health workforce readiness, health training institutions, eHealth literacy, claims administration or curriculum reform in relation to Kenya's health sector. Fifth, they provided credible contextual evidence on health financing, primary health care networks, equity, governance or institutional capacity in Kenya.

Sources were excluded if they were not directly relevant to SHA, UHC financing, health service delivery or training-institution preparedness in Kenya. Opinion pieces, social media posts, unverifiable commentary and duplicated news summaries were not used as core evidence.

Media sources were included only where they reported specific implementation developments and where the information could be interpreted cautiously as emerging evidence rather than definitive evaluation. Sources were also excluded where the claims could not be attributed to an identifiable institution, author, legal document, government statement or recognised publication outlet. This screening process was intended to reduce selection bias and ensure that the synthesis was based on verifiable and relevant evidence.

Screening and Source Appraisal

The screening process was conducted in three stages. In the first stage, titles, headings and publication sources were reviewed to determine whether each document was relevant to SHA implementation, health financing reform, service delivery or training institutions. In the second stage, abstracts, executive summaries or introductory sections were examined to assess whether the source contained usable evidence for the paper's objectives. In the third stage, the full text of retained sources was reviewed to extract information on reform architecture, implementation progress, institutional challenges, governance risks and training implications.

Each retained source was appraised using four quality considerations: relevance, credibility, recency and evidential value. Relevance referred to the source's direct connection to SHA, UHC reform, health service delivery or training institutions. Credibility referred to whether the source came from a peer-reviewed journal, government institution, legal repository, recognised policy organisation, official institutional communication or reputable media outlet. Recency was important because SHA is a fast-changing reform and implementation figures can change quickly. Evidential value referred to whether the source provided legal provisions, empirical data, administrative statistics, implementation updates, policy analysis or documented stakeholder concerns. Peer-reviewed and official sources were treated as stronger forms of evidence, while media reports were used mainly to capture recent implementation concerns that had not yet been fully analysed in academic literature.

Data Extraction and Thematic Synthesis

Data were extracted thematically rather than statistically because the reviewed sources differed in design, purpose and level of evidence. The extraction focused on seven themes: legal and institutional architecture; financing and purchasing design; enrolment, means testing and contribution readiness; facility onboarding and provider payment; digital systems, governance and accountability; county-level and service-delivery disparities; and training-institution preparedness. Under each theme, evidence was compared across source types to identify points of convergence, contradiction and emerging implementation concern.

The synthesis distinguished between operational implementation bottlenecks and structural policy design issues. Operational bottlenecks were understood as problems arising during rollout, such as slow means testing, incomplete profile updates, provider reimbursement delays, digital system downtime, facility onboarding challenges, weak public understanding and county-specific registration gaps. Structural design issues were understood as deeper institutional or policy questions, including the sustainability of the contribution model, clarity of benefit packages, purchasing arrangements, digital system ownership, claims governance, accountability mechanisms and the long-term alignment between health financing reform and workforce preparation. This distinction was important because short-term implementation failures may require administrative correction, while structural weaknesses may require policy redesign, stronger regulation or institutional reform.

The review also used triangulation across source types. For example, official Ministry of Health updates were used to establish rollout figures, legal documents were used to clarify the formal mandate of SHA, peer-reviewed studies were used to interpret health financing and workforce implications, and credible media reports were used cautiously to identify emerging governance and provider-payment concerns. This approach strengthened the review by avoiding reliance on a single source category and by allowing policy claims to be interpreted alongside early implementation evidence.

Ethical Considerations

The paper did not involve primary data collection from human participants, health facilities, students, patients or health workers. It was based entirely on publicly available literature, legal documents, policy reports, government updates and published implementation information. For that reason, institutional ethical approval was not required. Nevertheless, the review followed principles of academic integrity by attributing all ideas, statistics and claims to their respective sources using APA in-text citations. Media-based claims were treated cautiously and were not presented as conclusive empirical findings unless supported by official or peer-reviewed evidence.

METHODOLOGICAL LIMITATIONS

The study has several methodological limitations. First, SHA is still in the early stages of implementation, and some of the available evidence consists of official updates, policy briefs and media reports rather than completed independent evaluations. Second, implementation indicators such as registration numbers, means-testing figures, claims paid, facility onboarding and provider reimbursement may change rapidly as the reform matures. Third, county-level data remain unevenly available, which limits the extent to which the review can provide a fully comparative assessment across all counties. Fourth, some provider-reported figures on reimbursement delays, system failures or service disruption may reflect stakeholder experience but may not have been independently audited at the time of reporting. Fifth, because the review did not collect primary data from facilities, training institutions or beneficiaries, its conclusions should be understood as early implementation lessons rather than final impact findings.

Despite these limitations, the structured approach used in this review provides a credible basis for analysing SHA's early implementation trajectory. The available evidence is sufficient to show that SHA is not merely a financing reform, but also a governance, digital administration, service-delivery and workforce-preparedness reform. The methodological approach therefore allows the paper to move beyond policy description and identify the institutional and training-related conditions that will determine whether the reform contributes meaningfully to universal health coverage in Kenya.

Policy and Institutional Context of SHA Reform

Kenya's Reform Trajectory Toward Universal Health Coverage

Kenya's Social Health Authority reform should be understood as part of a longer health-sector reform journey rather than as an isolated replacement of the National Health Insurance Fund. The country's pursuit of universal health coverage has been shaped by repeated attempts to expand financial protection, improve access to essential services, strengthen primary health care, and reduce the burden of out-of-pocket expenditure on households. However, earlier reforms were constrained by fragmented pooling arrangements, weak purchasing mechanisms, uneven provider payment systems, limited protection for poor and informal-sector households, and persistent gaps in county-level service readiness (Okech & Lelegwe, 2016; Ng'ang'a et al., 2024). These historical weaknesses created the policy justification for a broader reform that would go beyond insurance registration and address the relationship between financing, service delivery, digital administration and governance capacity.

The SHA reform therefore emerged from the recognition that health financing cannot deliver universal health coverage on its own. In the NHIF era, expanded membership did not always translate into reliable access to services because providers faced delayed reimbursement, households still experienced financial barriers, and facilities operated within uneven county health systems. This means that the challenge was not merely to create a new insurer, but to build a more coherent architecture through which funds, facilities, providers, patients and digital systems could interact more efficiently (Edwin, 2026; Ng'ang'a et al., 2024). In that sense, SHA represents an attempt to redesign the institutional machinery of health financing and service delivery at the same time.

This historical context is important because it explains why the current reform is ambitious and also why it is difficult to implement. SHA is expected to improve pooling, expand contribution compliance, strengthen purchasing, support primary health care, improve claims management, and increase accountability in the use of health funds. These are not simple administrative functions because they require institutional coordination across national government, county governments, health facilities, regulatory agencies, digital system managers, training institutions and the public (PATH, 2024; Kenya Law, 2024). The success of SHA therefore depends not only on the existence of a new law, but also on the ability of institutions to translate that law into routine practice.

The Four-Law Reform Package

The legal foundation of the current reform is based on four interconnected laws enacted in 2023: the Primary Health Care Act, the Social Health Insurance Act, the Facility Improvement Financing Act and the Digital Health

Act. These laws should be interpreted as a single reform package because each one addresses a different part of the health-system problem. The Primary Health Care Act focuses on strengthening the service-delivery foundation of universal health coverage. The Social Health Insurance Act establishes SHA and restructures health financing through a three-fund model. The Facility Improvement Financing Act addresses the flow and management of funds at facility level. The Digital Health Act provides the legal basis for digital health administration, interoperability and data use in the health sector (PATH, 2024; Kenya Law, 2024).

This legal package shows that Kenya's reformers recognised that weaknesses in the previous system were not located in financing alone. If health insurance is expanded without a strong primary health care platform, members may be registered but still unable to obtain timely and appropriate care. If facilities receive funds but cannot retain or manage them effectively, service improvement remains limited. If claims, eligibility verification and health records are not supported by reliable digital systems, provider payment and service continuity become vulnerable to delays, disputes and fraud (PATH, 2024; Ng'ang'a et al., 2024). The four laws therefore attempt to address financing, service delivery, facility autonomy and digital governance within one coordinated reform moment.

Table 1: Legal architecture of Kenya's 2023 health reform package

Law	Main reform role	Relevance to SHA implementation
Primary Health Care Act, 2023	Strengthens primary health care structures and supports the organisation of services closer to communities.	Provides the service-delivery foundation through which SHA members can access primary healthcare and referral pathways (PATH, 2024; Amboko et al., 2025).
Social Health Insurance Act, 2023	Repeals NHIF and establishes the Social Health Authority and the three health financing funds.	Creates the institutional and financing structure for registration, contributions, empanelment, contracting, claims and benefits administration (Kenya Law, 2024; PATH, 2024).
Facility Improvement Financing Act, 2023	Provides a framework for managing funds generated or received at public health facilities.	Supports facility-level financial autonomy and may improve the ability of facilities to use received funds for service improvement (PATH, 2024).
Digital Health Act, 2023	Establishes the legal framework for digital health systems, interoperability, health data governance and digital administration.	Supports digital registration, eligibility verification, provider portals, claims administration, data exchange and monitoring of health service delivery (PATH, 2024; Ministry of Health, 2024a).

The table shows that SHA is part of a broader health-system redesign. The Social Health Insurance Act may be the most visible part of the reform, but its implementation depends heavily on the other three laws. Primary health care structures determine where and how members receive services. Facility financing rules influence whether health facilities can convert reimbursements into improved care. Digital health governance determines whether registration, claims, referrals and service data can be processed reliably (Kenya Law, 2024; PATH, 2024). Therefore, SHA should not be analysed narrowly as a health insurance institution. It should be analysed as one component of a wider reform architecture that seeks to connect financing reform with delivery-system readiness.

Governance and Regulatory Structure of SHA

The Social Health Authority is mandated to perform several functions that are central to the operation of the new health financing model. These include member registration, contribution administration, fund management, provider empanelment, contracting, benefits administration, pre-authorization, claims processing and payment. The Social Health Insurance Regulations, 2024 further clarify the implementation framework for the Primary Health Care Fund, the Social Health Insurance Fund and the Emergency, Chronic and Critical Illness Fund. They

also provide rules relating to mandatory registration, means testing, tariffs, empanelment and claims settlement (Kenya Law, 2024).

The governance significance of this mandate is considerable. SHA is not simply a passive payer that reimburses facilities after services have been delivered. It is expected to function as a purchaser, regulator, administrator and accountability mechanism within the health financing system. This places SHA at the centre of relationships between households, employers, counties, health facilities, providers, the national government and digital platform managers (Kenya Law, 2024; Ng'ang'a et al., 2024). If SHA manages these relationships effectively, it can strengthen financial protection, improve provider payment discipline and enhance service coordination. However, if governance is weak, the same central position can become a source of delay, mistrust, fraud, exclusion or service disruption.

The regulatory structure also places means testing at the heart of implementation. Since the scheme is expected to determine contribution capacity and identify those who require public support, means testing becomes more than a technical exercise. It is a mechanism for equity, subsidy targeting and financial sustainability (Kenya Law, 2024; FSD Kenya & KNBS, 2025). Weak means testing may lead to under-collection of contributions, exclusion of eligible households, inaccurate subsidy allocation or disputes over entitlement. This is why the gap between registration and means testing is one of the most important indicators of early SHA implementation quality.

Provider empanelment and contracting are equally important. For SHA to translate coverage into care, facilities must be contracted, digitally connected, capable of verifying eligibility, and able to submit claims correctly. Tariffs must be clear, payment timelines must be predictable, and claims-review mechanisms must be credible (Kenya Law, 2024; Ministry of Health, 2025a). If providers experience uncertainty in claims approval or reimbursement, they may reduce participation, delay services, demand out-of-pocket payment or deny care. This shows that SHA's governance framework has direct consequences for service delivery and public trust.

Primary Health Care Networks as the Service-Delivery Foundation

Primary health care networks are central to the service-delivery logic of the SHA reform. Universal health coverage cannot be achieved through hospital-based financing alone because most health needs begin at household, community and primary-care levels. A strong primary health care platform helps ensure early diagnosis, continuity of care, referral coordination, preventive services and reduced pressure on higher-level hospitals (Amboko et al., 2025; PATH, 2024). The Primary Health Care Act therefore provides an important service-delivery foundation for SHA by linking financing reform to organised care pathways.

The relevance of primary health care networks is that they give practical meaning to the Primary Health Care Fund and the referral logic of the broader SHA model. If primary care facilities are functional, accessible and properly connected to referral facilities, SHA can support care that is closer to communities and more affordable for the health system (Amboko et al., 2025; Kenya Law, 2024). However, if primary facilities lack staff, medicines, equipment, digital systems or claims capacity, the reform may produce registration without meaningful access. This is especially important in counties with historically weaker infrastructure and lower health-system capacity.

The primary health care foundation also has implications for training institutions. Health workers entering the system must understand not only clinical care, but also referral pathways, eligibility verification, patient guidance, digital documentation, claims-related records and continuity of care under SHA. Training institutions therefore need to align their curricula with the operational logic of primary health care networks and social health insurance (Aldousari et al., 2025; Okoroafor et al., 2022). Without such alignment, the reform may create new administrative and service-delivery demands that the existing workforce is not fully prepared to meet.

Institutional Coordination as a Condition for Reform Success

The policy and institutional context of SHA shows that the reform is highly interdependent. The Ministry of Health may lead the reform at national level, but implementation depends on county governments, health facilities, employers, digital system managers, regulatory bodies, public administrators, providers, communities

and training institutions. Each actor controls a different part of the implementation chain. Counties influence service readiness and facility performance, facilities determine whether patients experience the scheme as functional, digital systems determine whether eligibility, claims and data can move efficiently, and training institutions determine whether the workforce has the competencies needed to operate within the new model (Ministry of Health, 2024a, 2024b, 2026a; Okoroafor et al., 2022).

This interdependence explains why early SHA implementation challenges should not be dismissed as minor transition problems. Delayed means testing, provider-payment stress, digital system instability, fraud risks, public confusion and uneven county uptake all point to the same underlying issue: the success of the reform depends on the capacity of institutions to work together (Daily Nation, 2025; Ministry of Health, 2025a; Ng'ang'a et al., 2024). A legal reform can establish authority, but it cannot by itself guarantee institutional readiness. SHA will therefore succeed only if the legal framework is matched with administrative capacity, transparent governance, functional digital infrastructure, service-delivery preparedness and workforce training.

In this regard, the institutional context supports the central argument of the paper. SHA is not only a financing reform. It is also a service-delivery reform, a digital governance reform, an accountability reform and a workforce-preparedness reform (Aldousari et al., 2025; Kenya Law, 2024; PATH, 2024). The four-law package provides the legal foundation, but the quality of implementation will depend on how effectively institutions convert that legal framework into practical access to care.

Financing Architecture and Strategic Purchasing Logic

The Three-Fund Structure

A defining feature of Kenya's Social Health Authority reform is the shift from a single dominant national insurer to a differentiated three-fund structure. The Social Health Insurance Regulations, 2024 provide for the Primary Health Care Fund, the Social Health Insurance Fund, and the Emergency, Chronic and Critical Illness Fund. This structure reflects an attempt to separate routine primary care financing, contributory insurance purchasing, and catastrophic or high-cost care financing within one broader social health protection framework (Kenya Law, 2024; PATH, 2024). The design is important because it recognises that different levels of care require different financing arrangements, payment mechanisms and accountability systems.

The Primary Health Care Fund is intended to finance primary healthcare services in primary health facilities. Its purpose is to reduce financial barriers at the first point of contact with the health system and support the broader policy objective of strengthening primary health care. This fund is central to universal health coverage because most households interact with the health system through dispensaries, health centres, community-level services and lower-level facilities before moving to higher levels of care. If properly funded and managed, the Primary Health Care Fund can improve early access, reduce unnecessary referrals and support continuity of care (Kenya Law, 2024; Amboko et al., 2025).

The Social Health Insurance Fund is the main contributory fund through which SHA purchases services from empanelled and contracted providers. It is expected to pool contributions and use those resources to pay for services provided at contracted facilities, especially where care is accessed through referral pathways. This fund therefore carries the main purchasing responsibility of the reform. Its effectiveness depends on accurate registration, reliable means testing, contribution compliance, clear tariffs, provider contracts, claims verification and timely reimbursement (Kenya Law, 2024; FSD Kenya & KNBS, 2025).

The Emergency, Chronic and Critical Illness Fund is intended to protect households from high-cost health needs that may otherwise lead to catastrophic expenditure. It is particularly important for conditions requiring specialised, long-term, emergency or expensive care. In a health system where many households remain financially vulnerable, this fund can strengthen financial protection if eligibility rules, benefits, referral pathways and provider payment mechanisms are clear and adequately financed (Kenya Law, 2024; World Bank, 2025).

Table 2: Financing logic of the three SHA funds

Fund	Main purpose	Service-delivery relevance	Key implementation risk
Primary Health Care Fund	Financing primary healthcare services at primary-level facilities.	Supports early access, preventive care, continuity of care and community-level service delivery.	Underfunding, weak county facility readiness, poor referral coordination and inadequate primary care capacity.
Social Health Insurance Fund	Pooling contributions and purchasing services from empanelled and contracted providers.	Supports access to services beyond primary care through contracted facilities and referral pathways.	Weak contribution compliance, delayed means testing, unclear tariffs, delayed claims and provider dissatisfaction.
Emergency, Chronic and Critical Illness Fund	Financing emergency, chronic and high-cost care needs.	Protects households from catastrophic expenditure and improves access to specialised care.	Fiscal pressure, unclear benefit limits, weak pre-authorization, claims inflation and possible inequity in access to specialised services.

This three-fund design is conceptually stronger than a single undifferentiated financing pool because it attempts to match funding streams to different levels of need. However, the existence of three funds also increases the complexity of implementation. Each fund requires clear eligibility rules, predictable financing, accountable purchasing, reliable claims administration and effective coordination with health facilities. If the boundaries between funds are unclear, or if referral pathways and benefit entitlements are poorly understood, patients and providers may experience confusion, delayed access or disputes over payment (Kenya Law, 2024; Ng'ang'a et al., 2024).

Contributions, Mandatory Registration and Resource Mobilisation

SHA's financing model is built on mandatory registration and contribution mobilisation. Under the regulations, residents are expected to register, and means testing is used to determine the capacity of individuals and households to contribute to the scheme (Kenya Law, 2024). This design reflects the social insurance logic of pooling resources across population groups so that health risks can be shared and access to services can be supported. However, the credibility of this model depends on the ability of the system to move beyond registration and establish contribution readiness (FSD Kenya & KNBS, 2025; Ng'ang'a et al., 2024).

The early implementation evidence shows that registration expanded faster than means testing. This distinction is important because a registered person is not necessarily a fully assessed contributor. If large numbers of registered members have not undergone means testing, the scheme may appear successful in coverage terms while remaining weaker in revenue mobilisation, subsidy targeting and benefit administration. A contributory system becomes financially vulnerable when the number of people expecting benefits grows faster than the number of people whose contribution capacity has been assessed and collected (Ministry of Health, 2025a, 2025b).

This issue is especially important in Kenya because a large share of the population works in the informal sector, where income is irregular, difficult to verify and often outside formal payroll systems. In such a context, contribution assessment cannot rely only on formal employment records. It requires credible means testing, household-level data, digital verification, community outreach and public trust. If informal-sector households perceive contributions as unaffordable or unclear, compliance may remain weak even where registration is mandatory. Therefore, contribution design is not only a financial issue; it is also an administrative, social and political issue (FSD Kenya & KNBS, 2025; Daily Nation, 2025).

Resource mobilisation under SHA must also be judged by the relationship between collections, claims and liabilities. Large financial inflows may demonstrate the scale of the reform, but they also increase the need for strong financial controls. If claims grow faster than sustainable collections, or if fraud and overbilling are not controlled, the system may face fiscal pressure. If claims are delayed to protect cash flow, provider confidence may decline and patients may face service restrictions. The sustainability of SHA therefore depends on maintaining a balance between contribution collection, subsidy financing, benefit commitments and provider payment obligations (Ministry of Health, 2026; KBC Digital, 2025; Chelangat, 2026).

Strategic Purchasing Logic

Strategic purchasing is one of the most important ambitions of the SHA reform. Strategic purchasing means that the purchaser does not merely reimburse providers passively but uses available resources to buy defined services from selected providers in ways that improve access, quality, efficiency and equity. In the SHA model, this requires clear benefits packages, provider empanelment, contracting, tariffs, referral pathways, pre-authorization, claims verification, quality controls and payment discipline. The Social Health Insurance Fund is therefore expected to operate not just as a pool of contributions but as an active purchaser of services from contracted providers (Kenya Law, 2024; Ng'ang'a et al., 2024).

This marks an important shift from a limited reimbursement model to a more organised purchasing framework. In principle, SHA can use contracting and payment mechanisms to influence provider behaviour, encourage adherence to referral pathways, reduce unnecessary care, improve accountability and strengthen service delivery. However, this promise depends on the quality of implementation. Strategic purchasing cannot function where providers do not understand tariffs, where claims are delayed, where patients are unclear about benefits, where digital systems fail, or where fraud-control systems are weak (Kenya Law, 2024; KBC Digital, 2025; Ministry of Health, 2026b).

A strong purchasing system requires three conditions. First, the purchaser must define what services are covered, where they can be accessed, and under what conditions. Second, providers must know the payment rules, documentation requirements and timelines for reimbursement. Third, the system must verify claims and monitor service quality without creating excessive administrative barriers to care. If any of these conditions is weak, strategic purchasing may become a source of conflict rather than efficiency. For example, unclear tariffs can lead to disputes between providers and SHA, weak claims verification can expose the scheme to fraud, slow reimbursement can reduce provider willingness to serve SHA members, and poor communication of benefits can leave patients confused about what they are entitled to receive (Kenya Law, 2024; KBC Digital, 2025; GeoPoll, 2025).

The strategic purchasing logic also depends on referral discipline. The three-fund structure assumes that patients will move through appropriate care pathways, beginning with primary healthcare where appropriate and moving to higher levels when necessary. This can reduce unnecessary use of expensive hospital services and improve continuity of care. However, referral discipline only works where primary facilities are functional, patients trust lower-level facilities, digital records support continuity and providers follow agreed protocols. If primary healthcare facilities are under-resourced, patients may bypass them, and SHA may face higher claims at upper-level facilities (Amboko et al., 2025; Kenya Law, 2024).

Sustainability Risks in the Financing Design

Although the three-fund structure is policy-relevant, it carries several sustainability risks. The first risk is the gap between enrolment and active contribution. Registration may expand quickly because it is politically visible and administratively measurable. However, financial sustainability depends on whether members are assessed, contributions are collected, subsidies are financed and claims are paid. If many members are registered but few are active contributors, the system may become financially strained, especially if service utilisation rises (Ministry of Health, 2025a, 2025b; FSD Kenya & KNBS, 2025).

The second risk is the affordability of contributions for informal-sector households. Means testing is expected to determine ability to pay, but the process is administratively demanding. Informal incomes are unstable,

seasonal and often unrecorded. If the system overestimates household ability to pay, vulnerable groups may be excluded or discouraged from using the scheme. If it underestimates ability to pay, the scheme may lose revenue. Accurate means testing is therefore central to both equity and sustainability (Daily Nation, 2025; FSD Kenya & KNBS, 2025).

The third risk is claims inflation. As SHA expands, providers may submit more claims, patients may demand more services, and the system may face pressure from high-cost conditions. Without strong pre-authorization, claims audit, fraud detection and tariff enforcement, the scheme may experience leakage or expenditure growth beyond available resources. This risk is especially relevant to the Emergency, Chronic and Critical Illness Fund because high-cost care can quickly absorb large amounts of financing (Kenya Law, 2024; Chelangat, 2026).

The fourth risk is provider payment instability. A financing reform can lose credibility if providers experience delayed reimbursement or unclear payment rules. Provider confidence matters because patients experience the reform through facilities, not through legal documents. If facilities believe SHA payments are unreliable, they may limit services, demand cash payments, delay treatment or withdraw cooperation. Therefore, the financial sustainability of SHA is directly linked to the credibility of its provider payment system (KBC Digital, 2025; Ministry of Health, 2026b).

The fifth risk concerns governance and digital infrastructure. SHA depends heavily on digital registration, eligibility verification, claims submission and data management. If digital systems are not reliable, transparent, secure and accountable, financing risks increase. System downtime can interrupt care, weak data governance can undermine trust, and poor system ownership arrangements can raise accountability concerns. Therefore, digital health infrastructure is not a separate technical issue; it is part of the financial architecture of SHA (Citizen Digital, 2025a; Nairobi Leo, 2025; Ministry of Health, 2026b).

Claims Governance, Fraud Control and Provider Confidence

Claims governance is the practical centre of the SHA financing model. The system can only function if claims are submitted correctly, verified fairly, audited consistently and paid within predictable timelines. Strong claims governance protects the fund from fraud while also protecting providers from unnecessary delays. This balance is difficult but essential. If claims review is too weak, the scheme may suffer from fraud and overpayment. If claims review is too slow or punitive, providers may become frustrated and patients may experience service interruptions (KBC Digital, 2025; Chelangat, 2026).

Fraud control is therefore a core sustainability issue. Health insurance schemes are vulnerable to false claims, inflated billing, ghost patients, unnecessary procedures, collusion and misclassification of services. As SHA handles larger financial flows, the risk of fraud increases unless there are strong safeguards. These safeguards should include digital claims tracking, facility audits, biometric or identity verification where appropriate, clinical review, sanctions for fraudulent providers, whistle-blower protections and public reporting on enforcement actions. However, fraud-control measures must be implemented carefully so that legitimate providers are not discouraged and patients are not denied care due to administrative suspicion (Chelangat, 2026; Ministry of Health, 2026b).

Provider confidence is equally important. The willingness of facilities to participate in SHA depends on whether they trust the payment system. Even a well-designed benefit package can fail if providers experience delayed claims, unclear tariffs, weak helpdesk support or unpredictable audit decisions. For this reason, provider payment should be monitored through clear indicators, including claims submitted, claims approved, claims rejected, claims pending, average payment time, reasons for rejection and facility-level payment status. Such indicators would make financing performance more transparent and help distinguish between genuine fraud control and administrative delay (KBC Digital, 2025; Ministry of Health, 2025c; Ministry of Health, 2026).

Why Financing Design Alone Is Insufficient

The financing architecture of SHA is ambitious, but financing design alone cannot guarantee universal health coverage. The three-fund structure, mandatory registration, means testing and strategic purchasing model create

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a legal and financial framework for reform. However, the value of this framework depends on institutional capacity. SHA must be able to assess contribution capacity, contract providers, manage claims, pay facilities, prevent fraud, protect data, resolve disputes and communicate benefits to the public. Counties must ensure that facilities are ready to provide services, while training institutions must prepare health workers who can operate within the financing, digital and administrative requirements of the new model (Kenya Law, 2024; Ng'ang'a et al., 2024; Aldousari et al., 2025).

This means that the main question is not whether SHA has a more sophisticated financing design than NHIF. The more important question is whether the financing design can be implemented reliably across counties, providers and population groups. If the contribution model is weak, the system may struggle financially. If claims governance is weak, fraud and provider dissatisfaction may grow. If digital systems are unreliable, patients may be denied care despite being registered. If training institutions do not adapt, future health workers may lack the competencies required for claims administration, patient guidance, digital documentation and insurance-related service delivery (Ministry of Health, 2025a; KBC Digital, 2025; Aldousari et al., 2025).

Therefore, SHA should be analysed as a financing reform whose success depends on governance, digital infrastructure, provider trust, county service readiness and workforce preparedness. The reform's sustainability will not be determined by the existence of three funds alone, but by whether those funds are adequately financed, transparently managed, strategically used and connected to real improvements in health service delivery (Edwin, 2026; Ng'ang'a et al., 2024; Amboko et al., 2025).

Early Implementation Progress

Registration trajectory and enrolment momentum

Early implementation evidence shows that SHA moved quickly from legal establishment to large-scale administrative rollout. Registration expanded rapidly within the first months of implementation, suggesting strong state mobilisation and public uptake. On 5 February 2025, the Ministry of Health reported that 18,988,530 Kenyans had been enrolled under SHA, while 4.3 million individuals who had migrated from NHIF still needed to update their profiles. At that point, 3.1 million registered persons had undergone means testing, representing approximately 16.3 percent of total registered members (Ministry of Health, 2025b). This indicated that registration was moving faster than the administrative process required to determine contribution capacity and benefit eligibility.

By 12 February 2025, SHA registration had risen to more than 19.3 million people. However, only 3.33 million registered persons had been means tested, representing approximately 17.3 percent of those registered. The same Ministry update reported that 8,813 out of 17,755 active facilities had enrolled, while 89 percent of enrolled facilities were already accessing the system.

Since October 2024, more than one million Kenyans had accessed primary healthcare services under SHA (Ministry of Health, 2025a). These figures demonstrate that SHA had moved beyond policy announcement into actual service use, facility onboarding and claims-related administration. At the same time, the low proportion of means-tested members showed that the depth of enrolment remained weaker than the headline registration numbers suggested.

By mid-May 2025, the Ministry of Health reported that more than 22 million Kenyans had registered, 1.2 million people had received services from healthcare providers, and claims worth KSh 45 billion had been processed (Ministry of Health, 2025c).

Later reporting in 2026 indicated that the scale of the system had grown further, with 29.8 million Kenyans transitioned, KSh 142.8 billion collected, and KSh 109 billion paid in claims (Ministry of Health, 2026). Taken together, these figures show that SHA had become a major national health financing platform within a short period. However, the same figures also show why implementation quality, claims governance, fraud control, provider confidence and digital system reliability became increasingly important as the reform expanded.

Table 3: Selected early SHA implementation indicators

Date/period	Reported implementation indicator	Quantitative status	Interpretation
5 February 2025	Registered members	18,988,530	Demonstrates rapid enrolment in the early rollout phase.
5 February 2025	Means-tested members	3.1 million	Approximately 16.3 percent of registered members had been means tested, showing a large registration-to-assessment gap.
12 February 2025	Registered members	Over 19.3 million	Registration continued to rise within one week.
12 February 2025	Means-tested members	3.33 million	Approximately 17.3 percent of registered members had been means tested, indicating only modest improvement in contribution assessment.
12 February 2025	Facilities enrolled	8,813 out of 17,755 active facilities	Shows that approximately 49.6 percent of active facilities had enrolled.
12 February 2025	Enrolled facilities accessing the system	89 percent	Indicates that most enrolled facilities were already using the system.
Since October 2024	Primary healthcare users under SHA	Over 1 million	Confirms that SHA had moved into actual service utilisation.
13 May 2025	Registered members	Over 22 million	Shows continued expansion of membership.
13 May 2025	People served by healthcare providers	1.2 million	Approximately 5.5 percent of the 22 million registered members had reportedly received services by this point.
13 May 2025	Claims processed	KSh 45 billion	Indicates that SHA had entered active claims administration and provider payment.
March 2026	Members transitioned	29.8 million	Suggests further system expansion beyond the first year of implementation.
March 2026	Funds collected	KSh 142.8 billion	Demonstrates large-scale financial mobilisation.
March 2026	Claims paid	KSh 109 billion	Represents approximately 76.3 percent of reported collections, showing substantial claims activity but also raising the importance of payment governance and sustainability.

The table shows that the most important early implementation issue was not whether SHA could register people, but whether registration could be converted into assessed, contributing, service-ready and administratively traceable membership. The difference between total registered members and means-tested members is especially important because means testing is central to contribution determination, subsidy targeting, benefit access and the financial credibility of the scheme. Therefore, enrolment figures should not be interpreted as full implementation success unless they are accompanied by evidence of contribution readiness, provider participation, service access and timely claims settlement.

Means testing as the central implementation bottleneck

Means testing emerged as one of the clearest early implementation bottlenecks. Although registration expanded quickly, the proportion of registered members whose contribution capacity had been assessed remained low. On 5 February 2025, only 3.1 million out of 18,988,530 registered persons had been means tested, representing approximately 16.3 percent of registered members. By 12 February 2025, the number of means-tested persons had increased to 3.33 million, but because registration had also increased to more than 19.3 million, the proportion of assessed members was still only about 17.3 percent (Ministry of Health, 2025a, 2025b). This means that more than four out of every five registered members had not yet been fully assessed for contribution purposes during this early period.

The same challenge was reflected in later reporting. By mid-April 2025, SHA registration had reportedly reached 21,390,659 people, but only about 4.3 million had undergone means testing. This represented approximately 20.1 percent of registered members. Although this was an improvement from February 2025, it still showed that nearly 80 percent of registered members had not completed a key administrative step required for contribution determination and full benefit access. The same report noted that fewer than 18,000 individuals had undergone biometric and medical tests, that average contributions were approximately KSh 590 among assessed individuals, and that 3 million out of 12 million NHIF records had been removed as false or unverifiable during data clean-up (Daily Nation, 2025). The data therefore suggest that the reform's early problem was not simply public registration, but the slower conversion of registered persons into financially classified and administratively active members.

This gap matters because SHA's contribution model depends on the ability to determine who should pay, how much they should pay, and who should receive state support. Where means testing lags behind registration, the scheme may appear large in membership terms while remaining incomplete in revenue mobilisation, subsidy targeting and benefit administration. The means-testing gap may also affect service access if members are registered but not fully assessed, or if facilities cannot verify eligibility smoothly during patient encounters. For this reason, means testing should be treated as a central implementation indicator rather than a minor administrative step.

Facility empanelment and early utilization

Facility empanelment was another important marker of early implementation. SHA could not function only as a registration database; it also required contracted and digitally connected providers who could deliver services, verify eligibility, submit claims and receive payments. On 12 February 2025, the Ministry of Health reported that 8,813 out of 17,755 active facilities had enrolled, meaning that approximately 49.6 percent of active facilities were formally onboarded. The Ministry also reported that 89 percent of enrolled facilities were accessing the system. This showed meaningful provider participation during the early phase of implementation and suggested that SHA was beginning to create an operational network through which registered members could seek services (Ministry of Health, 2025a).

However, facility onboarding should be interpreted cautiously. The enrolment of facilities does not automatically mean that all facilities had adequate staff capacity, digital readiness, claims literacy, stable connectivity or confidence in reimbursement processes. A facility may be formally onboarded but still face operational difficulties in patient verification, pre-authorization, claims submission, system downtime or payment follow-up. Therefore, future implementation monitoring should distinguish between facilities that are merely registered, facilities that are actively using the system, facilities that are submitting claims successfully, and facilities that are receiving payments on time.

Early service utilisation was also visible. Since October 2024, more than one million Kenyans had reportedly accessed primary healthcare services under SHA, and by May 2025, 1.2 million people had been served by healthcare providers (Ministry of Health, 2025a, 2025c). These figures are important because they show that SHA was not only a legal or administrative reform but had already begun affecting actual service delivery. Nevertheless, the number of people served remained small relative to the total registered population. If 1.2 million people had received services out of more than 22 million registered members by May 2025, this

represented approximately 5.5 percent of registered members. This does not necessarily indicate poor performance, since not every registered person requires healthcare within a short period, but it shows that utilisation data should be interpreted alongside enrolment, facility readiness and claims settlement data.

Claims Activity and Provider-Payment Implications

Claims processing became increasingly important as SHA expanded. By May 2025, claims worth KSh 45 billion had reportedly been processed, while later reporting in 2026 indicated that KSh 142.8 billion had been collected and KSh 109 billion had been paid in claims (Ministry of Health, 2025c, 2026). The reported claims paid represented approximately 76.3 percent of the amount collected, suggesting substantial financial activity within the new system. This level of claims activity demonstrates that SHA had moved from legal creation to active purchasing and reimbursement.

However, claims volume alone cannot establish implementation success. The quality of claims administration depends on whether claims are verified fairly, paid promptly, audited properly and protected from fraud. High claims activity may signal service use and provider engagement, but it may also increase exposure to fraud, disputed claims, delayed payments and provider dissatisfaction if governance systems are weak. Therefore, claims data should be read alongside evidence on reimbursement timelines, rejected claims, pending claims, fraud investigations, facility suspensions and provider complaints. This is particularly important because provider trust is essential to the continuity of care under SHA. If providers perceive the system as unreliable, delayed or financially risky, patients may face service denial, informal payments or reduced access despite being registered.

County Disparities and Uneven Implementation Capacity

Early implementation evidence also showed geographic disparities in uptake. In February 2025, the Ministry of Health identified Turkana, West Pokot, Garissa and Samburu among counties with low registration. A later Ministry update again identified Turkana, West Pokot and Samburu as counties where uptake remained limited and indicated that outreach would be expanded beyond health service points to improve registration (Ministry of Health, 2025a, 2025b). This pattern suggests that national enrolment figures can conceal uneven county-level implementation. Counties with weaker infrastructure, lower digital access, dispersed populations, limited administrative capacity or lower awareness may lag behind despite the existence of a national legal framework.

This county-level variation is important because UHC reform is ultimately judged by whether it reduces, rather than reproduces, inequity. If counties with historically weaker access to health services also record lower registration, weaker digital readiness or poorer provider participation, SHA may risk deepening existing inequalities unless corrective measures are taken. County-specific outreach, assisted registration, community health promoter engagement, mobile registration drives, local-language communication and real-time county dashboards are therefore necessary to ensure that enrolment is not concentrated in better-connected areas only.

County disparities also raise questions about service-delivery readiness. A county may record formal registration growth, but if facilities are not adequately connected to the digital system, if patients do not understand benefit pathways, or if providers struggle with claims submission, the practical value of registration remains limited. For this reason, county-level monitoring should include not only the number of people registered but also the proportion means tested, facilities onboarded, facilities actively using the system, claims submitted, claims paid, service utilisation and patient complaints.

Interpreting Early Implementation Progress

The early implementation record presents a mixed picture. On the positive side, SHA achieved rapid registration growth, visible provider onboarding, early primary healthcare utilisation and large-scale claims processing within a short period. These achievements show strong political commitment and administrative mobilisation. They also demonstrate that the reform had moved beyond legal design into practical implementation.

At the same time, the evidence shows that enrolment momentum was stronger than implementation depth. Means testing remained far behind registration, facility onboarding did not necessarily guarantee full digital and claims

readiness, county uptake was uneven, and claims activity created new demands for payment discipline, fraud control and provider accountability. The reform's early experience therefore suggests that legal redesign and mass registration are necessary but insufficient indicators of success.

The evidence also allows a clearer distinction between operational bottlenecks and structural design concerns. Operational bottlenecks include delays in means testing, incomplete profile updates, provider onboarding challenges, system-use difficulties, reimbursement delays, public understanding gaps and county-specific registration weaknesses. These can be addressed through better administration, training, outreach, technical support and faster claims management. Structural design concerns include the long-term sustainability of the contribution model, governance of the digital infrastructure, clarity of benefit packages, provider-payment arrangements, fraud-control architecture, purchasing accountability and the alignment of health financing reform with workforce preparation. These require deeper policy attention because they affect the credibility and sustainability of SHA beyond the first phase of rollout.

Overall, the early implementation evidence indicates that SHA should not be evaluated only by how many people have registered. A stronger assessment should examine whether registered members have been means tested, whether facilities are actively and effectively using the system, whether claims are paid on time, whether counties are progressing equitably, whether fraud is controlled, and whether health workers and training institutions are prepared for the operational demands of the new model. This interpretation directly supports the central argument of the paper: SHA is not only a financing reform but also a governance, service-delivery, digital systems and workforce-preparedness reform.

Institutional Capacities and Training Response

Workforce Readiness under the SHA Transition

One of the clearest early lessons from Kenya's Social Health Authority transition is that health financing reform quickly becomes a workforce-capacity issue. SHA does not only require citizens to register and facilities to be empanelled; it also requires health workers, facility managers, claims officers, health records personnel, administrators, human resource officers and county health teams to understand and operate a new financing and digital administration model. The daily functioning of the reform depends on whether frontline and administrative staff can interpret benefit packages, guide patients, verify eligibility, support registration, process referrals, use provider portals, document services accurately, submit claims correctly and maintain continuity of care during system disruptions.

This means that SHA has expanded the meaning of health workforce preparedness. In the previous insurance environment, many health workers could treat insurance administration as a separate back-office function. Under SHA, however, the boundaries between clinical care, digital documentation, patient guidance, claims administration and provider payment have become closer. A nurse, clinical officer, doctor, health records officer or facility administrator may now interact with the financing system directly or indirectly during service delivery. Therefore, weaknesses in workforce readiness may translate into delayed care, poor patient guidance, inaccurate claims, service denial, reimbursement disputes or loss of public trust.

This concern is consistent with broader evidence on Kenya's health labour market. Okoroafor et al. (2022) show that Kenya's workforce challenge is not only about the number of health workers, but also about the composition, distribution, training alignment and ability of the system to deploy workers according to population health needs. In the SHA era, this alignment question has become more urgent because the reform introduces new competencies that are not purely clinical. Health workers now need practical knowledge of social health insurance, digital health systems, referral documentation, claims workflows, health data ethics and patient communication within a publicly financed service-delivery framework.

The policy environment also recognises this need for alignment. In February 2026, the Ministry of Health and the Ministry of Education established a joint task force to align health training programmes with national health needs, including universal health coverage reforms and digital transformation in the health sector (Ministry of Health, 2026a). This development is significant because it confirms that training institutions are no longer

peripheral to health reform implementation. They are part of the reform infrastructure because they shape the knowledge, skills and professional attitudes of the workforce that must implement SHA at facility and community levels.

Training, Transition Support and Institutional Preparedness

Early SHA implementation also shows that institutional preparedness depends on practical training and transition support. In September 2024, the Ministry of Health announced a master trainer programme for the Health Provider Portal as part of the transition from NHIF to SHA. The programme was intended to prepare trainers who would support facility-level rollout of the provider portal, improve readiness in health management information systems and assist registration processes (Ministry of Health, 2024a). This initiative is important because it demonstrates that the reform cannot operate through legislation and digital platforms alone. It requires people who understand the system well enough to train others, troubleshoot implementation problems and translate policy rules into daily practice.

A similar logic is visible in the training of human resource professionals. In October 2024, the Ministry of Health reported that more than 500 human resource officers from state agencies, higher education institutions, commissions and independent offices had been trained on the SHA employer portal and encouraged to undertake internal sensitisation of employees (Ministry of Health, 2024b). This shows that SHA implementation extends beyond hospitals and clinics. Employers, universities, public institutions and administrative departments also require literacy on the system because they are involved in staff registration, contribution processes, record management and communication of benefits.

These examples suggest that SHA implementation depends on cascading institutional literacy. National-level training is useful only if it is translated into facility-level routines, employer-level compliance, patient-facing communication and continuous technical support. Training institutions can support this process by producing graduates who already understand health financing, digital systems and administrative workflows before they enter practice. They can also support in-service staff through short courses, refresher programmes and continuing professional development modules designed around SHA's operational requirements.

Curriculum Adaptation and the Role of KMTC

The response of the Kenya Medical Training College illustrates how training institutions can adapt to SHA's implementation needs. In February 2025, KMTC was reported to have introduced a Medical Insurance course to support SHA implementation, with emphasis on competencies such as pre-authorization, claims management and service efficiency under the new health financing system (Citizen Digital, 2025). Although this development should ideally be supported by an official institutional source in the final manuscript, it remains a useful example of how training institutions can respond to emerging reform demands.

The curriculum implication is broader than one course. SHA has created competency needs that cut across clinical practice, health administration, health records, public health, health informatics, finance and governance. Future health workers should not only know how to diagnose and treat patients; they should also understand how patients move through an insurance-supported system, how eligibility is verified, how referral pathways are documented, how claims are generated, how pre-authorization works, how fraud risks arise and how digital health data should be handled ethically. These competencies are no longer optional because they influence whether patients can access services smoothly and whether facilities can be reimbursed accurately.

Training institutions should therefore mainstream SHA-related content into relevant programmes rather than treating medical insurance as a narrow administrative specialisation. Programmes in nursing, clinical medicine, medicine, public health, health records, health systems management, health informatics and community health should include structured content on social health insurance, benefit interpretation, claims documentation, provider payment models, digital health platforms, patient rights, reimbursement ethics and fraud prevention. This would help ensure that graduates enter the health system with a practical understanding of how financing reforms affect service delivery.

Student Preparedness, eHealth Literacy and Public Understanding

Empirical evidence suggests that readiness gaps already exist among future health workers. Aldousari et al. (2025) found that among 207 undergraduate healthcare students drawn from 21 institutions in Kenya, only 21.7 percent had adequate knowledge of SHA/SHIF, while 54 percent demonstrated high eHealth literacy. The same study indicated that students with higher eHealth literacy were more likely to understand the new health financing system. This finding is important because SHA is both a financing reform and a digital administration reform. A student may understand clinical care but still be unprepared to function in a system that depends on digital eligibility verification, electronic claims, provider portals and data-driven service monitoring.

This evidence raises a serious workforce-preparedness concern. If a large proportion of future health professionals lack adequate knowledge of the country's main health financing model, the reform may face operational difficulties even after registration numbers increase. Patients often ask health workers to explain eligibility, benefits, referrals and payment expectations. Where health workers lack SHA literacy, they may give incomplete information, refer patients incorrectly, delay documentation or fail to support patients in navigating the system. Training institutions must therefore treat SHA literacy as part of professional competence.

Public understanding also remains uneven. A 2025 GeoPoll survey found that awareness of SHA/SHIF was high, but detailed understanding was weaker, with respondents reporting different levels of knowledge and relying heavily on television, social media, radio, government websites, word of mouth and healthcare providers for information (GeoPoll, 2025). This finding reinforces the role of training institutions and health workers as communication bridges. If the public depends partly on providers for information, then provider knowledge becomes a determinant of public trust and service utilisation. Training institutions should therefore prepare health workers not only to use the system but also to communicate it clearly to patients and communities.

Training Institutions as Implementation Partners

The SHA reform requires training institutions to move beyond their traditional role of producing graduates and become active implementation partners. Universities, medical colleges and professional training bodies can contribute in at least three ways. First, they can revise curricula so that SHA-related competencies are embedded in pre-service education. Second, they can provide continuing professional development for staff already working in facilities, counties and employer institutions. Third, they can generate implementation evidence through research on workforce readiness, county-level bottlenecks, patient experience, provider payment, digital literacy, claims management and fraud prevention.

This role is particularly important because SHA is still evolving. Implementation problems will continue to emerge as enrolment expands, utilisation rises and claims activity increases. Training institutions are well placed to document these changes, evaluate capacity gaps and provide feedback to policymakers. They can also support county governments and facilities by designing targeted short courses for claims officers, health records officers, facility managers, nurses, clinical officers, community health promoters and county health administrators. In this sense, training institutions should be treated as part of the corrective learning system of SHA implementation.

The central lesson is that SHA cannot succeed through financing design alone. Its success depends on whether the health workforce can operate the reform competently and ethically. Legal frameworks, contribution models and digital portals may create the structure of reform, but people implement the reform. Training institutions therefore stand at the centre of SHA's long-term sustainability because they determine whether Kenya's health workforce will be prepared for the technical, administrative, digital and ethical demands of universal health coverage.

Governance and Accountability Challenges

Procurement and Digital System Ownership Concerns

Governance and accountability have become major concerns in the early implementation of SHA. Because SHA relies heavily on digital registration, eligibility verification, provider portals, claims processing and data

management, the ownership and control of the digital infrastructure supporting the system are central to public trust. In March 2025, media reports citing Auditor General findings indicated that the government had invested KSh 104.8 billion in the SHA system while questions remained about state ownership and control of the platform. Citizen Digital reported that the system, its components and intellectual property were linked to a consortium arrangement, raising concerns about accountability, control and long-term governance of the reform's core digital infrastructure (Citizen Digital, 2025a).

Although these concerns require confirmation through official audit and oversight documents, they are analytically important because a health financing reform that depends on digital infrastructure must have clear rules on system ownership, data control, procurement accountability, cybersecurity, interoperability, dispute resolution and public oversight. If the state has limited control over the system that processes registration, claims and health financing data, the reform may face risks related to accountability, continuity, cost escalation and public trust.

The procurement concerns reported by Citizen Digital and The Star also point to broader governance questions about how large health-system technologies are acquired and financed. The reports suggested that the procurement arrangement had raised questions about competition, long-term deductions from member contributions and facility claims, and the relationship between public health financing and private technology control (Citizen Digital, 2025a; The Star, 2025a). These concerns do not by themselves prove wrongdoing, but they indicate the need for stronger transparency. For SHA to maintain legitimacy, the government should make procurement arrangements, ownership structures, data governance rules and audit findings clear to the public.

Fraud Risks, Facility Suspensions and Claims Integrity

Fraud risk is another major governance issue in SHA implementation. Health insurance systems are vulnerable to false claims, inflated billing, ghost patients, unnecessary procedures, collusion between providers and beneficiaries, and misclassification of services. As SHA expands in membership, facility participation and claims volume, these risks also increase. This makes claims integrity central to the reform's financial sustainability and credibility.

In April 2026, Daily Nation reported that 12 hospitals had been shut down over alleged SHA-related fraud and that many more facilities were either under investigation, forensic audit or review by investigative agencies. The report also identified several counties as hotspots of concern and suggested that the issue had moved beyond isolated administrative errors into a broader claims-governance challenge (Chelangat, 2026). While these cases should be understood as reported investigations unless confirmed through official enforcement outcomes, audit reports or court processes, they show why fraud prevention must be treated as a central part of SHA implementation rather than a secondary administrative function.

Fraud has several consequences for health service delivery. First, it threatens financial sustainability because funds meant for legitimate patient care may be diverted through false or inflated claims. Second, it can interrupt care if facilities are suspended, claims are frozen or patients are redirected during investigations. Third, it weakens public confidence because citizens may become reluctant to contribute to a scheme perceived as vulnerable to abuse. Fourth, it may create tension between providers and SHA if fraud-control mechanisms are implemented in a way that delays legitimate reimbursement. Therefore, anti-fraud systems must be strong, fair and transparent.

A credible fraud-control framework should include digital claims tracking, identity verification, facility audits, clinical review, risk-based claims monitoring, provider sanctions, whistle-blower channels and public reporting on enforcement actions. At the same time, fraud control should not become a blanket justification for delaying legitimate claims or denying patients care. The governance challenge is to protect the fund while also protecting service continuity and the rights of patients.

Reimbursement Strain and Provider Confidence

Provider reimbursement has also emerged as a sensitive implementation issue. SHA depends on provider participation, and providers are more likely to participate consistently when payment rules are clear, claims are processed fairly and reimbursements are made within predictable timelines. If providers experience delayed payments, unclear tariffs, frequent claim rejections or system difficulties, they may lose confidence in the scheme. This can directly affect patients because service delivery happens at facility level.

In February 2025, KBC Digital reported that the Rural and Urban Private Hospitals Association of Kenya had threatened to suspend SHA services, citing concerns that included unpaid NHIF arrears, outpatient reimbursement challenges, system failures and delayed payments. The same report cited provider-reported figures indicating that some facilities had experienced payment delays, portal failures and difficulties with patient eligibility checks (KBC Digital, 2025). These figures should be interpreted as provider-reported concerns rather than independently audited national indicators. Even so, they are important because they show how providers were experiencing the reform during early implementation.

Provider confidence is not only a financial matter; it is also a service-delivery matter. When providers doubt whether they will be paid, patients may face delays, restrictions, denial of care or pressure to pay out of pocket. This can undermine the purpose of universal health coverage. Therefore, SHA's credibility depends on a provider-payment system that is transparent, timely and supported by effective communication. Providers need to know what services are covered, what tariffs apply, how claims should be submitted, why claims are rejected, and when approved claims will be paid.

The government and SHA should therefore consider regular public reporting on claims performance. Useful indicators would include the number of claims submitted, approved, rejected, pending and paid; average payment time; value of arrears; reasons for rejection; and facility-level payment status. Such reporting would help reduce uncertainty, strengthen provider confidence and allow the public to distinguish between genuine claims review, fraud investigation and administrative delay.

Digital System Downtime and Continuity of Care

Digital systems are central to SHA because they support registration, eligibility verification, facility empanelment, claims submission, data exchange and monitoring. However, digital dependence also creates implementation risk. When systems fail, patients may be unable to confirm eligibility, providers may be unable to submit or verify claims, and facilities may delay or deny care. Digital reliability is therefore not merely a technical concern; it is directly linked to continuity of care.

In March 2026, the Ministry of Health publicly warned health facilities against denying patients care because of SHA system downtime and directed contracted providers to continue offering services despite technical challenges (Ministry of Health, 2026b). This official communication is important because it confirms that system downtime had become serious enough to require national-level intervention. It also shows that digital failures can move quickly from back-office inconvenience to frontline service-delivery risk.

The implication is that SHA requires contingency arrangements for digital disruption. Facilities should have clear protocols for continuing services when the system is down, including temporary verification procedures, manual fallback documentation, delayed claim submission rules and helpdesk escalation channels. Without such arrangements, patients may be disadvantaged by technical failures beyond their control. Training institutions and continuing professional development programmes should also include system-downtime procedures so that health workers know how to protect service continuity while maintaining proper documentation.

Accountability, Transparency and Public Trust

The governance challenges discussed above point to a broader issue: SHA's long-term success depends on public trust. Citizens are more likely to register, contribute and use the system if they believe that funds are managed

transparently, providers are paid fairly, fraud is punished, digital systems are reliable, and benefits are communicated clearly. Conversely, trust may decline where the public hears repeated reports of procurement controversy, system ownership questions, fraud allegations, reimbursement disputes and service denial.

Public trust requires more than official reassurance. It requires visible accountability mechanisms. SHA should regularly publish implementation data, claims performance reports, audit summaries, fraud-control actions, facility payment updates, system downtime reports and county-level performance indicators. Public reporting would make it easier for citizens, providers, counties, researchers and training institutions to assess whether the reform is improving or facing persistent risks. It would also reduce dependence on fragmented media reports as the main source of implementation information.

Transparency is especially important because SHA is still in its early phase. Early implementation challenges are not unusual in large health reforms, but they can become politically and institutionally damaging if they are not acknowledged and corrected. A transparent learning approach would allow government and implementing agencies to distinguish between temporary rollout problems and deeper structural weaknesses. It would also create space for training institutions, researchers and professional bodies to support reform improvement through evidence, capacity-building and implementation feedback.

Governance Lessons for Training Institutions

Governance and accountability challenges also have implications for training institutions. If SHA requires stronger claims integrity, fraud detection, digital accountability and patient protection, these topics must be reflected in health-sector training. Training institutions should prepare students and in-service workers to understand not only how to use SHA systems but also how to uphold ethical and accountable practice within them. This includes training on accurate documentation, claims ethics, patient confidentiality, health data governance, conflict of interest, fraud prevention, referral integrity and responsible use of digital health platforms.

This is particularly important because governance failures are often experienced at the facility level. A fraudulent claim, inaccurate record, poor eligibility explanation or mishandled digital process may begin as a small administrative act but can have serious consequences for the patient, provider and financing system. Therefore, accountability should not be taught only as a policy topic. It should be embedded into the practical training of clinicians, health records officers, health administrators, claims officers, facility managers and community health workers.

The governance lesson from early SHA implementation is that universal health coverage depends on trust as much as it depends on financing. Trust is built when systems are transparent, providers are paid fairly, patients are protected, fraud is addressed, and health workers understand their ethical obligations. Training institutions have a direct role in building this trust because they prepare the people who will operate the reform in everyday practice.

Early Lessons and Implications for Training Institutions

SHA Implementation Is Exposing a Skills and Systems Gap

The early implementation of SHA shows that the reform is not only a financing issue but also a skills, systems and institutional-readiness issue. Kenya has made visible progress in registration, facility onboarding, claims processing and public mobilisation, but the same process has exposed gaps in means testing, claims administration, digital system use, provider reimbursement, fraud control, county-level outreach and public understanding. These gaps are not abstract policy problems. They are experienced in health facilities, county systems, employer institutions, training institutions and patient-provider interactions.

This means that the success of SHA will depend partly on whether the health workforce has the competencies required to operate within the new model. Health workers and administrators need to understand benefit packages, referral rules, eligibility verification, pre-authorization, claims documentation, patient

communication, digital health systems, data protection and fraud prevention. Without these competencies, patients may remain registered in the system but still face confusion, delays, denial of care or unnecessary out-of-pocket payments. Therefore, training institutions should be treated as part of the implementation infrastructure rather than as distant education providers.

The evidence on student preparedness makes this concern more urgent. Aldousari et al. (2025) found that only 21.7 percent of surveyed undergraduate healthcare students had adequate knowledge of SHA/SHIF, while 54 percent demonstrated high eHealth literacy. This suggests that many future health workers may enter practice without sufficient knowledge of the financing and digital systems that now shape service delivery. If this gap is not addressed, SHA may continue to face implementation problems even after enrolment expands.

Curriculum Implications for Training Institutions

Training institutions should revise curricula to reflect the operational demands of SHA. Health financing should no longer be treated as a distant policy topic that only concerns managers or accountants. It should be integrated into the practical training of students in medicine, nursing, clinical medicine, public health, health records, health informatics, community health, health administration and health systems management. This is necessary because SHA affects how patients enter the system, how services are documented, how referrals are made, how claims are processed and how facilities are reimbursed.

A practical curriculum response should include social health insurance design, SHA benefit interpretation, means testing, contribution categories, patient eligibility verification, pre-authorization, claims documentation, provider payment models, referral pathways, fraud prevention, health data governance, digital health platforms and patient communication. These topics should not be taught only theoretically. Students should be exposed to case studies, simulations, claims forms, provider portal demonstrations, patient scenarios and facility-level workflow exercises. This would help graduates understand how policy rules affect patient care in real settings.

The reported introduction of a medical insurance course by KMTC provides an example of how training institutions can respond to reform needs (Citizen Digital, 2025). However, the response should not be limited to one course or one institution. The competencies required by SHA cut across the health sector and should be mainstreamed across relevant programmes. Training institutions should also work with regulatory bodies, professional councils and the Ministry of Health to ensure that SHA-related competencies are reflected in curriculum standards, practicum requirements and professional assessment frameworks.

Continuing Professional Development and Transitional Training

Pre-service education alone will not be sufficient because many workers currently implementing SHA were trained before the reform was introduced. This makes continuing professional development essential. Facility managers, health records officers, claims officers, nurses, clinical officers, doctors, HR officers, community health promoters, county health administrators and finance officers require targeted in-service training on SHA processes. The Ministry of Health’s master trainer programme and training of HR professionals show that transitional training has already been recognised as necessary (Ministry of Health, 2024a, 2024b).

Continuing professional development should be short, practical and directly tied to implementation gaps. Priority modules should include provider portal use, eligibility verification, claims submission, pre-authorization procedures, tariff interpretation, data quality, fraud risk detection, patient guidance, system downtime procedures and service continuity planning. Such training should also include ethical issues, especially accurate documentation, patient confidentiality, conflict of interest, false claims, and responsible handling of health financing data.

The CPD approach should be decentralised so that county governments, training institutions and professional bodies can support facilities based on local needs. Counties with low registration, weak digital readiness or frequent provider-payment concerns may require more intensive support. This would make training responsive to actual implementation conditions rather than generic national messaging. Training institutions can support

this by developing modular short courses that are accessible to working professionals through blended learning, weekend sessions, online platforms and facility-based workshops.

Training Institutions as Implementation Research Partners

Training institutions should also become research and feedback partners in SHA implementation. SHA is still being assessed largely through official statistics, media reports and early administrative updates. Universities, medical colleges and research institutes can help fill this gap by generating primary and county-level evidence on how the reform is working in practice.

Training institutions can conduct studies on student SHA literacy, eHealth literacy, provider claims readiness, patient understanding, county registration barriers, system downtime, reimbursement delays, facility-level claims rejection, fraud prevention capacity and patient experience. Such studies would help move the debate beyond national enrolment figures and provide evidence on where implementation is working and where correction is needed. This would also strengthen the link between training, research and policy improvement.

The 2026 joint task force between the Ministry of Health and the Ministry of Education provides an important opportunity to formalise this role (Ministry of Health, 2026a). If sustained, this collaboration can help align health training programmes with national reform priorities while also creating a feedback system through which training institutions support evidence-based adjustment of SHA. In that sense, training institutions should not only produce workers for SHA; they should also help the country learn how to implement SHA better.

Practical Lessons for Training Institutions

The early lessons from SHA point to five practical responsibilities for training institutions. First, they should integrate SHA-related competencies into pre-service curricula across clinical, public health, records, informatics and administration programmes. Second, they should provide continuing professional development for health workers and administrators already working under the new system. Third, they should support county governments and facilities through targeted training on claims, digital systems and patient communication. Fourth, they should embed ethics, accountability and fraud prevention into training because governance failures can weaken the credibility of the reform. Fifth, they should conduct implementation research that provides real-time evidence on workforce readiness, service-delivery bottlenecks and patient experience.

These responsibilities show why training institutions are central to the sustainability of SHA. Legal reform can create a new financing framework, but implementation depends on people who understand and apply that framework correctly. If training institutions adapt, they can help reduce confusion, strengthen provider readiness, improve patient guidance and support accountable service delivery. If they remain disconnected from the reform, Kenya may continue to experience a gap between policy ambition and operational practice.

RECOMMENDATIONS

The recommendations below are drawn from the main implementation lessons identified in this review.

Strengthen Governance, Digital Ownership and Public Accountability

The Ministry of Health, SHA and relevant oversight institutions should strengthen governance around procurement, digital system ownership, data control, claims integrity and public reporting. The early controversy around the ownership and control of SHA's digital infrastructure shows that digital governance is not a minor technical issue; it is central to the credibility of the reform. The government should therefore publish clear information on system ownership, procurement arrangements, data governance safeguards, cybersecurity responsibilities and dispute-resolution mechanisms.

SHA should also institutionalise regular public reporting on claims audits, provider sanctions, fraud investigations, system performance and corrective actions. Such reporting would help reduce speculation, strengthen public confidence and allow citizens and providers to see whether accountability mechanisms are

working. Public reporting should be written in accessible language and made available through official government platforms rather than relying on scattered media updates.

Stabilise Provider Payment and Introduce Claims Dashboards

SHA should stabilise provider reimbursement by making claims processing more predictable, transparent and measurable. Provider confidence is essential because patients experience SHA through facilities. If facilities are not paid on time or do not understand the rules of reimbursement, they may delay services, deny care or request direct payment from patients. This would undermine the financial protection objective of universal health coverage.

A practical step would be the introduction of a public or provider-facing claims dashboard. The dashboard should show the number and value of claims submitted, approved, rejected, pending and paid. It should also show average payment time, reasons for rejection, arrears by period, and facility-level payment status where appropriate. This would help distinguish between legitimate claims review, fraud-control measures and administrative delays. It would also give providers clearer expectations and reduce mistrust.

Close the Gap between Registration, Means Testing and Contribution Readiness

SHA should shift from emphasising registration numbers alone to tracking the quality and completeness of enrolment. Registration is important, but it does not automatically create contribution readiness, subsidy targeting or full benefit access. The large gap between registered members and means-tested members shows that the reform needs stronger administrative systems for assessing household contribution capacity.

The government should accelerate means testing through assisted registration, mobile outreach, community health promoters, local administration structures and digital support desks. Priority should be given to informal-sector households, rural communities, low-uptake counties and groups with limited digital access. SHA should also publish periodic statistics showing registered members, means-tested members, active contributors, subsidised households and members who have accessed services. This would provide a more accurate picture of implementation depth.

Strengthen County-Level Reporting and Equity Monitoring

SHA implementation should be monitored at county level because national totals can hide regional disparities. Counties such as Turkana, West Pokot, Garissa and Samburu were identified in the early rollout as areas with lower uptake. This suggests that implementation challenges may be more severe in counties with weaker infrastructure, dispersed populations, lower digital access or limited administrative capacity.

SHA and the Ministry of Health should therefore introduce county-level reporting dashboards. These should track registration, means testing, active contribution, facility onboarding, facility system use, claims submitted, claims paid, service utilisation, complaints and outreach activities by county. County dashboards would help identify areas needing targeted support and would prevent the reform from being judged only through national averages. Equity monitoring should also include vulnerable groups, informal-sector workers, rural households, persons with disabilities and communities in marginalised counties.

Reposition Training Institutions as Core Reform Partners

Training institutions should be formally recognised as implementation partners in SHA. The Ministry of Health, Ministry of Education, regulatory bodies, professional councils and training institutions should work together to integrate SHA-related competencies into health training curricula. These competencies should include social health insurance, claims administration, patient eligibility verification, provider payment, pre-authorization, referral documentation, digital health systems, health data governance, fraud prevention and patient communication.

This recommendation should not be limited to pre-service education. Training institutions should also provide continuing professional development for current health workers and administrators. Short courses should target

facility managers, claims officers, HR officers, health records officers, nurses, clinical officers, doctors, community health promoters and county health officials. This would help bridge the gap between policy design and daily implementation.

Build an Implementation Research and Learning Agenda

Kenya should establish a structured implementation research agenda for SHA. The reform is still evolving, and many early lessons are based on administrative data, media reports and stakeholder experiences. More facility-level, county-level and training-institution-level evidence is needed to validate these early findings and guide improvement.

Universities, medical training colleges, research institutions, counties and the Ministry of Health should collaborate on studies examining means testing, provider payment, claims rejection, patient experience, system downtime, fraud prevention, county disparities, student preparedness and health worker readiness. Findings from these studies should be used to revise policies, improve training, strengthen dashboards and correct implementation bottlenecks. This would move SHA from reactive crisis management toward evidence-based learning and continuous improvement.

CONCLUSION

Kenya's Social Health Authority reform represents one of the most ambitious attempts in the country's recent history to align health financing, primary health care, provider payment, digital administration and universal health coverage within one national framework. The early implementation record shows clear momentum. Registration expanded rapidly, facilities were onboarded, primary healthcare services were accessed, claims were processed, and later reports indicated that 29.8 million Kenyans had been transitioned, KSh 142.8 billion had been collected, and KSh 109 billion had been paid in claims. These figures show that SHA has moved beyond policy intention and has become a large national health financing and service-delivery platform.

However, the evidence reviewed in this paper shows that enrolment alone is not a sufficient measure of success. The reform continues to face gaps in means testing, contribution readiness, provider reimbursement, digital system reliability, fraud control, county-level equity, public understanding and workforce preparedness. These challenges show that SHA is legally significant and administratively ambitious, but still operationally fragile. The central implementation task is therefore to convert registration into meaningful access, predictable financing, accountable claims management, timely provider payment and reliable service delivery.

The paper has argued that SHA should not be understood only as a financing reform. It is also a governance reform, a digital systems reform, a service-delivery reform and a workforce-preparedness reform. Its success will depend on whether the country can strengthen accountability, stabilise claims and provider payment, close the gap between registration and means testing, monitor county disparities, and prepare health workers for the practical demands of the new system. Training institutions are central to this process because they shape the competencies, ethics and digital readiness of the workforce that will implement SHA in everyday practice.

The early lesson is therefore clear. Kenya's progress toward universal health coverage will not be secured by legal redesign or mass registration alone. It will depend on the alignment of policy ambition with institutional capacity, transparent governance, reliable digital infrastructure, service-delivery readiness and workforce preparation. If these elements are strengthened, SHA can become a credible pathway toward universal health coverage. If they remain weak, the reform may reproduce the same implementation gaps that constrained earlier health financing reforms.

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Ethics Approval

This article did not involve primary data collection from human participants, patients, health workers, students or health facilities. It was based on publicly available literature, legal documents, policy reports, government implementation updates and published sources. Therefore, institutional ethics approval was not required.

Data and Materials

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